

**TENTATIVE GENERAL SCHEDULE
NCOIL SPRING MEETING
MARCH 14 - 17, 2019**

As of February 15, 2019, and Subject to Change

**The Sheraton Grand Nashville Downtown
Nashville, Tennessee**



NCOIL SPRING MEETING

Nashville, Tennessee

March 14 - 17, 2019

TENTATIVE SCHEDULE

THURSDAY, MARCH 14TH

CIP Member & Sponsor Reception	6:30 p.m.	-	7:30 p.m.
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FRIDAY, MARCH 15TH

Registration	7:00 a.m.	-	6:00 p.m.
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Exhibits Open: 8:30 a.m. – 6:15 p.m.

Welcome Breakfast	8:15 a.m.	-	9:30 a.m.
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Networking Break	9:30 a.m.	-	9:45 a.m.
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General Session	9:45 a.m.	-	11:15 a.m.
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Assignment of Benefits (AOB) Clauses:
A Tool for Abuse or a Benefit to Homeowners?

Joint State – Federal Relations and International Insurance Issues Committee	11:15 a.m.	-	12:15 p.m.
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The Institutes Griffith Foundation Legislator Luncheon	12:15 p.m.	-	1:15 p.m.
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Mega-Trends in Insurance: The Long View

Health Insurance and Long Term Care Issues Committee	1:15 p.m.	-	3:00 p.m.
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Networking Break	3:00 p.m.	-	3:15 p.m.
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Financial Services Committee	3:15 p.m.	-	4:15 p.m.
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NCOIL – NAIC Dialogue	4:15 p.m.	-	5:15 p.m.
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Special Committee on Natural Disaster Recovery	5:15 p.m.	-	6:15 p.m.
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Adjournment	6:15 p.m.		
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Reception	6:15 p.m.	-	7:15 p.m.
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SATURDAY, MARCH 16TH

Registration <i>Exhibits Open: 8:30 a.m. – 2:00 p.m.</i>	8:00 a.m.	-	2:00 p.m.
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IEC Board Meeting	8:15 a.m.	-	9:00 a.m.
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Life Insurance & Financial Planning Committee	9:00 a.m.	-	10:00 a.m.
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Networking Break	10:00 a.m.	-	10:15 a.m.
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General Session Business Interruption Coverage: Are Businesses <i>Really</i> Covered?	10:15 a.m.	-	11:30 a.m.
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Legislative Micro Meetings	11:30 a.m.	-	12:00 p.m.
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Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.
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Workers' Compensation Insurance Committee	1:30 p.m.	-	2:30 p.m.
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Articles of Organization & Bylaws Revision Committee	2:30 p.m.	-	2:50 p.m.
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Adjournment	2:50 p.m.		
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Tour of Tennessee State Capitol	3:30 p.m.		
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SUNDAY, MARCH 17TH

Registration <i>Exhibits Open: 8:30 a.m. – 10:30 a.m.</i>	8:00 a.m.	-	9:00 a.m.
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Property & Casualty Insurance Committee	9:00 a.m.	-	10:45 a.m.
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Networking Break	10:45 a.m.	-	11:00 a.m.
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Business Planning Committee and Executive
Committee

11:00 a.m. - 12:00 p.m.

Adjournment

12:00 p.m.



*****Please Note all speakers listed are scheduled to speak as of Feb. 13, 2019. There may be modifications between now and the start of the Meeting****

THURSDAY, MARCH 14TH, 2019

CIP Member & Sponsor Reception

March 14, 2019

6:30 p.m. – 7:30 p.m.

FRIDAY, MARCH 15TH, 2019

Welcome Breakfast

Friday, March 15, 2019

8:15 a.m. – 9:30 a.m.

1. Welcome to Nashville
2. Keynote Address
3. **Senator Dan “Blade” Morrish (LA) – NCOIL President**
 - a.) President’s Welcome
 - b.) New Member Welcome and Introduction
4. Any Other Business
5. Adjournment

Networking Break

Friday, March 15, 2019

9:30 a.m. – 9:45 a.m.

General Session

Assignment of Benefits (AOB) Clauses: A Tool for Abuse or a Benefit to Homeowners?

Friday, March 15, 2019

9:45 a.m. – 11:15 a.m.

*Christine Turner Ashburn
Chief of Comm., Legislative & External Affairs
Citizens Property Insurance Corp. of Florida*

*James Lynch, FCAS MAAA
Chief Actuary–VP of Research and Education
Insurance Information Institute (III)*

Greg Raab
President
Nat'l Assoc. of Insurance Adjusters (NAPIA)

Richie Kidwell
President
Restoration Assoc. of Florida (RAF)

Joint State-Federal Relations and International Insurance Issues Committee

Friday, March 15, 2019

11:15 a.m. – 12:15 p.m.

Chair: Sen. Jerry Klein (ND)

Vice Chair: Sen. Roger Picard (RI)

1. Call to Order/Roll Call/Approval of December 7, 2018 Committee Meeting Minutes
2. Continued Discussion on Development of NCOIL Insurance Business Transfer (IBT) Model Law
Asm. Andrew Garbarino (NY)
Rep. Lewis Moore (OK)
The Hon. Beth Dwyer, Supt. of Insurance, RI Dep't of Business Regulation
Buddy Combs, Oklahoma Deputy Commissioner of Insurance Business Transfers
Doug Wheeler, Senior Vice President – Gov't Affairs, New York Life
Amy Lazzaro, VP – Regulatory Affairs, Cigna State Gov't Affairs
Robert Redpath, Senior Vice President & US Legal Director, Enstar
3. Discussion on Proposed Amendments to NCOIL Market Conduct Surveillance Model Law
Paul Martin, Regional VP – Southwestern Region, NAMIC
4. Interstate Insurance Product Regulation Commission (IIPRC) Update
Karen Schutter, Executive Director, Interstate Insurance Product Regulation
Commissioner (IIPRC)
5. Any Other Business
6. Adjournment

The Institutes Griffith Foundation Legislator Luncheon

Friday, March 15, 2019

12:15 p.m. – 1:15 p.m.

Mega-Trends in Insurance: The Long View

Christopher McDaniel, President, The Institute's RiskBlock Alliance

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

Health Insurance and Long Term Care Issues Committee

Friday, March 15, 2019

1:15 p.m. – 3:00 p.m.

Chair: Asw. Pam Hunter (NY)

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

1. Call to Order/Roll Call/Approval of December 8, 2018 Committee Meeting Minutes
2. Discussion on Pharmaceutical Value-Based Contracting
Rachel Licata, VP of Policy & Research, PhRMA
3. Continued Discussion on Draft NCOIL Model Law on Drug Pricing Transparency
Rep. Tom Oliverson, M.D. (TX)
Sen. Dan "Blade" Morrish (LA) – NCOIL President
Alex Jung, Partner/Managing Director, EY-Parthenon
Saiza Elyada, Director – State Policy – PhRMA
Josh Keepes, Regional Director – State Affairs, AHIP
Melodie Shrader, Senior Director – State Affairs, PCMA
Derek Oestreicher, Attorney for the Office of the Montana State Auditor, Commissioner of Securities and Insurance
4. Discussion on Potential Model Law on Short Term Limited Duration (STLD) Plans
5. Discussion/Consideration of Resolution in Support of Amending ERISA to Enable State Policymakers to Enact More Meaningful State Healthcare Reforms
Asm. Kevin Cahill (NY) – NCOIL Secretary
Rep. Jim Dunnigan (UT)
6. Any Other Business
7. Adjournment

Networking Break

Friday, March 15, 2019

3:00 p.m. – 3:15 p.m.

Financial Services Committee

Friday, March 15, 2019

3:15 p.m. – 4:15 p.m.

Chair: Sen. Bob Hackett (OH)

Vice Chair: Rep. Bart Rowland (KY)

1. Call to Order/Roll Call/Approval of December 6, 2018 Committee Meeting Minutes
2. Discussion on the Impact of Blockchain in the Insurance and Financial Services Industries
Christopher McDaniel, President, The Institute's RiskBlock Alliance
3. Discussion on Insurance Modernization Initiatives
 - a.) Rebate Reform Initiatives
Jamie Anderson-Parson, JD – Assistant Professor, Department of Finance, Banking and Insurance – Appalachian State University
 - b.) Electronic Issuance of Salvage Titles
Jim Taylor, VP, Auto Data Direct
 - c.) Optional Electronic Delivery of Policyholder Information
Alex Hageli, Director – Policy & International, APCI
4. Any Other Business
5. Adjournment

NCOIL – NAIC Dialogue
Friday, March 15, 2019
4:15 p.m. – 5:15 p.m.

Chair: Rep. Matt Lehman (IN) – NCOIL Vice President
Vice Chair: Sen. Jim Seward (NY)

1. Call to Order/Roll Call/Approval of December 7, 2018 Committee Meeting Minutes
2. Update on NAIC Annuity Suitability Working Group
3. Discussion on Development of New Capital Standards for Insurance Holding Companies
4. Discussion on Data Call Principles
5. Update on State Adoption of NAIC Insurance Data Security Model Law
6. Discussion on Life Insurance Underwriting Developments
7. Any Other Business
8. Adjournment

Special Committee on Natural Disaster Recovery
Friday, March 15, 2019
5:15 p.m. – 6:15 p.m.

1. Call to Order/Roll Call
2. Discussion on Proposed Amendments to NCOIL State Flood Disaster Mitigation and Relief Model Act
The Hon. David Maurstad, Chief Executive of the NFIP and Deputy Associate Administrator for Insurance & Mitigation, FEMA
Lisa Miller, President & CEO, Lisa Miller & Associates
National Association of Realtors Representative
Paul Martin, Regional VP – Southwestern Region, NAMIC
3. Any Other Business
4. Adjournment

Reception
Friday, March 15, 2019
6:15 p.m. – 7:15 p.m.

SATURDAY, MARCH 16TH, 2019

IEC Board Meeting
Saturday, March 16, 2019
8:15 a.m. – 9:00 a.m.

Life Insurance & Financial Planning Committee
Saturday, March 16, 2019
9:00 a.m. – 10:00 a.m.

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

1. Call to Order/Roll Call/Approval of December 6, 2018 Committee Meeting Minutes
2. Update on SEC Best Interest Standard Proposal/State Fiduciary Laws
Bill Mandia, Esq., Partner, Stradley Ronon
3. Discussion/Consideration of Resolution in Support of Good Samaritans' Efforts to Prevent Loss of Life Due to Opioid Overdose
Asw. Pamela Hunter (NY)
Karen Melchert, Regional VP – State Relations, ACLI
4. Re-adoption of Model Laws
 - a. Life Settlements Model Act
 - b. Unclaimed Life Insurance Benefits Act
5. Any Other Business
6. Adjournment

Networking Break
Saturday, March 16, 2019
10:00 a.m. – 10:15 a.m.

General Session
Business Interruption Coverage: Are Businesses Really Covered?
Saturday, March 16, 2019
10:15 a.m. – 11:30 a.m.

Amy Bach, Esq.
Executive Director
United Policyholders

Gene Killian, Esq.
Partner
The Killian Law Firm

Edward Brown, Esq.
Associate
Wiley Rein LLP

Legislative Micro Meetings
Saturday, March 16, 2019
11:30 a.m. – 12:00 p.m.

Facilitator: Hon. Tom Considine, NCOIL CEO

Luncheon with Keynote Address
Saturday, March 16, 2019
12:00 p.m. – 1:30 p.m.

Workers' Compensation Insurance Committee
Saturday, March 16, 2019
1:30 p.m. – 2:30 p.m.

Chair: Asw. Maggie Carlton (NV)
Vice Chair: Rep. David Santiago (FL)

1. Call to Order/Roll Call/Approval of December 8, 2018 Committee Meeting Minutes
2. 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
3. Discussion on Development of NCOIL Workers' Compensation Drug Formulary Model Act
Rep. Matt Lehman (IN) – NCOIL Vice President
Ken Eichler, Vice President, ODG by MCG Health
Brian Allen, Vice President - Gov't Affairs, Mitchell
Abbie Hudgens, Administrator - Tennessee's Workers' Compensation Program
Robert Nydam, Project Director, MAXIMUS
4. Any Other Business
5. Adjournment

Articles of Organization & Bylaws Revision Committee
Saturday, March 16, 2019
2:30 p.m. – 2:50 p.m.

Chair: Rep. Deborah Ferguson (AR)
Vice Chair: Asm. Andrew Garbarino (NY)

1. Call to Order/Roll Call/Approval of December 7, 2018 Committee Meeting Minutes
2. Discussion/Consideration of Proposed Amendments to Articles of Organization & Bylaws
3. Any Other Business
4. Adjournment

Tour of Tennessee State Capitol
Saturday, March 16, 2019
3:30 p.m.

SUNDAY, MARCH 17TH, 2019

Property & Casualty Insurance Committee
Sunday, March 17, 2019
9:00 a.m. – 10:45 a.m.

Chair: Rep. Edmond Jordan (LA)

Vice Chair: Rep. Richard Smith (GA)

1. Call to Order/Roll Call/Approval of December 7, 2018 Committee Meeting Minutes
2. Discussion on Development of Model Legislation in Response to American Law Institute's Restatement of Law of Liability Insurance
The Hon. Tom Considine, NCOIL CEO
Erin Collins, Asst. VP – State Affairs, NAMIC
3. Discussion on Insurance Developments in the Sharing Economy
4. Discussion on Efforts to Modernize and Streamline Data Reporting
Robin Westcott, VP of Gov't Affairs & General Counsel, American Assoc. of Insurance Services (AAIS)
Paul Martin, Regional VP – Southwestern Region, NAMIC
5. Any Other Business
6. Adjournment

Networking Break

Sunday, March 17, 2019

10:45 a.m. – 11:00 a.m.

Business Planning and Executive Committee

Sunday, March 17, 2019

11:00 a.m. – 12:00 p.m.

Chair: Sen. Dan "Blade" Morrish (LA) – NCOIL President

Vice Chair: Rep. Matt Lehman (IN) – NCOIL Vice President

1. Call to Order/Roll Call/Approval of December 8, 2018 Committee Meeting Minutes
2. 2021 Summer Meeting Locations
3. Administration
 - a.) Meeting Report
 - b.) Receipt of Financials
4. Consent Calendar
 - Committee Reports Including Resolutions and Model Laws Adopted/Readopted Therein
5. Articles of Organization & Bylaws Revision Committee Report
6. Other Sessions
 - a.) The Institutes Griffith Foundation Legislator Luncheon
 - b.) Featured Speakers
7. Any Other Business
8. Adjournment

Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08726
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine



PRESIDENT: Sen. Dan "Blade" Morrish, LA
VICE PRESIDENT: Rep. Matt Lehman, IN
TREASURER: Asm. Ken Cooley, CA
SECRETARY: Asm. Kevin Cahill, NY

IMMEDIATE PAST PRESIDENTS:
Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

National Council of Insurance Legislators (NCOIL)

Insurance Business Transfer Model Act

**Sponsored by Asm. Andrew Garbarino (NY) and Rep. Lewis Moore (OK)
*Initial Discussion Draft based on Oklahoma SB 1101 – The Insurance Business Transfer Act (enacted on May 7, 2018) – To be discussed during the Joint State-Federal Relations and International Insurance Issues Committee on March 15th, 2019 and throughout 2019**

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Court Authority
Section 5.	Notice Requirements
Section 6.	Application Procedure
	A. Submitting Application of Insurance Business Transfer Plan to Insurance Commissioner
	B. Application to the Court for Approval of the Insurance Business Transfer Plan
	C. Approval of the Insurance Business Transfer Plan
	D. Implementation of Insurance Business Transfer Plan
Section 7.	Ongoing Oversight by Insurance Commissioner
Section 8.	Fees and Costs
Section 9.	Effective Date

Section 1. Title

This act shall be known and may be cited as the "Insurance Business Transfer Act".

Section 2. Purpose

This act is adopted to provide a basis and procedures for the transfer and statutory novation of policies from a transferring insurer to an assuming insurer by way of an Insurance Business Transfer without the affirmative consent of policyholders or reinsureds. The novation is effected by court order. This act establishes the requirements for notice and disclosure and standards and procedures for the approval of the transfer

and novation by the State Insurance Commissioner and a District Court pursuant to an Insurance Business Transfer Plan. This act does not limit or restrict other means of effecting a transfer or novation.

Section 3. Definitions

A. "Affiliate" means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the person specified.

B. "Applicant" means a transferring insurer or reinsurer applying under Section 6 of this act.

C. "Assuming insurer" means an insurer domiciled in this State that assumes or seeks to assume policies from a transferring insurer pursuant to this act. An assuming insurer may be a company established pursuant to the State Captive Insurance Company Act.

D. "Court" means the [District Court].

Drafting Note: Each state shall identify the specific court that shall have jurisdiction and venue

E. "Department" means the State Insurance Department.

Drafting Note: In certain states "State Insurance Department" may be replaced with the regulatory body that has jurisdiction over insurance

F. "Commissioner" means the State Insurance Commissioner.

G. "Implementation order" means an order issued by the Court under Section 6 of this act.

H. "Insurance Business Transfer" means a transfer and novation in accordance with this act. Insurance Business Transfers will transfer insurance obligations or risks, or both, of existing or in-force contracts of insurance or reinsurance from a transferring insurer to an assuming insurer. Once approved pursuant to this act, the Insurance Business Transfer will effect a novation of the transferred contracts of insurance or reinsurance with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer and the transferring insurer's insurance obligations or risks, or both, under the contracts are extinguished.

I. "Insurance Business Transfer Plan" or "Plan" means the plan submitted to the Department to accomplish the transfer and novation pursuant to an Insurance Business Transfer, including any associated transfer of assets and rights from or on behalf of the transferring insurer to the assuming insurer.

J. "Independent expert" means an impartial person who has no financial interest in either the assuming insurer or transferring insurer, has not been employed by or acted as an officer, director, consultant or other independent contractor for either the assuming insurer or transferring insurer within the past twelve (12) months, is not appointed by the Commissioner to assist in any capacity in any insurer rehabilitation or delinquency proceeding and is receiving no compensation in connection with the transaction governed by this act other than a fee based on a fixed or hourly basis that is not contingent on the approval or consummation of an Insurance Business Transfer and provides proof of insurance coverage that is satisfactory to the Commissioner.

K. "Insurer" means an insurance or surety company, including a reinsurance company, and shall be deemed to include a corporation, company, partnership, association, society, order, individual or aggregation of individuals engaging in or proposing or attempting to engage in any kind of insurance or surety business, including the exchanging of reciprocal or inter-insurance contracts between individuals, partnerships and corporations.

L. "Policy" means a policy, contract or certificate of insurance or a contract of reinsurance pursuant to which the insurer agrees to assume an obligation or risk, or both, of the policyholder or to make payments on behalf of, or to, the policyholder or its beneficiaries, and shall include property, casualty, life, health and any other line of insurance the Commissioner finds via regulation is suitable for an insurance business transfer.

M. "Policyholder" means an insured or a reinsured under a policy that is part of the subject business.

N. "Subject business" means the policy or policies that are the subject of the Insurance Business Transfer Plan.

O. "Transfer and novation" means the transfer of insurance obligations or risks, or both, of existing or in-force policies from a transferring insurer to an assuming insurer, and is intended to effect a novation of the transferred policies with the result that the assuming insurer becomes directly liable to the policyholders of the transferring insurer on the transferred policies and the transferring insurer's insurance obligations or risks, or both, under the transferred policies are extinguished.

P. "Transferring insurer" means an insurer or reinsurer that transfers and novates or seeks to transfer and novate obligations or risks, or both, under one or more policies to an assuming insurer pursuant to an Insurance Business Transfer Plan.

Section 4. Court Authority

Notwithstanding any other provision of law, the court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this act. No

provision of this act shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of power.

Section 5. Notice Requirements

A. Whenever notice is required to be given by the applicant under the Insurance Business Transfer Act and except as otherwise permitted or directed by the court or the Insurance Commissioner, the applicant shall, within fifteen (15) days of the event triggering the requirement, cause transmittal of the notice:

1. To the chief insurance regulator in each jurisdiction in which the applicant:
 - a. holds or has ever held a certificate of authority, and
 - b. in which policies that are part of the subject business were issued or policyholders currently reside;
2. To the National Conference of Insurance Guaranty Funds, the National Organization of Life and Health Insurance Guaranty Associations and all state insurance guaranty associations for the states in which the applicant:
 - a. holds or has ever held a certificate of authority, and
 - b. in which policies that are part of the subject business were issued or policyholders currently reside;
3. To reinsurers of the applicant pursuant to the notice provisions of the reinsurance agreements applicable to the policies that are part of the subject business, or where an agreement has no provision for notice, by internationally recognized delivery service;
4. To all policyholders holding policies that are part of the subject business, at their last-known address as indicated by the records of the applicant or to the address to which premium notices or other policy documents are sent. A notice of transfer shall also be sent to the transferring insurer's agents or brokers of record on the subject business; and
5. By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in such other publications that the Commissioner requires.

B. If notice is given in accordance with this section, any orders under this act shall be conclusive with respect to all intended recipients of the notice, whether or not they receive actual notice.

C. Where this act requires that the applicant provide notice but the Commissioner has been named receiver of the applicant, the Commissioner shall provide the required notice.

D. Notice under this section may take the form of first-class mail, facsimile and/or electronic notice.

Section 6. Application Procedure

A. Application Procedure.

1. An Insurance Business Transfer Plan must be filed by the applicant with the Insurance Commissioner for his or her review and approval. The Plan must contain the information set forth below or an explanation as to why the information is not included. The Plan may be supplemented by other information deemed necessary by the Commissioner:

- a. the name, address and telephone number of the transferring insurer and the assuming insurer and their respective direct and indirect controlling persons, if any,
- b. summary of the Insurance Business Transfer Plan,
- c. identification and description of the subject business,
- d. most recent audited financial statements and statutory annual and quarterly reports of the transferring insurer and assuming insurer filed with their domiciliary regulator,
- e. the most recent actuarial report and opinion that quantify the liabilities associated with the subject business,
- f. pro-forma financial statements showing the projected statutory balance sheet, results of operations and cash flows of the assuming insurer for the three (3) years following the proposed transfer and novation,
- g. officers' certificates of the transferring insurer and the assuming insurer attesting that each has obtained all required internal approvals and authorizations regarding the Insurance Business Transfer Plan and completed all necessary and appropriate actions relating thereto,
- h. proposal for Plan implementation and administration, including the form of notice to be provided under the Insurance Business Transfer Plan to any policyholder whose policy is part of the subject business,
- i. full description as to how such notice shall be provided,

- j. description of any reinsurance arrangements that would pass to the assuming insurer under the Insurance Business Transfer Plan,
- k. description of any guarantees or additional reinsurance that will cover the subject business following the transfer and novation,
- l. a statement describing the assuming insurer's proposed investment policies and any contemplated third-party claims management and administration arrangements,
- m. evidence of approval or nonobjection of the transfer from the chief insurance regulator of the state of the transferring insurer's domicile, and
- n. a report from an independent expert, selected by the Commissioner from a list of at least two nominees submitted jointly by the transferring insurer and the assuming insurer, to assist the Commissioner and the court in connection with their review of the proposed transaction. Should the Commissioner, in his or her sole discretion, reject the nominees, he or she may appoint the independent expert. The report shall provide the following:
- (1) a statement of the independent expert's professional qualifications and descriptions of the experience that qualifies him or her as an expert suitable for the engagement,
 - (2) whether the independent expert has, or has had, direct or indirect interest in the transferring or assuming insurer or any of their respective affiliates,
 - (3) the scope of the report,
 - (4) a summary of the terms of the Insurance Business Transfer Plan to the extent relevant to the report,
 - (5) documents, reports and other material information the independent expert has considered in preparing the report and whether any information requested was not provided,
 - (6) the extent to which the independent expert has relied on information provided by and the judgment of others,
 - (7) the people on whom the independent expert has relied and why, in his or her opinion, such reliance is reasonable,

(8) the independent expert's opinion of the likely effects of the Insurance Business Transfer Plan on policyholders and claimants, distinguishing between:

(a) transferring policyholders and claimants,

(b) policyholders and claimants of the transferring insurer whose policies will not be transferred, and

(c) policyholders and claimants of the assuming insurer,

(9) for each opinion that the independent expert expresses in the report the facts and circumstances supporting the opinion, and

(10) consideration as to whether the security position of policyholders that are affected by the Insurance Business Transfer are materially adversely affected by the transfer.

2. The independent expert's report as required by subparagraph n of paragraph 1 of this subsection shall include, but not be limited to, a review of the following:

a. analysis of the transferring insurer's actuarial review of reserves for the subject business to determine the reserve adequacy,

b. analysis of the financial condition of the transferring and assuming insurers and the effect the transfer will have on the financial condition of each company,

c. review of the plans or proposals the assuming insurer has with respect to the administration of the policies subject to the proposed transfer,

d. whether the proposed transfer has a material, adverse impact on the policyholders and claimants of the transferring and the assuming insurers,

e. analysis of the assuming insurer's corporate governance structure to ensure that there is proper board and management oversight and expertise to manage the subject business, and

f. any other information that the Commissioner requests in order to review the Insurance Business Transfer.

3. The Commissioner shall have sixty (60) business days from the date of receipt of a complete Insurance Business Transfer Plan to review the Plan to determine if the applicant is authorized to submit it to the court. The Commissioner may extend the sixty-day review period for an additional thirty (30) business days.

4. The Commissioner shall authorize the submission of the Plan to the court unless he or she finds that the Insurance Business Transfer would have a material adverse impact on the interests of policyholders or claimants that are part of the subject business.

5. If the Commissioner determines that the Insurance Business Transfer would have a material adverse impact on the interests of policyholders or claimants that are part of the subject business, he or she shall notify the applicant and specify any modifications, supplements or amendments and any additional information or documentation with respect to the Plan that must be provided to the Commissioner before he or she will allow the applicant to proceed with the court filing.

6. The applicant shall have thirty (30) days from the date the Commissioner notifies him or her, pursuant to paragraph 5 of this subsection, to file an amended Insurance Business Transfer Plan providing the modifications, supplements or amendments and additional information or documentation as requested by the Commissioner. If necessary the applicant may request in writing an extension of time of thirty (30) days. If the applicant does not make an amended filing within the time period provided for in this paragraph, including any extension of time granted by the Commissioner, the Insurance Business Transfer Plan filing will terminate and a subsequent filing by the applicant will be considered a new filing which shall require compliance with all provisions of this act as if the prior filing had never been made.

7. The Commissioner's review period in paragraph 2 of this subsection shall recommence when the modification, supplement, amendment or additional information requested in paragraph 5 of this subsection is received.

8. If the Commissioner determines that the Plan may proceed with the court filing, the Commissioner shall confirm that fact in writing to the applicant.

B. Application to the court for approval of the Insurance Business Transfer Plan.

1. Within thirty (30) days after notice from the Commissioner that the applicant may proceed with the court filing, the applicant shall apply to the court for approval of the Insurance Business Transfer Plan. Upon written request by the applicant, the Commissioner may extend the period for filing an application with the court for an additional thirty (30) days.

2. The applicant shall inform the court of the reasons why he or she petitions the court to find no material adverse impact to policyholders or claimants affected by the proposed transfer.

3. The application shall be in the form of a verified petition for implementation of the Insurance Business Transfer Plan in the court. The petition shall include the

Insurance Business Transfer Plan and shall identify any documents and witnesses which the applicant intends to present at a hearing regarding the petition.

4. The Commissioner shall be a party to the proceedings before the court concerning the petition and shall be served with copies of all filings pursuant to the Rules for District Courts of the State. The Commissioner's position in the proceeding shall not be limited by his or her initial review of the Plan.

5. Following the filing of the petition, the applicant shall file a motion for a scheduling order setting a hearing on the petition.

6. Within fifteen (15) days after receipt of the scheduling order, the applicant shall cause notice of the hearing to be provided in accordance with the notice provisions of Section 5 of this act. Following the date of distribution of the notice, there shall be a sixty-day comment period.

7. The notice to policyholders shall state or provide:

- a. the date and time of the approval hearing,
- b. the name, address and telephone number of the assuming insurer and transferring insurer,
- c. that a policyholder may comment on or object to the transfer and novation,
- d. the procedures and deadline for submitting comments or objections on the Plan,
- e. a summary of any effect that the transfer and novation will have on the policyholder's rights,
- f. a statement that the assuming insurer is authorized, as provided in this section, to assume the subject business and that court approval of the Plan shall extinguish all rights of policyholders under policies that are part of the subject business against the transferring insurer,
- g. that policyholders shall not have the opportunity to opt out of or otherwise reject the transfer and novation,
- h. contact information for the Insurance Department where the policyholder may obtain further information, and
- i. information on how an electronic copy of the Insurance Business Transfer Plan may be accessed. In the event policyholders are unable to

readily access electronic copies, the applicant shall provide hard copies by first-class mail.

8. Any person, including by their legal representative, who considers himself, herself or itself to be adversely affected can present evidence or comments to the court at the approval hearing. However, such comment or evidence shall not confer standing on any person. Any person participating in the approval hearing must follow the process established by the court and shall bear his or her own costs and attorney fees.

C. Approval of the Insurance Business Transfer Plan.

1. After the comment period pursuant to paragraph 6 of subsection B of this section has ended the Insurance Business Transfer Plan shall be presented by the applicant for approval by the court.

2. At any time before the court issues an order approving the Insurance Business Transfer Plan, the applicant may withdraw the Insurance Business Transfer Plan without prejudice.

3. If the court finds that the implementation of the Insurance Business Transfer Plan would not materially adversely affect the interests of policyholders or claimants that are part of the subject business, the court shall enter a judgment and implementation order. The judgment and implementation order shall:

a. order implementation of the Insurance Business Transfer Plan,

b. order a statutory novation with respect to all policyholders or reinsureds and their respective policies and reinsurance agreements under the subject business, including the extinguishment of all rights of policyholders under policies that are part of the subject business against the transferring insurer, and providing that the transferring insurer shall have no further rights, obligations, or liabilities with respect to such policies, and that the assuming insurer shall have all such rights, obligations, and liabilities as if it, instead of the transferring insurer, were the original insurer of such policies,

c. release the transferring insurer from any and all obligations or liabilities under policies that are part of the subject business,

d. authorize and order the transfer of property or liabilities, including, but not limited to, the ceded reinsurance of transferred policies and contracts on the subject business, notwithstanding any non-assignment provisions in any such reinsurance contracts. The subject business shall vest in and become liabilities of the assuming insurer,

e. order that the applicant provide notice of the transfer and novation in accordance with the notice provisions in Section 5 of this act, and

f. make such other provisions with respect to incidental, consequential and supplementary matters as are necessary to assure the Insurance Business Transfer Plan is fully and effectively carried out.

4. If the court finds that the Insurance Business Transfer Plan should not be approved, the court by its order may:

a. deny the petition, or

b. provide the applicant leave to file an amended Insurance Business Transfer Plan and petition.

5. Nothing in this section in any way effects the right of appeal of any party.

D. Implementation of Insurance Business Transfer Plan.

The Commissioner shall have the authority to promulgate rules to effectuate the provisions of the Insurance Business Transfer Act.

Section 7. Ongoing oversight by Insurance Commissioner

Insurers subject to this act consent to the jurisdiction of the Insurance Commissioner with regard to ongoing oversight of operations, management and solvency relating to the transferred business, including the authority of the Commissioner to conduct financial analysis and examinations.

Section 8. Fees and Costs

A. At the time of filing its application with the Insurance Commissioner for review and approval of an Insurance Business Transfer Plan, the applicant shall pay a nonrefundable fee to the Insurance Department.

B. The Commissioner may retain independent attorneys, appraisers, actuaries, certified public accountants, authorized consultants, or other professionals and specialists to assist Department personnel in connection with the review required by the Insurance Business Transfer Act, the cost of which shall be borne by the applicant.

C. Failure to pay any of the requisite fees or costs within thirty (30) days of demand shall be grounds for the Commissioner to request that the court dismiss the petition for approval of the Insurance Business Transfer Plan prior to the filing of an implementation order by the court or, if after the filing of an implementation order, the Commissioner may suspend or revoke the assuming insurer's certificate of authority to transact insurance business in this state.

Section 9. Effective Date

This act shall become effective _____.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL) MARKET CONDUCT SURVEILLANCE MODEL LAW

**Adopted by the NCOIL Executive Committee on November 11, 2006. Readopted by the NCOIL Executive Committee on November 20, 2011 and November 20, 2016.*

**To be discussed during the Joint State-Federal Relations and International Insurance Issues Committee on March 15th, 2019*

Table of Contents

Section 1	Short Title
Section 2	Purpose/Legislative Intent
Section 3	Definitions
Section 4	Domestic Responsibility and Deference to Other States
Section 5	Market Analysis Procedures
Section 6	Protocols for Market Conduct Actions
Section 7	Protocols for Targeted Market Conduct Examinations
Section 8	Confidentiality Requirements
Section 9	Market Conduct Surveillance Personnel
Section 10	Immunity for Market Conduct Surveillance Personnel
Section 11	Fines and Penalties
Section 12	Data Collection and Participation in National Market Conduct Databases
Section 13	Coordination with Other States through the NAIC
Section 14	Additional Duties of the Commissioner
Section 15	Effective Date

Section 1. Short Title

This Act shall be known and may be cited as the Market Conduct Surveillance Law.

Section 2. Purpose/Legislative Intent

The purpose of this act is to establish a framework for Insurance Department market conduct actions, including:

- Processes and systems for identifying, assessing and prioritizing market conduct problems that have a substantial adverse impact on consumers, policyholders and claimants;

- Market conduct actions by a commissioner to substantiate such market conduct problems and a means to remedy significant market conduct problems; and
- Procedures to communicate and coordinate market conduct actions among states to foster the most efficient and effective use of resources.

Drafting Note 1: States should take into consideration the fact that this Act may contain language that could conflict with its existing laws and should address and modify statutes accordingly.

Drafting Note 2: For those states that require proposed legislation to contain a “Scope” section, the following language is suggested: “All market analysis, market conduct actions, and market conduct examinations in this State shall be undertaken as provided in this Act.”

Drafting Note 3: States should treat responses to data calls and other requests for information as part of a market conduct action as well as explicitly protect the confidentiality of such materials.

Section 3. Definitions

- (a) “Commissioner” means the chief insurance regulatory official of the state, or his or her designee. Drafting Note: Where the word “commissioner” appears in the Model Act, the appropriate designation for the chief insurance regulatory official of the state, if different, should be substituted.
- (b) “Complaint” means a written or documented oral communication to the Insurance Department primarily expressing a grievance, meaning an expression of dissatisfaction. For health companies, a grievance is a written complaint submitted by or on behalf of a covered person.
- (c) “Comprehensive Market Conduct Examination” means a review of one or more lines of business of an insurer domiciled in this state that is not conducted for cause. The term includes a review of rating, tier classification, underwriting, policyholder service, claims, marketing and sales, producer licensing, complaint handling practices, or compliance procedures and policies.
- (d) “Insurance Compliance Audit” means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance with laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of a company licensed or regulated under this Code, or which involves an activity regulated under this Code.
- (e) “Insurance Compliance Self-Evaluative Audit Document” means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit

document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit.

(f) “Market Conduct Action” means any of the full range of activities that the Commissioner may initiate to assess the market and practices of individual insurers, beginning with market analysis and extending to targeted examinations. The Commissioner’s activities to resolve an individual consumer complaint or other reports of a specific instance of misconduct are not market conduct actions for purposes of this Act.

(g) “Market Analysis” means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports and other sources in order to develop a baseline and to identify patterns or practices of insurers licensed to do business in this state that deviate significantly from the norm or that may pose a potential risk to the insurance consumer.

(h) “Market Conduct Examination” means the examination of the insurance operations of an insurer licensed to do business in this state in order to evaluate compliance with the applicable laws and regulations of this state. A market conduct examination may be either a comprehensive examination or a targeted examination. A market conduct examination is separate and distinct from a financial examination of an insurer performed pursuant to [cite section], but may be conducted at the same time.

(i) “Market Conduct Surveillance Personnel” means those individuals employed or contracted by the Commissioner to collect, analyze, review or act on information on the insurance marketplace, which identifies patterns or practices of insurers.

(j) “National Association of Insurance Commissioners” (NAIC) means the organization of insurance regulators from the 50 states, the District of Columbia, and the four U.S. territories.

Drafting Note: If statutory drafting conventions require further description, the following language should be used: “Its mission is to assist insurance regulators in protecting the public interest, promoting competitive markets, facilitating the fair and equitable treatment of insurance consumers, promoting the reliability, solvency, and financial solidity of insurance institutions, and supporting and improving state regulation of insurance.”

(1) “NAIC Market Regulation Handbook” means a handbook, developed and adopted by the NAIC, or successor product, which:

(A) outlines elements and objectives of market analysis and the process by which states can establish and implement market analysis programs, and

(B) sets up guidelines that document established practices to be used by market conduct surveillance personnel in developing and executing an examination.

(2) “NAIC Market Conduct Uniform Examination Procedures” means the set of guidelines developed and adopted by the NAIC designed to be used by market conduct surveillance personnel in conducting an examination.

(3) “NAIC Standard Data Request” means the set of field names and descriptions developed and adopted by the NAIC for use by market conduct surveillance personnel in an examination.

(k) “Qualified Contract Examiner” means a person under contract to the Commissioner, who is qualified by education, experience and, where applicable, professional designations, to perform market conduct actions.

(l) “Targeted Examination” means a focused exam conducted for cause, based on the results of market analysis indicating the need to review either a specific line of business or specific business practices, including but not limited to underwriting and rating, marketing and sales, complaint handling operations/management, advertising materials, licensing, policyholder services, non-forfeitures, claims handling, or policy forms and filings. A targeted examination may be conducted by desk examination or by an on-site examination.

(1) “Desk Examination” means a targeted examination that is conducted by an examiner at a location other than the insurer’s premises. A desk examination is usually performed at the Insurance Department’s offices with the insurer providing requested documents by hard copy, microfiche, discs or other electronic media, for review.

(2) “On-site Examination” means a targeted examination conducted at the insurer’s home office or the location where the records under review are stored.

(m) “Third Party Model or Product” means a model or product provided by an entity separate from and not under direct or indirect corporate control of the insurer using the model or product.

Section 4. Domestic Responsibility and Deference to Other States

(a) The Commissioner is responsible for conducting market conduct examinations for [insert state] policyholder protection, which shall be accomplished by comprehensive or targeted examinations of domestic insurers and targeted examinations of foreign insurers as deemed necessary by the Commissioner, based on the results of market analysis. The Commissioner may delegate responsibility for conducting an examination of a domestic insurer, foreign insurer, or an affiliate of an insurer to the Insurance Commissioner of

another state if that Insurance Commissioner agrees to accept the delegated responsibility for the examination.

(b) The Commissioner may delegate such responsibility to a Commissioner of a state in which the domestic insurer, foreign insurer, or affiliate has a significant number of policies or significant premium volume.

Drafting Note: States may want to consider including definitions of “significant number of policies” and “significant premium volume.”

(c) If the Commissioner elects to delegate responsibility for examining an insurer, the Commissioner shall accept a report of the examination prepared by the Commissioner to whom the responsibility has been delegated.

(d) In lieu of conducting a market conduct examination of an insurer, the Commissioner shall accept a report of a market conduct examination on such insurer prepared by the Insurance Commissioner of the insurer’s state of domicile or another state, provided:

(1) The laws of that state applicable to the subject of the examination are deemed by the Commissioner to be substantially similar to those of this state;

(2) The examining state has a market conduct surveillance system that the Commissioner deems comparable to the market conduct surveillance system required under this Act; and;

(3) The examination from the other state’s Commissioner has been conducted within the past three years.

(e) If the Insurance Commissioner to whom the examination responsibility was delegated pursuant to paragraph (a) of this Section or the report of a market conduct examination prepared by the Insurance Commissioner of another state pursuant to paragraph (d) of this Section, did not evaluate the specific area or issue of concern to the Commissioner or a specific requirement of [insert state] law, the Commissioner may pursue a targeted examination or market analysis of the unexamined area pursuant to this statute.

(f) The Commissioner’s determination under Subsection (d) is discretionary with the Commissioner and is not subject to appeal.

(g) Subject to a determination under Subsection (d), if a market conduct examination conducted by another state results in a finding that an insurer should modify a specific practice or procedure, the Commissioner shall accept documentation that the insurer has made a similar modification in this state, in lieu of initiating a market conduct action or examination related to that practice or procedure. The Commissioner may require other or additional practice or procedure modifications as are necessary to achieve compliance with specific state laws or regulations, which differ substantially from those of the state that conducted the examination.

Section 5. Market Analysis Procedures

(a) (1) The Commissioner shall gather information from data currently available to the Insurance Department, as well as surveys and required reporting requirements, information collected by the NAIC and a variety of other sources in both the public and private sectors, and information from within and outside the insurance industry from objective sources, information from websites for insurers, agents and other organizations and information from other sources, provided the sources are published at least annually in a bulletin or circular, prior to use.

(2) Such information shall be analyzed in order to develop a baseline understanding of the marketplace and to identify for further review insurers and/or practices that deviate significantly from the norm or that may pose a potential risk to the insurance consumer. The Commissioner shall use the NAIC Market Analysis Handbook as one resource in performing this analysis (or procedures, adopted by regulation, that are substantially similar to the foregoing NAIC product).

(3) The Commissioner shall use the following policies and procedures in performing the analysis required under this section:

(A) Identify key lines of business for systematic review;

(B) Identify companies for further analysis based on available information.

(b) If the analysis compels the Commissioner to inquire further into a particular insurer or practice, the following continuum of market conduct actions may be considered prior to conducting a targeted, on-site market conduct examination. The action selected shall be made known to the insurer in writing. These actions may include, but are not limited to:

(1) Correspondence with Insurer

(2) Insurer Interviews

(3) Information Gathering

(4) Policy and Procedure Reviews

(5) Interrogatories

(6) Review of Insurer Self-Evaluation (if not subject to a privilege of confidentiality) and compliance programs, including membership in a best-practice organization

Drafting Note: A best practice organization has as its central mission the promotion of high ethical standards in the marketplace.

- (c) The Commissioner shall select a market conduct action that is cost effective for the Insurance Department and the insurer, while still protecting the insurance consumer.
- (d) The Commissioner shall take those steps reasonably necessary to eliminate requests for duplicate information provided as part of an insurer's annual financial statement, the annual market conduct statement of the National Association of Insurance Commissioners, or other required schedules, surveys, or reports that are regularly submitted to the Commissioner, or with data requests made by other states if that information is available to the Commissioner, unless the information is state specific, and coordinate market conduct actions and findings with other states.
- (e) Causes or conditions, if identified through market analysis, that may trigger a targeted examination, are:
 - (1) Information obtained from a market conduct annual statement, market survey or report of financial examination indicating potential fraud, that the insurer is conducting the business of insurance without a license or is engaged in a potential pattern of unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts].
 - (2) A number of complaints against the insurer or a complaint ratio sufficient to indicate potential fraud, conducting the business of insurance without a license, or a potential pattern of unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts]. For the purposes of this section, a complaint ratio shall be determined for each line of business.
 - (3) Information obtained from other objective sources, such as published advertising materials indicating potential fraud, conducting the business of insurance without a license, or evidencing a potential pattern of unfair trade practice in violation of [cite appropriate statutory reference for the state's Unfair Trade and Claims Practices Acts].
 - (4) Patterns of violations of Insurance [Code/Law] and administrative regulations promulgated thereunder that cause consumer harm. Drafting note: It is contemplated that Section 5 (e)(4) would encompass items such as rate filings, form filings and termination requirements.

Section 6. Protocols for Market Conduct Actions

- (a) Market conduct actions taken as a result of a market analysis shall focus on the general business practices and compliance activities of insurers, rather than identifying infrequent or unintentional random errors that do not cause consumer harm.

(b) (1) The Commissioner is authorized to determine the frequency and timing of such market conduct actions. The timing shall depend upon the specific market conduct action to be initiated, unless extraordinary circumstances indicating a risk to consumers require immediate action.

(2) If the Commissioner has information that more than one insurer is engaged in common practices that may violate statute or regulations, he/she may schedule and coordinate multiple examinations simultaneously.

(c) The insurer shall be notified of any practice or procedure which is to be the subject of a market conduct action and shall be given an opportunity to resolve such matters that arise as a result of a market analysis to the satisfaction of the Commissioner before any additional market conduct actions are taken against the insurer. If the insurer has modified such practice or procedure as a result of a market conduct action taken by the Commissioner of another state, the Commissioner shall accept appropriate documentation that the insurer has satisfactorily modified the practice or procedure and made similar modification to such practice or procedure in this state.

Section 7. Protocols for Targeted Market Conduct Examinations

(a) When market analysis identifies a pattern of conduct or practice by an insurer which requires further investigation, and less intrusive market conduct actions identified in section 5 (b) are not appropriate, the Commissioner has the discretion to conduct targeted, market conduct examinations in accordance with the NAIC Market Conduct Uniform Examination Procedures and the Market Regulation Handbook (or procedures, adopted by regulation, that are substantially similar to the foregoing NAIC products).

(b) If the insurer to be examined is not a domestic insurer, the Commissioner shall communicate with and may coordinate the examination with the insurance Commissioner of the state in which the insurer is organized.

(c) Concomitant with the notification requirements established in subsection (f) of this section, the commissioner shall post notification on the NAIC Examination Tracking System, or comparable NAIC product as determined by the Commissioner, that a market conduct examination has been scheduled.

(d) The Commissioner may not conduct a comprehensive market conduct examination more frequently than once every three years. The Commissioner may waive conducting a comprehensive market conduct examination based on market analysis.

Drafting note: It is anticipated that as states adopt this NCOIL model law, or similar statutes, the practice of "domestic deference," whereby states rely on market conduct examinations performed by other states, will reduce and eventually eliminate unnecessary duplication of effort in the area of market conduct regulation.

- (e) (1) Prior to commencement of a targeted on-site market conduct examination, market conduct surveillance personnel shall prepare a work plan and proposed budget. Such proposed budget, which shall be reasonable for the scope of the examination, and work plan shall be provided to the company under examination.
- (2) Market conduct examinations shall, to the extent feasible, utilize desk examinations and data requests prior to a targeted on-site examination.
- (3) Market conduct examinations shall be conducted in accordance with the provisions set forth in the NAIC Market Regulation Handbook and the NAIC Market Conduct Uniform Examinations Procedures (or procedures, adopted by regulation, that are substantially similar to the foregoing NAIC products).
- (4) Prior to the conclusion of a market conduct examination, the individual among the market conduct surveillance personnel who is designated as the examiner-in-charge shall schedule an exit conference with the insurer.
- (f) Announcement of the examination shall be sent to the insurer and posted on the NAIC's Examination Tracking System (or comparable NAIC product, as determined by the commissioner) as soon as possible but in no case later than 60 days before the estimated commencement of the examination. Such announcement shall contain:
- (1) The name and address of the insurer(s) being examined;
 - (2) The name and contact information of the examiner-in-charge;
 - (3) The reason(s) for and the scope of the targeted examination;
 - (4) The date the examination is scheduled to begin;
 - (5) Identification of any non-insurance department personnel who will assist in the examination, if known at the time the notice is prepared;
 - (6) A time estimate for the examination;
 - (7) A budget and work plan for the examination and identification of reasonable and necessary costs and fees that will be included in the bill, if the cost of the examination is billed to the company; and
 - (8) A request for the insurer to name its examination coordinator.
- (g) If a targeted examination is expanded beyond the reasons provided to the insurer in the notice of the examination required under this section, the Commissioner shall provide written notice to the insurer, explaining the extent of the expansion and the reasons for the expansion. The department shall provide a revised work plan to the insurer before the

beginning of any significantly expanded examination, unless extraordinary circumstances indicating a risk to consumers require immediate action.

(h) The Commissioner shall conduct a pre-examination conference with the insurer examination coordinator and key personnel to clarify expectations thirty (30) days prior to commencement of the examination.

(i) The department shall use the NAIC Standard Data Request (or comparable product, adopted by regulation, that is substantially similar to the foregoing NAIC product).

(1) A company responding to a Commissioner's request to produce information shall produce it as it is kept in the usual course of business or shall organize and label it to correspond with the categories in the demand.

(2) If a Commissioner's request does not specify the form or forms for producing electronically stored information, a company responding to the request must produce the information in a form or forms in which the company ordinarily maintains it or in a form or forms that are reasonably usable.

(3) A company responding to an information request need not produce the same electronically stored information in more than one form.

(4) A company responding to an information request need not provide the electronically stored information from sources that the company identifies as not reasonably accessible because of undue burden or cost.

Drafting Note: Sections (i) (1)-(4) are based on proposed amendments to the Federal Rules of Civil Procedure relating to discovery of electronic data. Approved by the United States Supreme Court, the amendments will take effect on December 1, 2006, unless Congress enacts modifying legislation.

(j) (1) The commissioner shall adhere to the following timeline, unless a mutual agreement is reached with the insurer to modify the timeline:

(A) The Commissioner shall deliver the draft report to the insurer within 60 days of the completion of the examination. Completion of the examination shall be defined as the date the Commissioner confirms in writing that the examination is completed.

(B) The insurer must respond with written comments within 30 days of receipt of the draft report.

(C) The department shall make a good faith effort to resolve issues and prepare a final report within 30 days of receipt of the insurer's written comments, unless a mutual agreement is reached to extend the deadline.

The commissioner may make corrections and other changes, as appropriate.

(D) The insurer shall, within 30 days, accept the final report, accept the findings of the report, file written comments, or request a hearing. An additional 30 days shall be allowed if agreed to by the Commissioner and the insurer. Any such hearing request must be made in writing and must follow [insert reference to appropriate administrative procedure act].

(2) The final written and electronic market conduct report shall include the insurer's written response and any agreed-to corrections or changes. The response may be included either as an appendix or in text of the examination report. The company is not obligated to submit a response. References to specific individuals by name shall be limited to an acknowledgement of their involvement in the conduct of the examination.

Drafting Note: States should rely upon the NAIC Market Regulation Handbook to establish specific standards for examination reports.

(k) (1) Upon adoption of the examination report pursuant to subsection (j), the Commissioner shall continue to hold the content of the examination report as private and confidential for a period of thirty (30) days, except to the extent provided in paragraph 2 of this subsection. During this time, the report shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private action, provided no court of competent jurisdiction has ordered production. Thereafter, the Commissioner shall open the report for public inspection, provided no court of competent jurisdiction has stayed its publication. This section may not be construed to limit the Commissioner's authority to use any final or preliminary market conduct examination report, and examiner or company work papers or other documents, or any other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner, in the Commissioner's sole discretion may deem appropriate.

(2) Nothing contained in this Act shall prevent or be construed as preventing the commissioner from disclosing the content of an examination report, preliminary examination report or results, or any matter relating thereto, to the insurance department of this or any other state or agency of the federal government at any time, provided the agency or office receiving the report or matters relating thereto agrees to hold it confidential and in a manner consistent with this Act.

(l) (1) Where the reasonable and necessary cost and fees of a market conduct examination are to be assessed against the insurer under examination, such costs and fees shall be consistent with that otherwise authorized by law. Such costs and fees shall be itemized and bills shall be provided to the insurer on a monthly basis for review prior to submission for payment.

(2) The Commissioner shall maintain active management and oversight of examination costs and fees, including costs and fees associated with the use of department personnel and examiners and with retaining qualified contract examiners necessary to perform an examination. To the extent the Commissioner retains outside assistance, the Commissioner must have in writing protocols that:

- (A) Clearly identify the types of functions to be subject to outsourcing;
- (B) Provide specific timelines for completion of the outsourced review;
- (C) Require disclosure of contract examiners' recommendations;
- (D) Establish and utilize a dispute resolution or arbitration mechanism to resolve conflicts with insurers regarding examination costs and fees; and
- (E) Require disclosure of the terms of the contracts with the outside consultants that will be used, specifically the costs and fees and/or hourly rates that can be charged.

(3) The Commissioner shall review and affirmatively endorse detailed billings from the qualified contract examiner before the detailed billings are sent to the insurer.

(4) The Commissioner may contract in accordance with applicable state contracting procedures, for such qualified contract actuaries and examiners as the Commissioner deems necessary, provided that the compensation and per diem allowances paid to such contract persons shall not exceed one hundred twenty-five percent (125%) of the compensation and per diem allowances for examiners set forth in the guidelines adopted by the National Association of Insurance Commissioners, unless the Commissioner demonstrates that one hundred twenty-five percent (125%) is inadequate under the circumstances of the examination.

Drafting Note: In states in which alternative dispute resolution (ADR) of examination disputes is not currently available, states may want to include within the Market Conduct Surveillance Law provisions authorizing the use of such ADR procedures to resolve disputes.

Section 8. Confidentiality Requirements

(a) Except as otherwise provided by law, market conduct surveillance personnel shall have free and full access to all books and records, employees, officers and directors, as practicable, of the insurer during regular business hours. An insurer utilizing a third-party model or product for any of the activities under examination shall cause, upon the request of market conduct surveillance personnel, the details of such models or products to be made available to such personnel. All documents, whether from a third party or an

insurer, including but not limited to working papers, third party models or products, complaint logs, and copies thereof, created, produced or obtained by or disclosed to the Commissioner or any other person in the course of any market conduct actions made pursuant to this Act, or in the course of market analysis by the commissioner of the market conditions of an insurer, or obtained by the NAIC as a result of any of the provisions of this Act, shall be confidential by law and privileged, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private civil action.

Drafting Note: In order to prevent potential claims for the unauthorized release of proprietary third-party models, insurers may have to amend their contracts with third-party vendors to permit such production, when requested by a Commissioner. It is therefore suggested that the requirements of this section, relating to insurer production of third-party models, be phased in over a 12 to 18 month period to allow insurers to amend existing contracts with their vendors.

Drafting Note: If the state has enacted the NCOIL Insurance Compliance Self-Evaluative Privilege Model Act, the provisions of Section 8 (a) may need to be revised to be consistent with that model act.

(b) No waiver of any applicable privilege or claim of confidentiality in the documents, materials, or information shall occur as a result of disclosure to the Commissioner under this section.

(c) Market conduct surveillance personnel shall be vested with the power to issue subpoenas and examine insurance company personnel under oath when such action is ordered by the Commissioner pursuant to (cite the appropriate state authority).

(d) Notwithstanding the provisions of paragraph (a) of this subsection, in order to assist in the performance of the Commissioner's duties, the Commissioner may:

(1) share documents, materials or other information, including the confidential and privileged documents, materials or information subject to paragraph (a), with other state, federal and international regulatory agencies and law enforcement authorities and the NAIC and its affiliates and subsidiaries, provided that the recipient agrees to and has the legal authority to maintain the confidentiality and privileged status of the document, material, communication or other information;

(2) receive documents, materials, communications or information, including otherwise confidential and privileged documents, materials or information, from the NAIC and its affiliates or subsidiaries, and from regulatory and law enforcement officials of other foreign or domestic jurisdictions, and shall maintain as confidential or privileged any document, material or information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material or information; and

(3) enter into agreements governing the sharing and use of information consistent with this subsection.

(4) notwithstanding the provisions of this section, no insurer shall be compelled to disclose an insurance compliance self-evaluative audit document or waive any statutory or common law privilege, but may voluntarily disclose such document to the Commissioner in response to any market analysis, market conduct action or examination as provided in this Act.

Drafting Note: States should enact the NCOIL Insurance Compliance Self-Evaluative Privilege Model Act to encourage insurers' to identify and remedy insurance and other compliance problems. The Model Act provides for a limited expansion of the protection against disclosure.

Section 9. Market Conduct Surveillance Personnel

(a) Market conduct surveillance personnel shall be qualified by education, experience and, where applicable, professional designations. The Commissioner may supplement the in-house market conduct surveillance staff with qualified outside professional assistance if he/she determines that such assistance is necessary.

(b) Market conduct surveillance personnel have a conflict of interest, either directly or indirectly, if they are affiliated with the management, have been employed by, or own a pecuniary interest in the insurer subject to any examination under this Act within the most recent five years prior to the use of the personnel. This section shall not be construed to automatically preclude an individual from being:

(1) A policyholder or claimant under an insurance policy;

(2) A grantee of a mortgage or similar instrument on the individual's residence from a regulated entity if done under customary terms and in the ordinary course of business;

(3) An investment owner in shares of regulated diversified investment companies;
or

(4) A settlor or beneficiary of a "blind trust" into which any otherwise permissible holdings have been placed.

Section 10. Immunity for Market Conduct Surveillance Personnel

(a) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or an examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

(b) No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive.

(c) A person identified in subsection (a) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

(d) This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified subsection (a).

Section 11. Fines and Penalties

(a) Fines and penalties levied pursuant to this Act or other provisions of the state Insurance Law shall be consistent, reasonable and justified.

(b) The Commissioner shall take into consideration actions taken by insurers that maintain membership in best-practice organizations that exist to promote high ethical standards of conduct in the marketplace, and insurers that self assess, self-report and remediate problems detected to mitigate fines levied pursuant to this Act.

Drafting Note: It is anticipated that best practice organizations such as the Insurance Marketplace Standards Association (IMSA) in the life insurance industry, and the National Committee for Quality Assurance (NCQA) and the Utilization Review Accreditation Commission (URAC) in the health insurance industry, will play an important role in market conduct by expanding the frequency of voluntary insurer compliance programs. To the extent that these or similar organizations, through their compliance qualification process and procedures, can foster a culture of compliance, their contribution to market conduct surveillance should be recognized.

Section 12. Data Collection and Participation in National Market Conduct Databases

The Commissioner shall collect and report market data to the NAIC's market information systems, including the Complaint Database System, the Examination Tracking System, and the Regulatory Information Retrieval System, or other comparable successor NAIC products as determined by the Commissioner. In addition to complaint data, the accuracy of insurer-specific information reported to the NAIC to be used for market analysis purposes or as the basis for market conduct actions shall be reviewed by appropriate personnel in the Insurance Department and by the insurer.

(a) Information collected and maintained by the Insurance Department shall be compiled in a manner that meets the requirements of the NAIC.

(b) After completion of any level of Market Analysis, prior to further market conduct action, the state shall contact the insurer to review the analysis.

(c) (1) A company responding to a Commissioner's request to produce information shall produce it as it is kept in the usual course of business or shall organize and label it to correspond with the categories in the demand.

(2) If a Commissioner's request does not specify the form or forms for producing electronically stored information, a company responding to the request must produce the information in a form or forms in which the company ordinarily maintains it or in a form or forms that are reasonably usable.

(3) A company responding to an information request need not produce the same electronically stored information in more than one form.

(4) A company responding to an information request need not provide the electronically stored information from sources that the company identifies as not reasonably accessible because of undue burden or cost.

Drafting Note: Sections (d) (1)-(4) are based on proposed amendments to the Federal Rules of Civil Procedure relating to discovery of electronic data. Approved by the United States Supreme Court, the amendments will take effect on December 1, 2006, unless Congress enacts modifying legislation.

Section 13. Coordination with Other States Through the NAIC

The Commissioner shall share information and coordinate the Insurance Department's market analysis and examination efforts with other states through the NAIC.

Drafting Note: The NAIC Market Analysis Working Group is the national, confidential forum established by the NAIC to provide regulators with opportunities to share and coordinate the results of their market analysis programs and market conduct actions. States participating in MAWG are expected to conduct their market analysis programs in a manner consistent with guidelines adopted by the NAIC. Adoption of this (or a similar) model law, coupled with expanded participation in MAWG by states, will help foster the goal of domestic deference, thereby helping to fulfill the goal of making market conduct surveillance a national system of regulation that is more standard and uniform.

Section 14. Additional Duties of the Commissioner

(a) At least once per year, or more frequently if deemed necessary, the Commissioner shall make available in an appropriate manner to insurers and other entities subject to the

scope of [cite Insurance Code citation] information on new laws and regulations, enforcement actions and other information the Commissioner deems pertinent to ensure compliance with market conduct requirements.

(b) The Commissioner shall designate a specific person or persons within the Insurance Department whose responsibilities shall include the receipt of information from employees of insurers and licensed entities concerning violations of laws, rules or regulations by employers, as defined in this section. Such person or persons shall be provided with proper training on the handling of such information, which shall be deemed a confidential communication for the purposes of this section.

(c) For any change made to a work product referenced in this Act, which materially changes the way in which market analysis, market conduct actions, or market conduct examinations are conducted, the Commissioner shall give notice and provide parties with an opportunity for a public hearing pursuant to [cite appropriate state administrative procedures act].

Drafting Note 1: The provisions of subsection (b) relating to the designation by the Commissioner of an employee to receive “whistleblower” type complaints may be added to an existing whistleblower statute, added as drafted above or omitted.

Drafting Note 2: States that choose to impose additional duties or responsibilities on their own Insurance Commissioners may insert additional subdivisions to this section.

Section 15. Effective Date

This Act shall take effect [insert chosen date].

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Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

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)*

**To be discussed during the Health Insurance and Long Term Care Issues on March 15th, 2019*

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Disclosure of Prescription Drug Pricing Information
Section 5.	Disclosure of Pharmacy Benefit Management Information
Section 6.	Disclosure of Health [Carrier/Insurer] Spending Information
Section 7.	Severability
Section 8.	Effective Date

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 DEPARTMENT'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 [INSURANCE 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.

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Sen. Travis Holdman, IN

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

RESOLUTION IN SUPPORT OF AMENDING ERISA TO ENABLE STATE POLICYMAKERS TO ENACT MORE MEANINGFUL STATE HEALTHCARE REFORMS

**Sponsored by Asm. Kevin Cahill (NY) and Rep. Jim Dunnigan (UT)*

**To be discussed and considered during the Health Insurance and Long Term Care Issues Committee on March 15th, 2019*

WHEREAS, the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 et seq. (ERISA) was signed into law with the intent of establishing uniform federal standards to protect private employee pension plans from fraud and mismanagement, but the statute has come to apply to most other types of private employee benefit plans, including health plans; and

WHEREAS, the U.S. Supreme Court has held that:

- ERISA preempts “any and all” state laws that “relate to” an employee benefit plan;
- ERISA does not preempt state laws that regulate insurance;
- Self-insured employee benefit plans are not considered insurance under ERISA, therefore;
- ERISA preempts “any and all” state laws that “relate to” an employee benefit plan provided by a self-insured employer; and

WHEREAS, although federal law typically displaces conflicting state law in cases where compliance with state law would make compliance with the federal law impossible, ERISA goes further, broadly preempting “***any and all***” state laws that “relate to” a self-insured employee benefit plan, regardless of whether such laws conflict with existing federal laws; and

WHEREAS, courts’ broad interpretations of whether a state law “relates to” a self-insured employee benefit plan has put such plans essentially beyond the reach of most state health regulations, including those that seek to mandate health benefits, increase health insurance coverage, control healthcare costs, and gather information about healthcare prices and quality; and

WHEREAS, more than 60 percent of all workers with private, employer-based health insurance are in self-funded employee benefit plans; and

WHEREAS, ERISA has grown far beyond its original intent of establishing uniform federal standards to protect private employee pension plans from fraud and mismanagement, and has transformed into a critical barrier for states seeking to enact meaningful healthcare reforms; and

WHEREAS, in order to ensure that states continue serving their role as sources of healthcare innovation in the most meaningful way, federal action is needed to amend ERISA; and

WHEREAS, ERISA - unlike most federal healthcare statutes such as Medicaid, Medicare, and the Affordable Care Act (ACA) - does not contain waiver provisions that enable states to pursue policy experiments consistent with the states' role as "laboratories of democracy"; and

WHEREAS, statutory waivers can provide states flexibility to work within a federal statutory scheme and mitigate unintended consequences of federal laws; and

WHEREAS, amending ERISA to add a statutory waiver provision that would allow states to apply to the Department of Labor (DOL), which could coordinate with the Departments of Treasury and Health & Human Services, for approval to deviate from certain ERISA preemption provisions in order to pursue certain healthcare reforms would simultaneously preserve ERISA's preemption baseline and encourage supervised state experimentation with healthcare reform efforts in a proven, successful state regulatory scheme; and

WHEREAS, such a waiver process would not only restore states' autonomy and ability to experiment with policy solutions to benefit their citizens, but shift some of the authority over state healthcare reform efforts from courts to agencies, thereby relying on agencies' substantive expertise rather than courts' preemption precedents; and

WHEREAS, NCOIL recognizes that states can and do enact meaningful healthcare reforms, but such reforms would be much more meaningful if applicable to all of a state's privately insured citizens; and

WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges members of Congress to take action and pass legislation that would amend ERISA to add a waiver provision enabling states to include self-insured single state employers in a wide range of healthcare reforms; and

BE IT FINALLY RESOLVED, that a copy of this Resolution be sent to the members of the U.S. House Financial Services Committee; the members of the Senate Banking Committee; the Speaker and Minority Leader of the U.S. House of Representatives; the Majority Leader and Minority Leader of the U.S. Senate; the Secretary of the Department

of Labor; the Secretary of the U.S. Department of Health and Human Services; the National Association of Insurance Commissioners (NAIC); and the Chair of all state committees that have jurisdiction over insurance matters.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

State Flood Disaster Mitigation and Relief Model Act

Amended by the NCOIL Property-Casualty Insurance Committee on July 11, 2008, and Executive Committee on July 13, 2008.

Originally adopted by the NCOIL Property-Casualty Insurance and Executive Committees on November 21, 2003.

Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018; re-adoption extended by the NCOIL Property & Casualty Insurance Committee on December 7, 2018 and the NCOIL Executive Committee on December 8, 2018 (per NCOIL bylaws, 5 year re-adoption is pending while amendments are being considered)

****To be discussed by the Special Committee on Natural Disaster Recovery Committee on March 15th, 2019****

****Proposed Amendments Sponsored by Rep. David Santiago (FL)***

Table of Contents

Section 1 Purpose
Section 2 Short Title

Part I. Flood Insurance Coverage and Notice

Sec. 1 Flood insurance purchase and compliance requirements and escrow accounts
Sec. 2 Notice requirements
Sec. 3 Rules; report

Part II. Floodplain Regulation

Sec. 1 Purposes
Sec. 2 Definitions
Sec. 3 Regulation of flood hazard areas; prohibited uses
Sec. 4 Minimum standards for ordinances; variances for prohibited uses
Sec. 5 Acquisition of existing structures
Sec. 6 Delineation of flood hazard areas and 100-year floodplains; powers of the Agency; powers of local governments and of the Agency

- Sec. 7 Procedures in issuing permits
- Sec. 8 Violations and penalties
- Sec. 9 Other approvals required
- Sec.10 Floodplain management

Part III. Floodplain Management and Hazard Mitigation

- Sec. 1 Zoning restrictions in floodplain
- Sec. 2 Creation of plan by Secretary
- Sec. 3 Plan of conservation and development
- Sec. 4 Hazard mitigation and floodplain management account; funding
- Sec. 5 Definitions
- Sec. 6 Hazard mitigation and floodplain management grant program
- Sec. 7 Grants to municipalities for planning
- Sec. 8 Municipal report
- Sec. 9 Regulations
- Sec. 10 Model ordinance

Part IV. Miscellaneous Provisions Regarding Participation

- Sec. 1 Insurance producer qualification; continuing education
- Sec. 2 Insurance adjuster qualification; education
- Sec. 3 Real estate broker and salesperson qualification; education
- Sec. 4 Disclosure of real estate flood propensity

Part V. Facilitating Private Flood Insurance

- Sec. 1 Prior Form Approval
- Sec. 2 Rates
- Sec. 3 Duties of Insurer
- Sec. 4 Duties of an Agent
- Sec. 5 Other Provisions

Section 1. Purpose

The legislature finds that unforeseen periodic flood disasters cause personal hardship and economic distress, requiring substantial disaster relief that strains limited state resources. The legislature further finds managing these disasters requires the participation of state and local governments to mitigate the hazard and lower the magnitude of the disaster.

In order to provide a sustainable system to provide disaster relief, in 1968 the U.S. Congress has established the National Flood Insurance Program (NFIP), to which provides flood insurance in conjunction with the private insurance industry. This NFIP remains in operation, however the program has incurred significant losses and now has substantial debt as a result. While there have been various efforts by Congress to address the issue (Biggert Waters Flood Insurance Reform Act of 2012 and the Homeowner Flood Insurance Affordability Act of 2014), no permanent solution has been adopted.

In response to the uncertainties surrounding the program, many private insurers have begun to explore the possibility of offering private flood insurance policies to consumers.

The legislature ~~further~~ finds that in addition to the policies available via the NFIP, encouraging private insurers to offer flood insurance policies to consumers will enhance the long term stability of the state's property insurance market. Further, the viability of this essential program requires the participation of state and local governments to mitigate the hazard and lower the magnitude of the potential disasters.

This Act develops a multifaceted state program of insurance policy options; producer and realtor education; local floodplain zoning; mandatory purchase of flood insurance by, and notification by lenders to, property owners in a floodplain; property owner self-certification of compliance; and other measures to improve floodplain management and hazard mitigation.

Section 2. Short Title

This act may be called the State Flood Insurance and Disaster Mitigation ~~and~~ Relief Model Act.

PART I. FLOOD INSURANCE COVERAGE AND NOTICE

Sec. 1. Flood insurance purchase and compliance requirements and escrow accounts

(a) Requirement of State officers/agencies. After 60 days following the passage of this Act, no state officer or agency shall approve any financial assistance for acquisition or construction purposes for use in any area that has been identified by the Director of the Federal Emergency Management Agency (FEMA) or designee as an area having special flood hazards and in which the sale of flood insurance has been ~~made available under the National Flood Insurance Act, 42 U.S.C. Chapter 50,~~ unless the building or mobile home and any personal property to which such financial assistance relates is covered by flood insurance in an amount at least equal to its development or project cost (less estimated land cost) or to the maximum limit of coverage made available with respect to the particular type of property under the National Flood Insurance Act, 42 U.S.C. Chapter 50, whichever is less. If the financial assistance provided is in the form of a loan or an insurance or guaranty of a loan, the amount of flood insurance required need not exceed the outstanding principal balance of the loan and need not be required beyond the term of the loan. The requirement of maintaining flood insurance shall apply during the life of the property, regardless of transfer of ownership of such property.

(b) Requirement for mortgage loans.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation direct regulated lending institutions not to make, increase, extend, or renew any loan secured by improved real estate or a mobile home located or to be located in an area that has been identified by the Director as an area having special flood hazards and in which flood insurance has been ~~made available under the National Flood Insurance Act, 42 U.S.C. Chapter 50,~~ unless the building or mobile home and any personal property securing such loan is covered for the term of the loan by flood insurance in an amount at least equal to the outstanding principal balance of the loan or the maximum limit of coverage

made available under the Act with respect to the particular type of property, whichever is less.

(2) Applicability

(A) Existing coverage. Except as provided in subdivision (b)(1), this subsection shall apply [three months] after the effective date of this Act.

(B) New coverage. This subsection shall apply only with respect to any loan made, increased, extended, or renewed after the expiration of the one-year period beginning [three months] after the effective date of this Act.

(3) Small loans. Notwithstanding any other provision of this Sec. 1, subsections (a) and (b) of this section shall not apply to any loan having

(A) an original outstanding principal balance of \$5,000 or less; and

(B) a repayment term of one year or less.

(c) Escrow of flood insurance payments.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation require that, if a regulated lending institution requires the escrowing of taxes, insurance premiums, fees, or any other charges for a loan secured by residential improved real estate or a mobile home, then all premiums and fees for flood insurance ~~under the National Flood Insurance Act, 42 U.S.C. Chapter 50~~ for the real estate or mobile home shall be paid to the regulated lending institution or other servicer for the loan in a manner sufficient to make payments as due for the duration of the loan. Upon receipt of the premiums, the regulated lending institution or servicer of the loan shall deposit the premiums in an escrow account on behalf of the borrower. Upon receipt of a notice from the [State entity for lending regulation] or the provider of the insurance that insurance premiums are due, the regulated lending institution or servicer shall pay from the escrow account to the provider of the insurance the amount of insurance premiums owed.

(2) "Residential improved real estate" defined. For purposes of this subsection, the term "residential improved real estate" means improved real estate for which the improvement is a residential building.

(3) Applicability. This subsection shall apply only with respect to any loan made, increased, extended, or renewed after [one year following the passage of this Act].

(d) Placement of flood insurance by lender.

(1) Notification to borrower of lack of coverage. If, at the time of origination or at any time during the term of a loan secured by improved real estate or by a mobile home located in an area that has been identified by the Director (at the time of the origination of the loan or at any time during the term of the loan) as an area having special flood hazards and in which flood insurance is available ~~under the National Flood Insurance Act, 42 U.S.C. Chapter 50~~, the lender or servicer for the loan determines that the building or mobile home and any personal property securing the loan is not covered by flood insurance or is covered by such insurance in an amount less than the amount required for the property pursuant to subdivision (b)(1), (2), or (3) of this Sec. 1, the lender or servicer shall notify the borrower under the loan that the borrower should obtain, at the borrower's expense, an amount of flood insurance for the building or mobile home and such personal property that is not less than the amount under subdivision (b)(1) of this Sec.1, for the term of the loan.

(2) Purchase of coverage on behalf of borrower. If the borrower fails to purchase such flood insurance within 45 days after notification under subdivision (d)(1), the lender or servicer for the loan shall purchase the insurance on behalf of the borrower and may charge the borrower for the cost of premiums and fees incurred by the lender or servicer for the loan in purchasing the insurance.

(3) Review of determination regarding required purchase.

(A) In general. The borrower and lender for a loan secured by improved real estate or a mobile home may jointly request the Director to review a determination of whether the building or mobile home is located in an area having special flood hazards. Such request shall be supported by technical information relating to the improved real estate or mobile home. Not later than 45 days after the Director receives the request, the Director shall review the determination and provide to the borrower and the lender a letter stating whether or not the building or mobile home is in an area having special flood hazards. The determination of the Director shall be final.

(B) Effect of determination. Any person to whom a borrower provides a letter issued by the Director pursuant to subdivision (d)(3)(A), stating that the building or mobile home securing the loan of the borrower is not in an area having special flood hazards, shall have no obligation under this title to require the purchase of flood insurance for such building or mobile home during the period determined by the Director, which shall be specified in the letter and shall begin on the date on which such letter is provided.

(C) Effect of failure to respond. If a request under subdivision (d)(3)(A) is made in connection with the origination of a loan and the Director fails to provide a letter under subdivision (d)(3)(A) before the later of either (i) the expiration of the 45-day period under such subdivision, or (ii) the closing of the loan, no person shall have an obligation under this title to require the purchase of flood insurance for the building or mobile home securing the loan until such letter is provided.

(4) Applicability. This subsection (d) shall apply to all loans outstanding on or after [three months following the passage of this Act].

(e) Civil monetary penalties for failure to require flood insurance or to notify.

(1) Civil monetary penalties against regulated lenders. Any regulated lending institution that is found to have a pattern or practice of committing violations under subdivision (e)(2) (below) shall be assessed a civil penalty by the [appropriate State entity for lending regulation] in the amount provided under subdivision (e)(4) (below).

(2) Lender violations. The violations referred to in subdivision (e)(1) shall include:

- (A) making, increasing, extending, or renewing loans in violation of:
 - (i) the regulations issued pursuant to subsection (b) of this Sec. 1;
 - (ii) the escrow requirements under subsection (c) of this Sec. 1;
 - or
 - (iii) the notice requirements under Sec. 2 of this Part (below); or
- (B) failure to provide notice or purchase flood insurance coverage in violation of subsection (e) of this section.

(3) Notice and hearing. A penalty under this subsection (e) may be issued only after notice and an opportunity for a hearing on the record.

(4) Amount. A civil monetary penalty under this subsection may not exceed \$350 for each violation cited under subdivision (e)(2). The total amount of penalties assessed under this subsection against any single regulated lending institution or enterprise during any calendar year may not exceed \$100,000.

(5) Lender compliance. Notwithstanding any State or local law, for purposes of this subsection (e), any regulated lending institution that purchases flood insurance or renews a contract for flood insurance on behalf of or as an agent of a borrower of a loan for which flood insurance is required shall be considered to have complied with the regulations issued under subsection (b) of this Sec. 1.

(6) Effect of transfer on liability. Any sale or other transfer of a loan by a regulated lending institution that has committed a violation under subdivision (e)(1), which occurs subsequent to the violation, shall not affect the liability of the transferring lender with respect to any penalty under this subsection. A lender shall not be liable for any violations relating to a loan committed by another regulated lending institution that previously held the loan.

(7) Deposit of penalties. Any penalties collected under this subsection shall be paid into the Hazard Mitigation and Floodplain Management Account established in Sec. 4 of Part III of this Act. [Drafting note: This money could be targeted for floodplain mapping.]

(8) Additional penalties. Any penalty under this subsection shall be in addition to any civil remedy or criminal penalty otherwise available.

(9) Statute of limitations. No penalty may be imposed under this subsection after the expiration of the [four-year period] beginning on the date of the occurrence of the violation for which the penalty is authorized under this subsection.

(f) Other actions to remedy pattern of noncompliance.

(1) Authority of State entities for lending regulation. A [State entity for lending] regulation may require a regulated lending institution to take such remedial actions as are necessary to ensure that the regulated lending institution complies with the requirements of the National Flood Insurance Program if the State agency for lending regulation makes a determination under subdivision (f)(2) (below) regarding the regulated lending institution.

(2) Determination of violations. A determination under this subdivision shall be a finding that:

(A) the regulated lending institution has engaged in a pattern and practice of noncompliance in violation of the regulations issued pursuant to subsection (b), (c), or (d) of this Sec. 1 or the notice requirements under Sec. 2 of this Part; and

(B) the regulated lending institution has not demonstrated measurable improvement in compliance despite the assessment of civil monetary penalties under subsection (e) of this Sec. 1.

(g) Fee for determining location. Notwithstanding any other Federal or State law, any person who makes a loan secured by improved real estate or a mobile home or any servicer for such a loan may charge a reasonable fee for the costs of determining whether the building or mobile home securing the loan is located in an area having special flood hazards, but only in accordance with the following requirements:

(1) Borrower fee. The borrower under such a loan may be charged the fee, but only if the determination:

(A) is made pursuant to the making, increasing, extending, or renewing of the loan that is initiated by the borrower;

(B) is made pursuant to a revision or updating under 42 U.S.C. 4101(f) of the floodplain areas and flood-risk zones or publication of a notice or compendia under subsection (h) or (i) of 42 U.S.C. 4101(h) or (i) that affects the area in which the improved real estate or mobile home securing the loan is located or that, in the determination of the Director, may reasonably be considered to require a determination under this subsection; or

(C) results in the purchase of flood insurance coverage pursuant to the requirement under subdivision (d)(2) of this Sec. 1.

(2) Purchaser or transferee fee. The purchaser or transferee of such a loan may be charged the fee in the case of sale or transfer of the loan.

Sec. 2. Notice requirements

(a) Notification of special flood hazards.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, as a condition of making, increasing, extending, or renewing any loan secured by improved real estate or a mobile home that the regulated lending institution determines is located or is to be located in an area that has been identified by the Director under 42 U.S.C. Chapter 50 as an area having special flood hazards, to notify the purchaser or lessee (or to obtain satisfactory assurances that the seller or lessor has notified the purchaser or lessee) and the servicer of the loan of such special flood hazards, in writing, a reasonable period in advance of the signing of the purchase agreement, lease, or other documents involved in the transaction. The regulations also shall require that the regulated lending institution retain a record of the receipt of the notices by the purchaser or lessee and the servicer.

(2) Contents of notice. Written notification required under this subsection (a) shall include:

(A) a warning, in a form to be established by the [State entity for lending regulation], stating that the building on the improved real estate securing the loan is located, or the mobile home securing the loan is or is to be located, in an area having special flood hazards;

(B) a description of the flood insurance purchase requirements under section 102(b) of the Flood Disaster Protection Act, 42 U.S.C. Chapter 50;

(C) a statement that flood insurance coverage may be purchased under the National Flood Insurance Program and also is available from private insurers; and

(D) any other information that the [State entity for lending regulation] considers necessary to carry out the purposes of the National Flood Insurance Program.

(b) Notification of change of servicer.

(1) Lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, in connection with the making, increasing, extending, renewing, selling, or transferring any loan described in subdivision (b)(1) of this Sec. 1, to notify, in writing, the [State entity for lending regulation] of the servicer of the loan during the term of the loan. Such institutions shall also notify the [State entity for lending regulation] of any change in the servicer of the loan, not later than 60 days after the effective date of such

change. The regulations under this subsection shall provide that, upon any change in the servicing of a loan, the duty to provide notification under this subsection shall transfer to the transferee servicer of the loan.

(c) Notification of expiration of insurance. The [State entity for lending regulation] shall, not less than 45 days before the expiration of any contract for flood insurance under this chapter, issue notice of such expiration by first-class mail to the owner of the property covered by the contract, the servicer of any loan secured by the property covered by the contract, and (if known to the [State entity for lending regulation]) the owner of the loan.

Sec. 3. Rules; report

(a) The [State entity for lending regulation] is authorized to adopt rules to implement this Part I.

(b) The [State entity for lending regulation] shall submit a report to the legislature on the implementation of this Part I and on compliance with the rules one year after passage.

PART II. FLOODPLAIN REGULATION

Sec. 1. Purposes

The purposes of this Part are to:

- (1) Minimize the extent of floods by preventing obstructions that inhibit water flow and increase flood height and damage.
- (2) Prevent and minimize loss of life, injuries, property damage, and other losses in flood hazard areas.
- (3) Promote the public health, safety, and welfare of citizens of the State in flood hazard areas.

Sec. 2. Definitions

(a) As used in this Part:

- (1) "Agency" means the state agency in charge of floodplain regulation
- (2) "Artificial obstruction" means any obstruction to the flow of water in a stream that is not a natural obstruction, including any that, while not a significant obstruction in itself, is capable of accumulating debris and thereby reducing the flood-carrying capacity of the stream.
- (3) "Base flood" or "100-year flood" means a flood that has a one percent (1%) chance of being equaled or exceeded in any given year. The term "base flood" is used in the National Flood Insurance Program to indicate the minimum level of flooding to be addressed by a community in its floodplain management regulations.
- (4) "Base floodplain" or "100-year floodplain" means that area subject to a one percent (1%) or greater chance of flooding in any given year, as shown on the current floodplain maps prepared pursuant to the National Flood Insurance Program or approved by the Agency.
- (5) "Flood hazard area" means the area designated by a local government, pursuant to this Part, as an area where development must be regulated to

prevent damage from flooding. The flood hazard area must include and may exceed the base floodplain.

(6) "Local government" means any county or city.

(7) "Lowest floor," when used in reference to a structure, means the lowest enclosed area, including a basement, of the structure. An unfinished or flood-resistant enclosed area, other than a basement, that is usable solely for parking vehicles, building access, or storage is not a lowest floor.

(8) "Natural obstruction" includes any rock, tree, gravel, or other natural matter that is an obstruction and has been located within the 100-year floodplain by a nonhuman cause.

(9) "Secretary" means the Secretary of the Agency.

(10) "Stream" means a watercourse that collects surface runoff from an area of one square mile or greater.

(11) "Structure" means a walled or roofed building, including a mobile home and a gas or liquid storage tank.

(b) As used in this Part, the terms "artificial obstruction" and "structure" do not include any of the following:

(1) An electric generation, distribution, or transmission facility.

(2) A gas pipeline or gas transmission or distribution facility, including a compressor station or related facility.

(3) A water treatment or distribution facility, including a pump station.

(4) A wastewater collection or treatment facility, including a lift station.

(5) Processing equipment used in connection with a mining operation.

Sec. 3. Regulation of flood hazard areas; prohibited uses

(a) Powers of local government. A local government may adopt ordinances to regulate uses in flood hazard areas and may grant permits for the use of flood hazard areas that are consistent with the requirements of this Part II.

(b) Allowable uses. The following uses may be made of flood hazard areas without a permit issued under this Part, provided that these uses comply with local land-use ordinances and any other applicable laws or regulations:

(1) General farming, pasture, outdoor plant nurseries, horticulture, forestry, mining, wildlife sanctuary, game farm, and other similar agricultural, wildlife, and related uses;

(2) Ground-level loading areas, parking areas, rotary aircraft ports and other similar ground-level area uses;

(3) Lawns, gardens, play areas and other similar uses;

(4) Golf courses, tennis courts, driving ranges, archery ranges, picnic grounds, parks, hiking or horseback riding trails, open space, and other similar private and public recreational uses.

(5) Land application of waste at agronomic rates consistent with an approved animal waste-management plan.

(6) Land application of septage consistent with a permit issued by the State permit authority.

(c) Prohibited uses. New solid waste disposal facilities, hazardous waste management facilities, salvage yards, and chemical storage facilities are prohibited in the 100-year floodplain except as authorized under Sec. 4(b) (below).

Sec. 4. Minimum standards for ordinances; variances for prohibited uses

(a) A flood-hazard prevention ordinance adopted by a county or city pursuant to this Part shall, at a minimum:

- (1) Meet the requirements for participation in the National Flood Insurance Program and of this Sec. 4.
- (2) Prohibit new solid waste disposal facilities, hazardous waste management facilities, salvage yards, and chemical storage facilities in the 100-year floodplain except as authorized under subsection (b) of this Sec. 4.
- (3) Provide that a structure or tank for chemical or fuel storage incidental to a use that is allowed under this Sec. 4 or to the operation of a water treatment plant or wastewater treatment facility may be located in a 100-year floodplain only if the structure or tank is either elevated above base-flood elevation or designed to be watertight with walls substantially impermeable to the passage of water and with structural components capable of resisting hydrostatic and hydrodynamic loads and the effects of buoyancy.

(b) Variances. A flood-hazard prevention ordinance may include a procedure for granting variances for uses prohibited under Sec. 3(c). A county or city shall notify the Secretary of its intention to grant a variance at least 30 days prior to granting the variance. A county or city may grant a variance upon finding that all of the following apply:

- (1) The use serves a critical need in the community.
- (2) No feasible location exists for the location of the use outside the 100-year floodplain.
- (3) The lowest floor of any structure is elevated above the base-flood elevation or is designed to be watertight with walls substantially impermeable to the passage of water and with structural components capable of resisting hydrostatic and hydrodynamic loads and the effects of buoyancy.
- (4) The use complies with all other applicable laws and regulations.

Sec. 5. Acquisition of existing structures

A local government may acquire, by purchase, exchange, or condemnation an existing structure located in a flood hazard area in the area regulated by the local government if the local government determines that the acquisition is necessary to prevent damage from flooding. The procedure in all condemnation proceedings pursuant to this Sec. 5 shall conform as nearly as possible to the procedure provided in [State statute reference].

Sec. 6. Delineation of flood hazard areas and 100-year floodplains; powers of the Agency; powers of local governments and of the Agency

(a) Use of additional resources. For the purpose of delineating a flood hazard area and evaluating the possibility of flood damages, a local government may:

- (1) Request technical assistance from the competent State and federal agencies, including the Army Corps. of Engineers, the Natural Resources Conservation Service, the Federal Emergency Management Agency (FEMA), the Department of Public Safety, and the U.S. Geological Survey, or successor agencies.

(2) Utilize the reports and data supplied by federal and state agencies as the basis for the exercise by local ordinance or resolution of the powers and responsibilities conferred on responsible local governments by this Part II.

(b) Powers of the Agency. The Agency shall provide advice and assistance to any local government having responsibilities under this Part. In exercising this function, the Agency may furnish manuals, suggested standards, plans, and other technical data; conduct training programs; give advice and assistance with respect to delineation of flood hazard areas and the development of appropriate ordinances; and provide any other advice and assistance that the Agency deems appropriate. The Agency shall send a copy of every rule adopted to implement this Part to the governing body of each local government in the State.

(c) Delineation using maps and descriptions. A local government may delineate any flood hazard area subject to its regulation by showing it on a map or drawing, by a written description, or any combination thereof, to be designated appropriately and filed permanently with the clerk of superior court and with the register of deeds in the county where the land lies. A local government also may delineate a flood hazard area by reference to a map prepared pursuant to the National Flood Insurance Program. Alterations in the lines delineated shall be indicated by appropriate entries upon or addition to the appropriate map, drawing, or description. Entries or additions shall be made by or under the direction of the clerk of superior court. Photographic, typed, or other copies of the map, drawing, or description, certified by the clerk of superior court, shall be admitted in evidence in all courts and shall have the same force and effect as would the original map or description. A local government may provide for the redrawing of any map. A redrawn map shall supersede for all purposes the earlier map or maps that it is designated to replace upon the filing and approval thereof as designated and provided above.

(d) Preparation of maps. The Agency may prepare a floodplain map that identifies the 100- year floodplain and base-flood elevations for an area for the purposes of this Part II if all of the following conditions apply:

- (1) The 100-year floodplain and base-flood elevations for the area are not identified on a floodplain map prepared pursuant to the National Flood Insurance Program within the previous five years.
- (2) The Agency determines that the 100-year floodplain and the base-flood elevations for the area need to be identified and the use of the area regulated in accordance with the requirements of this Part II in order to prevent damage from flooding.
- (3) The Agency prepares the floodplain map in accordance with the federal standards required for maps to be accepted for use in administering the National Flood Insurance Program.

(e) Notice. Prior to preparing a floodplain map pursuant to subsection (d) of this Sec. 6, the Agency shall advise each local government whose jurisdiction includes a portion of the area to be mapped.

(f) Upon completing a floodplain map pursuant to subsection (d) of this Sec. 6, the Agency shall both:

- (1) Provide copies of the floodplain map to every local government whose jurisdiction includes a portion of the 100-year floodplain identified on the floodplain map.
- (2) Submit the floodplain map to the Federal Emergency Management Agency for approval for use in administering the National Flood Insurance Program.

(g) Responsibility upon approval of map. Upon approval by the Federal Emergency Management Agency of a floodplain map prepared pursuant to subsection (d) of this Sec. 6 for use in administering the National Flood Insurance Program, it shall be the responsibility of each local government whose jurisdiction includes a portion of the 100-year floodplain identified in the floodplain map to incorporate the revised map into its floodplain ordinance.

Sec. 7. Procedures in issuing permits

(a) Considerations. A local government may establish application forms and require maps, plans, and other information necessary for the issuance of permits in a manner consonant with the objectives of this Part II. For this purpose a local government may take into account anticipated development in the foreseeable future that may be adversely affected by the obstruction, as well as existing development. A local government shall consider the danger that a proposed artificial obstruction in a stream may pose to life and property by:

- (1) Water that may be backed up or diverted by the obstruction.
- (2) The danger that the obstruction will be swept downstream to the injury of others.
- (3) The injury or damage at the site of the obstruction itself.

(b) Ordinances. In prescribing standards and requirements for the issuance of permits under this Part II and in issuing permits, local governments shall enact ordinances.

(c) Issuance of permits. The local governing body is hereby empowered to adopt regulations it may deem necessary concerning the form, time, and manner of submission of applications for permits under this Part II. These regulations may provide for the issuance of permits under this Part by the local [governing body], as prescribed by the governing body. Every final decision granting or denying a permit under this Part shall be subject to review by the superior court of the county, with the right of jury trial at the election of the party seeking review. Pending the final disposition of an appeal, no action shall be taken that would be unlawful in the absence of a permit issued under this Part.

Sec. 8. Violations and penalties

(a) Violations. Any willful violation of this Part II or of any ordinance adopted (or of the provisions of any permit issued) under the authority of this Part shall constitute a [indicate level of crime] misdemeanor.

- (1) A local government may use all of the remedies available for the enforcement of ordinances to enforce an ordinance adopted pursuant to this Part II.

(b) Failure to remedy. Failure to remove any artificial obstruction or enlargement or replacement thereof, that violates this Part or any ordinance adopted (or the provision of any permit issued) under the authority of this Part, shall constitute a separate violation of

this Part for each day that the failure continues after written notice from the county board of commissioners or governing body of a city.

(c) Other proceedings. In addition to or in lieu of other remedies, the local governing body may institute any appropriate action or proceeding to restrain or prevent any violation of this Part II or of any ordinance adopted (or of the provisions of any permit issued) under the authority of this Part, or to require any person, firm, or corporation that has committed a violation to remove a violating obstruction or restore the conditions existing before the placement of the obstruction.

Sec. 9. Other approvals required

(a) Approvals required under separate statutes. The granting of a permit under the provisions of this Part II shall in no way affect any other type of approval required by any other statute or ordinance of the State or any political subdivision of the State, or of the United States, but shall be construed as an added requirement.

(b) Permits for construction. No permit for the construction of any structure to be located within a flood-hazard area shall be granted by a political subdivision unless the applicant has first obtained the permit required by any local ordinance adopted pursuant to this Part.

Sec. 10. Floodplain management

The provisions of this Part II shall not preclude the imposition by responsible local governments of land-use controls and other regulations in the interest of floodplain management for the 100-year floodplain.

PART III. FLOODPLAIN MANAGEMENT AND HAZARD MITIGATION

Sec. 1. Zoning restrictions in floodplain

(a) Definition. As used in this Sec. 1, "floodplain" means that area of a municipality located within the real or theoretical limits of the base flood or base flood for a critical activity, as determined by the Federal Emergency Management Agency in its flood insurance study or flood insurance–rate map for the municipality, prepared pursuant to the National Flood Insurance Program (44 C.F.R. Part 59 et seq.).

(b) Restrictions upon revising zoning requirements. Whenever a municipality, pursuant to the National Flood Insurance Program (44 C.F.R. Part 59 et seq.), is required to revise its zoning regulation or any other ordinance regulating a proposed building, structure, development, or use located in a floodplain, the revision shall provide for restrictions for flood storage and conveyance of water for floodplains that are not tidally influenced as follows:

- (1) Within a designated floodplain, all encroachments (including fill, new construction, substantial improvements to existing structures, and any other development) are prohibited unless the applicant provides certification to the commission by a registered professional engineer that such encroachment shall not result in any increase in base-flood elevation;
- (2) The water-holding capacity of the floodplain shall (A) not be reduced by any form of development unless such reduction is compensated for by deepening or

widening the floodplain, (B) be on-site, unless adjacent property owners grant easements, (C) be within the same hydraulic reach and a volume not previously used for flood storage, (D) be hydraulically comparable and incrementally equal to the theoretical volume of flood water at each elevation, up to and including the 100-year flood elevation, which would be displaced by the proposed project, and (E) have an unrestricted hydraulic connection to the same waterway or water body; and

(3) Any work within adjacent land subject to flooding, including work to provide compensatory storage, shall not restrict flows resulting in increased flood stage or velocity.

(c) Additional restrictions. Notwithstanding the provisions of subsection (b) of this Sec. 1, a municipality may adopt more stringent restrictions for flood storage and conveyance of water for floodplains that are not tidally influenced.

Sec. 2. Creation of plan by Secretary

The Secretary of the [State agency in charge of flood regulations], after consultation with all appropriate State, regional and local agencies and other appropriate persons shall, prior to [set date], (1) complete a revision of the existing plan and enlarge it to include policies relating to risks associated with natural hazards, including, but not limited to, flooding, high winds, and wildfires; (2) identify the potential impacts of natural hazards on infrastructure and property; and (3) make recommendations for the siting of future infrastructure and property development to minimize the use of areas prone to natural hazards, including, but not limited to, flooding, high winds, and wildfires.

Sec. 3. Plan of conservation and development

At least once every ten years, the [local entity in charge of planning] shall prepare or amend and shall adopt a plan of conservation and development for the municipality. Following adoption, the [local entity in charge of planning] shall regularly review and maintain such plan. The [local entity in charge of planning] may adopt such geographical, functional, or other amendments to the plan or parts of the plan, in accordance with the provisions of this Sec. 3, as it deems necessary. The [local entity in charge of planning] may, at any time, prepare, amend, and adopt plans for the redevelopment and improvement of districts or neighborhoods that, in its judgment, contain special problems or opportunities or show a trend toward lower land values. The [local entity in charge of planning] shall identify the potential impacts of natural hazards on infrastructure and property and shall prepare, adopt, and amend plans for the siting of future infrastructure and property development to minimize the use of areas prone to natural hazards, including, but not limited to, flooding, high winds, and wildfires.

Sec. 4. Hazard mitigation and floodplain management account

(a) General. There is established an account to be known as the “Hazard Mitigation and Floodplain Management Account.” Any balance remaining in the account at the end of any fiscal year shall be carried forward in the account for the fiscal year next succeeding. The account shall be available to the [State entity in charge of environmental protection] for the purposes of Sec.s 3 to 7, inclusive, of this Part III.

(b) Funding. The State shall increase the fee for land use permits [or similar fee] and

dedicate proceeds of the increase to the Hazard Mitigation and Floodplain Management Account.

Sec. 5. Definitions

As used in Sec.s 6 to 9, inclusive, of this Part III:

(a) "Hazard mitigation" means activities that include, but are not limited to, actions taken to reduce or eliminate long-term risk to human life, infrastructure, and property resulting from natural hazards including, but not limited to, flooding, high winds, and wildfires; and

(b) "Floodplain management" means activities that include, but are not limited to, actions taken to retain the existing capacity of designated floodplain areas to store and convey flood waters.

Sec. 6. Hazard mitigation and floodplain management grant program

(a) Purposes and applications. The [State entity in charge of environmental protection] shall establish and administer a hazard mitigation and floodplain management grant program to reimburse municipalities for costs incurred in the reduction or elimination of long-term risks to human life, infrastructure and property from natural hazards, including, but not limited to, flooding, high winds and wildfires, and in the retention of present capacity of designated floodplain areas to store and convey flood waters. Application for a grant shall be made in writing to the commissioner in such form as the [State entity] may prescribe and shall include a description of the purpose, objectives, and budget of the activities to be funded by the grant. The chief executive officer of the municipality applying for the grant may designate the town planner, director of public works, police chief, fire chief, or emergency management director as the agent to make the application.

(b) Awarding of grants; notice of program. The [State entity in charge of environmental protection] shall establish, by rules, relative priorities for the approval of grants under this Sec. 6. Such priorities may take into account the differing needs of municipalities, the need for consistency and equity in the distribution of grant awards, and the extent to which particular projects may advance the purposes of this section. The [State entity] may establish further criteria for the approval of grants under this Sec. 6 and shall develop and disseminate a pamphlet that describes the evaluation process for grant applications. In awarding grants under this section, the [State entity] shall consult with any person the commissioner deems necessary.

(c) Allocation of moneys. The [State entity] shall allocate not less than 60 percent of the moneys in the Hazard Mitigation and Floodplain Management Account in any fiscal year for grants under this section.

Sec. 7. Grants to municipalities for planning

(a) Effective date. On and after [insert date], the [State entity in charge of environmental protection] shall make grants to municipalities from the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, for hazard mitigation and floodplain management.

(b) Conditions of repayment. If the [State entity] finds that any grant awarded pursuant to this section is being used for other purposes or to supplant a previous source of funds, the commissioner may require repayment.

(c) Specific purposes. The [State entity] shall allocate moneys in the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, for (1) the preparation or revision of hazard mitigation plans by municipalities; (2) the preparation or revision of municipal plans of conservation and development that include the identification of the potential impacts of natural hazards, including, but not limited to, flooding, high winds, and wildfires; (3) reimbursement of costs associated with participation in the community rating system of the National Flood Insurance Program; (4) the execution of hazard mitigation projects by municipalities in accordance with approved hazard mitigation plans; and (5) costs for administering and providing financial assistance for the hazard mitigation and floodplain management grant program established under Sec. 6 of Part III of this Act.

(d) Submission of report. Annually, the [State entity] shall submit a report describing the activities performed with the allocated moneys for the preceding fiscal year to the joint standing committees of the General Assembly having cognizance of matters relating to planning and development and the environment.

Sec. 8. Municipal report

(a) Each municipality that receives a grant from the Hazard Mitigation and Floodplain Management Account, established under Sec. 4 of Part III of this Act, shall submit a report to the [State entity in charge of environmental protection], in such form as the [State entity] prescribes, not later than September first of the fiscal year following the year such grant was received. Such report shall contain a description of activities paid for with financial assistance under the grant. The chief executive officer of a municipality that receives a grant from the Hazard Mitigation and Floodplain Management Account may designate the town planner, director of public works, police chief, fire chief, or emergency management director of that municipality as the agent to make such report.

(b) Report of [State entity in charge of environmental protection]. On or before [insert date], and annually thereafter, the [State entity in charge of environmental protection] shall submit a report on grants made under Sec.s 6 and 7 of Part III of this Act for the preceding fiscal year to the joint standing committees of the General Assembly having cognizance of matters relating to planning and development and the environment. Each such report shall include: (1) a description of the grants made, including the amount, purposes, and the municipalities to which they were made; (2) a summary of the activities for which the Department of Environmental Protection used the moneys allocated to it under Sec. 6 of Part III of this Act; and (3) any findings or recommendations concerning the operation and effectiveness of the grant program.

Sec. 9. Model ordinance

The [State entity in charge of environmental protection] shall develop guidelines to be used by municipalities in revising ordinances restricting flood storage and conveyance of water for floodplains that are not tidally influenced. Such guidelines shall include, but not be limited to, a model ordinance that may be used by municipalities to comply with the

provisions of Sec. 1 of this Part III. The commissioner shall make the guidelines available to the public.

Sec. 10. Regulations

The [State entity in charge of environmental protection] shall adopt regulations to implement the provisions of this Part III.

PART IV. MISCELLANEOUS PROVISIONS REGARDING PARTICIPATION

Sec. 1. Insurance producer qualification; continuing education

The [State entity for regulating insurance] shall require:

(1) Pre-licensing requirement. The [State entity for regulating insurance] shall require all resident insurance producer applicants to demonstrate satisfactory knowledge and understanding of flood insurance and the National Flood Insurance Program, as determined by the [State entity for regulating insurance] in order to qualify for licensure.

(2) Continuing education requirement for existing licensees. The [State entity for regulating insurance] shall require resident insurance producers licensed on [the bill's effective date] to complete a basic or advanced continuing education course related to flood insurance and the National Flood Insurance Program before [a date certain at least two years from the bill's effective date]. The course may be online or instructor-led and shall be approved by the [State entity for regulating insurance]. Completion of the course will provide the licensee with continuing education credits as determined by the [State entity for regulating insurance].

Sec. 2. Insurance adjuster qualification; education

The [State entity for regulating insurance] shall require:

(1) Insurance-adjuster license applicants to demonstrate satisfactory knowledge and understanding of flood insurance, as determined by the [State entity for regulating insurance], in order to qualify; and

(2) An applicant for an insurance-adjuster license renewal to complete at least two hours of continuing educational programs in flood insurance every two years.

Sec. 3. Real estate broker and salesperson qualification; education

The [State entity for regulating the licensing of real estate brokers and salespersons] shall require:

(1) applicants for real-estate broker or salesperson licensing to demonstrate satisfactory knowledge and understanding of flood insurance, as determined by the [State entity for regulating the licensing of real estate brokers and salespersons], in order to qualify; and

(2) an applicant for real-estate broker or salesperson license renewal to complete at least two hours of continuing educational programs in flood insurance every two years.

Sec. 4. Disclosure of real estate flood propensity

The [State entity in charge of consumer protection or the State Real Estate Commission, as the case may be] shall, by regulations, require a written residential disclosure report to be provided to a real estate buyer that is to include information concerning flood propensity. [If a state already has a required form for disclosure, this provision could be added to it.]

PART V. FACILITATING PRIVATE FLOOD INSURANCE

In an effort to provide protection of lives and property from the increasing peril of flood, the legislature encourages a robust private flood insurance market to provide consumer choices to the existing NFIP.

Sec. 1. Prior Form Approval

The [State entity for regulating insurance] may ensure, through prior form approval, that an authorized insurer may issue an insurance policy, contract, or endorsement that meets or exceeds coverage available from the National Flood Insurance Program.

Sec. 2. Rates

(a) Flood coverage rates established pursuant to this paragraph are not subject to prior approval by the [state entity for regulation of insurance]. An insurer may establish and use flood insurance rates in accordance with a filed rating manual or a description of a single catastrophe model, or description of an average of models used to calculate the rates.

(b) Notwithstanding existing prohibitions regarding the use of catastrophe models in the underwriting and rating of personal property risk, the legislature finds that reliable methods for establishing rates for flood insurance are essential. The ability to accurately rate flood risks has been enhanced greatly in recent years through the use of catastrophe modeling. It is the public policy of this state to encourage the use of the most sophisticated actuarial methods to assure that consumers are charged lawful rates for flood insurance coverage.

(c) The legislature recognizes the need for expert evaluation of models and other recently developed or improved actuarial methodologies for projecting flood losses, in order to resolve conflicts among actuarial professionals, and in order to provide both immediate and continuing improvement in the sophistication of actuarial methods used to set rates charged to consumers.

(d) The [state entity for regulation of insurance] may adopt actuarial methods, principles, standards, models, or output ranges for personal lines residential flood loss no later than xx/xx/xxxx. It is the intent of the Legislature that such standards and guidelines be employed as soon as possible, and that they be subject to continuing review thereafter.

(e) The [state entity for regulation of insurance] may review any model to determine compliance with the adopted actuarial methods, principles, standards, models, or output ranges. Catastrophe models that meet the established standards and guidelines may be approved for use in establishing personal lines residential flood rates.

(f) Rate filings that utilize that a catastrophe model that has been reviewed and approved by the [state entity for regulation of insurance] may be exempt from the certification requirement listed in (a) above.

(g) The [state entity for regulation of insurance] may engage experts to assist in the review of the catastrophe models or the [state entity for regulation of insurance] may rely in whole or in part on another state or jurisdiction's review or approval of the same model where the state or jurisdiction has adopted standards that are substantially similar to those adopted by [state entity for regulation of insurance]. The cost of any expert retained by the [state entity for regulation of insurance] may be the responsibility of the insurer, filer or modeler.

(h) An insurer may notify the [state entity for regulation of insurance] of any change to such rates within 30 days after the effective date of the change. The notice must include the name of the insurer and the average statewide percentage change in rates. Actuarial data with regard to such rates for flood coverage must be maintained by the insurer for 2 years after the effective date of such rate change...

Sec. 3. Duties of Insurer

(a) Authorized insurers must notify the [State entity for regulating insurance] at least 30 days before writing flood insurance in this state; and

(b) File a plan of operation and financial projections or revisions to such plan.

Sec. 4. Duties of an Agent

An agent must provide written evidence to be signed by the applicant acknowledging that:

(a) the agent has explained the National Flood Insurance Program and private market alternatives to flood insurance coverage;

(b) that a homeowner's property insurance policy, unless endorsed for flood insurance coverage, does not include coverage for the peril of flood; and

(c) that unless purchased, the applicant has declined flood coverage.

Sec. 5. Other Provisions

(a) With respect to the regulation of flood coverage written in this state by authorized insurers, this section supersedes any other provision in the State Insurance Code in the event of a conflict.

(b) If federal law or rule requires a certification by the [state entity for regulation of insurance] as a condition of qualifying for private flood insurance or disaster assistance, the Executive of the [state entity for regulation of insurance] may provide the certification, and such certification is not subject to review under the State's Administrative Procedures Act.

(c) An authorized insurer offering flood insurance may request the [state entity for regulation of insurance] to certify that a policy, contract, or endorsement provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the National Flood Insurance Program. To be eligible for certification, such policy, contract,

or endorsement must contain a provision stating that it meets the private flood insurance requirements specified in 42 U.S.C. s. 4012a(b) and may not contain any provision that is not in compliance with 42 U.S.C. s. 4012a(b).

(d) The authorized insurer or its agent may reference or include a certification under paragraph (a) in advertising or communications with an agent, a lending institution, an insured, or a potential insured only for a policy, contract, or endorsement that is certified under this subsection. The authorized insurer may include a statement that notifies an insured of the certification on the declarations page or other policy documentation related to flood coverage certified under this subsection.

(e) An insurer or agent who knowingly misrepresents that a flood policy, contract, or endorsement is certified under this subsection commits an unfair or deceptive act under State Unfair Trade Practices Act.

The [state entity for regulation of insurance] may adopt rules to implement this law.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

RESOLUTION IN SUPPORT OF GOOD SAMARITANS’ EFFORTS TO PREVENT LOSS OF LIFE DUE TO OPIOID OVERDOSE

**Sponsored by Asw. Pam Hunter (NY)*

**To be discussed and considered during the Life Insurance & Financial Planning Committee on March 16th, 2019*

WHEREAS, the opioid crisis has claimed the lives of hundreds of thousands of Americans, and, on average, 130 Americans die every day from an opioid-related overdose¹; and

WHEREAS, as a result, the opioid crisis was declared a national Public Health Emergency by the President of the United States and consequently, the U.S. Department of Health and Human Services; and

WHEREAS, the use of proven opioid overdose-reversing drugs such as Naloxone – frequently referred to by its brand name Narcan – have been promoted by many as a vital part of the public health response to combat the opioid crisis, including the U.S. Surgeon General; and

WHEREAS, states have recognized the importance of increasing accessibility of Narcan by issuing “Standing Orders” which permit Narcan to be sold over-the-counter at a pharmacy without an individual prescription to people who meet certain criteria so that they can be in a position to save others, whether it be family members, friends, co-workers, or even strangers; and

WHEREAS, NCOIL has become aware of certain instances where applicants for life insurance have been denied coverage for carrying Narcan, even in states with “Standing Orders”; and

WHEREAS, while NCOIL understands that applying for and issuing life insurance is a detailed risk-assessment process, of which an applicant’s use of prescription drugs is a part, no applicant should be denied coverage solely for carrying Narcan; and

¹ U.S. Dep’t of Health and Human Services

WHEREAS, NOW, THEREFORE BE IT RESOLVED, that NCOIL supports the use of Narcan by good Samaritans to prevent the loss of life from an opioid overdose; and

WHEREAS, NOW, THEREFORE, BE IT FURTHER RESOLVED, that NCOIL urges life insurers to review accordingly their current policy application review procedures/guidelines and if necessary make appropriate changes so that no applicants are denied coverage solely for having a prescription for Narcan, and so that life insurers can identify applicants who obtained a supply of Narcan because of their role as medical professionals or first responders or Good Samaritans in a state with a “Standing Order”; and

WHEREAS, BE IT FINALLY RESOLVED, that a copy of this Resolution shall be distributed to the American Council of Life Insurers (ACLI); the National Association of Insurance Commissioners (NAIC); the members of the U.S. House Financial Services Committee; the members of the Senate Banking Committee; and the Chairs of the Committees of insurance jurisdiction in each Legislative Chamber of each State.

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National Council of Insurance Legislators (NCOIL)

Model Unclaimed Life Insurance Benefits Act

**Updated version adopted by the NCOIL Executive Committee on November 23, 2014.
Model originally adopted by the Executive Committee on November 20, 2011.
*To be considered for re-adoption by the Life Insurance & Financial Planning
Committee on March 16, 2019*

Section 1. Short Title

This Act shall be known as the Unclaimed Life Insurance Benefits Act.

Section 2. Purpose

This Act shall require recognition of the escheat or unclaimed property statutes of the adopting state and require the complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits regulated by the state's insurance department.

Section 3. Definitions

A. "Contract" means an annuity contract. The term "Contract" shall not include an annuity used to fund an employment-based retirement plan or program where (1) the insurer does not perform the Record Keeping Services or (2) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

B. "Death Master File" means the United States Social Security Administration's Death Master File or any other database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died.

C. "Death Master File Match" means a search of the Death Master File that results in a match of the social security number or the name and date of birth of an insured, annuity owner, or retained asset account holder.

D. “Knowledge of Death” shall mean (a) receipt of an original or valid copy of a certified death certificate or (b) a Death Master File Match validated by the Insurer in accordance with Section 4(A)(1)(a).

E. “Policy” means any policy or certificate of life insurance that provides a death benefit. The term “Policy” shall not include (i) any policy or certificate of life insurance that provides a death benefit under an employee benefit plan (a) subject to The Employee Retirement Income Security Act of 1974 [29 USC 1002], as periodically amended, or (b) under any Federal employee benefit program, or (ii) any policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement, or (iii) any policy or certificate of credit life or accidental death insurance, or (iv) any policy issued to a group master policyholder for which the insurer does not provide Record Keeping services.

F. “Record Keeping Services” means those circumstances under which the Insurer has agreed with a group Policy or Contract customer to be responsible for obtaining, maintaining and administering in its own or its agents' systems information about each individual insured under an Insured's group insurance contract (or a line of coverage thereunder), at least the following information: (1) Social Security number or name and date of birth, and (2) beneficiary designation information, (3) coverage eligibility, (4) benefit amount, and (5) premium payment status.

G. “Retained Asset Account” means any mechanism whereby the settlement of proceeds payable under a Policy or Contract is accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

Drafting note: All other terms used in this Act shall be interpreted in a manner consistent with the definitions used in [Insert State Insurance Code].

Section 4. Insurer Conduct

A. An insurer shall perform a comparison of its insureds' in-force Policies, Contracts, and Retained Asset Accounts against a Death Master File, on at least a semi-annual basis, by using the full Death Master File once and thereafter using the Death Master File update files for future comparisons to identify potential matches of its insureds. For those potential matches identified as a result of a Death Master File Match, the insurer shall:

1. within ninety (90) days of a Death Master File Match:
 - a. complete a good faith effort, which shall be documented by the insurer, to confirm the death of the insured or retained asset account holder against other available records and information;

b. determine whether benefits are due in accordance with the applicable policy or contract; and if benefits are due in accordance with the applicable policy or contract:

i. use good faith efforts, which shall be documented by the insurer, to locate the beneficiary or beneficiaries; and

ii. provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim including the need to provide an official death certificate, if applicable under the policy, contract.

2. With respect to group life insurance, insurers are required to confirm the possible death of an insured when the insurers maintain at least the following information of those covered under a policy or certificate: (1) Social Security number or name and date of birth, and (2) beneficiary designation information, (3) coverage eligibility, (4) benefit amount, and (5) premium payment status.

3. Every insurer shall implement procedures to account for:

a. common nicknames, initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

b. compound last names, maiden or married names, and hyphens, blank spaces or apostrophes in last names;

c. transposition of the “month” and “date” portions of the date of birth; and

d. incomplete social security number

4. To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer locate the beneficiary or a person otherwise entitled to payment of the claims proceeds.

B. An Insurer or its service provider shall not charge any beneficiary or other authorized representative for any fees or costs associated with a Death Master File Search or verification of a Death Master File Match conducted pursuant to this section.

C. The benefits from a Policy, Contract or a Retained Asset Account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in the event said beneficiaries or owners can not be found, shall escheat to the state as unclaimed property pursuant to [Cite state statute for escheat or unclaimed life insurance benefits]. Interest payable under [cite insurance code statutory interest law]

shall not be payable as unclaimed property under [cite state statute for escheat of unclaimed life insurance benefits].

Drafting note: Some states' insurance commissioners may want to develop an informational notice that apprises beneficiaries of their rights to the payment of interest on the benefits or proceeds of a life insurance policy or retained asset account. The written notice should be provided by a life insurer to a beneficiary prior to or concurrent with the payment of any life insurance proceeds or the settlement of any life insurance claim, where applicable.

D. An insurer shall notify the [Insert the state agency for unclaimed property] upon the expiration of the statutory time period for escheat that:

1. a Policy or Contract beneficiary or Retained Asset Account holder has not submitted a claim with the insurer; and
2. the insurer has complied with subsection A of this Section and has been unable, after good faith efforts documented by the insurer, to contact the Retained Asset Account holder, beneficiary or beneficiaries

E. Upon such notice, an insurer shall immediately submit the unclaimed Policy or Contract benefits or unclaimed Retained Asset Accounts, plus any applicable accrued interest, to the [Insert the state agency for unclaimed property].

F. Failure to meet any requirement of this section with such frequency as to constitute a general business practice is a violation of [Insert State Unfair Trade Practices Statute]. Nothing herein shall be construed to create or imply a private cause of action for a violation of this Section.

Drafting note: Some states' Unfair Trade Practices statutes specify that an act must be shown to be a "pattern" or "general business practice" in order to constitute a violation of that statute. In those instances, care should be taken in the adoption of this model to ensure consistency across those two statutes.

Section 6. Effective Date

This Act shall take effect no less than one year after the date signed into law.

Drafting note: To address other concerns with transparency and accountability in life insurer procedures relating to treatment of retained asset accounts, please refer to the NCOIL Beneficiaries' Bill of Rights, which requires extensive written disclosures to consumer and insurer reporting.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

LIFE SETTLEMENTS MODEL ACT

Readopted by the NCOIL Executive Committee on March 9, 2014

Adopted by the NCOIL Executive Committee on November 16, 2007

Amended by the NCOIL Life Insurance & Financial Planning Committee on November 15, 2007

Amended by the Executive Committee on July 16, 2004

Adopted by the Executive Committee on November 17, 2000.

**To be considered for re-adoption by the Life Insurance & Financial Planning Committee on March 16, 2019*

Table of Contents

Page Numbers

Section 1. Short Title	(2)
Section 2. Definitions	(2-8)
Section 3. Licensing Requirements	(8-11)
Section 4. License Suspension, Revocation or Refusal to Renew	(11)
Section 5. Contract Requirements	(11-12)
Section 6. Reporting Requirements and Privacy	(12-13)
Section 7. Examination	(13-16)
Section 8. Advertising	(16)
Section 9. Disclosure to Owners	(16-19)
Section 10. Disclosures to Insurer	(19-20)
Section 11. General Rules	(20-22)
Section 12. Authority to Promulgate Regulations; Conflict of Laws	(22-23)
Section 13. Prohibited Practices	(23-24)
Section 14. Fraud Prevention and Control	(24-27)
Section 15. Injunctions; Civil Remedies; Cease and Desist	(27)
Section 16. Penalties	(27-28)
Section 17. Unfair Trade Practices	(28)
Section 18. Effective Date	(28)

[DRAFTING NOTE: "It is an essential public policy objective to protect consumers against stranger- originated life insurance (STOLI). STOLI is a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include but are not limited to cases in which life insurance is purchased with resources or guarantees from or through a person, or entity, who, at the time of policy inception, could not lawfully

initiate the policy themselves, and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts, that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in Section 2L(2) of this Act.

Trusts that are created to give the appearance of insurable interest and are used to manufacture policies for investors are illegal STOLI schemes. As the United States Supreme Court held, a person with insurable interest cannot lend that insurable interest “as a cloak to what is in its inception a wager.” Grigsby v. Russell, 222 U.S. 149 (1911).

Therefore, states should consider adopting an amendment to their insurable interest laws, if necessary, to provide additional protection against trust-initiated STOLI and other schemes involving a cloak, as follows:

‘In accordance with Grigsby v. Russell, 222 U.S. 149, it shall be a violation of insurable interest for any person or entity without insurable interest to provide or arrange for the funding ultimately used to pay premiums, or the majority of premiums, on a life insurance policy, and, at policy inception have an arrangement for such person or entity to have an ownership interest in the majority of the death benefit of that life insurance policy.’”]

Section 1. Short Title

Sections 1 through 18 of this Act may be cited as the ‘Life Settlements Act.’

Section 2. Definitions

A. ‘Advertisement’ means any written, electronic or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet or similar communications media, including film strips, motion pictures and videos, published, disseminated, circulated or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a Person to purchase or sell, assign, devise, bequest or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a Life Settlement Contract.

B. ‘Broker’ means a Person who, on behalf of an Owner and for a fee, commission or other valuable consideration, offers or attempts to negotiate Life Settlement Contracts between an Owner and Providers. A Broker represents only the Owner and owes a fiduciary duty to the Owner to act according to the Owner’s instructions, and in the best interest of the Owner, notwithstanding the manner in which the Broker is compensated. A Broker does not include an attorney, certified public accountant or financial planner retained in the type of practice customarily performed in their professional capacity to

represent the Owner whose compensation is not paid directly or indirectly by the Provider or any other person, except the Owner.

C. 'Business of life settlements' means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking, of Life Settlement Contracts.

D. 'Chronically ill' means:

1. being unable to perform at least two (2) activities of daily living (i.e., eating, toileting, transferring, bathing, dressing or continence);
2. requiring substantial supervision to protect the individual from threats to health and safety due to severe cognitive impairment; or
3. having a level of disability similar to that described in Paragraph (1) as determined by the United States Secretary of Health and Human Services.

E. 'Commissioner' means the Commissioner or Superintendent of the Department of Insurance.

F. 'Financing Entity' means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a Provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a Life Settlement Contract, but:

1. whose principal activity related to the transaction is providing funds to effect the Life Settlement Contract or purchase of one or more policies; and
2. who has an agreement in writing with one or more Providers to finance the acquisition of Life Settlement Contracts. 'Financing Entity' does not include a non-accredited investor or Purchaser.

G. 'Financing Transaction' means a transaction in which a licensed Provider obtains financing from a Financing Entity including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

H. 'Fraudulent Life Settlement Act' includes:

1. Acts or omissions committed by any person who, knowingly and with intent to defraud, for the purpose of depriving another of property or for pecuniary gain, commits, or permits its employees or its agents to engage in acts including, but not limited to:
 - (a) Presenting, causing to be presented or preparing with knowledge and belief that it will be presented to or by a Provider, Premium Finance

lender, Broker, insurer, insurance producer or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

- (i) An application for the issuance of a Life Settlement Contract or insurance policy;
 - (ii) The underwriting of a Life Settlement Contract or insurance policy;
 - (iii) A claim for payment or benefit pursuant to a Life Settlement Contract or insurance policy;
 - (iv) Premiums paid on an insurance policy;
 - (v) Payments and changes in ownership or beneficiary made in accordance with the terms of a Life Settlement Contract or insurance policy;
 - (vi) The reinstatement or conversion of an insurance policy;
 - (vii) In the solicitation, offer to enter into, or effectuation of a Life Settlement Contract, or insurance policy;
 - (viii) The issuance of written evidence of Life Settlement Contracts or insurance;
 - (ix) Any application for or the existence of or any payments related to a loan secured directly or indirectly by any interest in a life insurance policy; or
 - (x) Enter into any practice or plan which involves STOLI.
- (b) Failing to disclose to the insurer where the request for such disclosure has been asked for by the insurer that the prospective insured has undergone a life expectancy evaluation by any person or entity other than the insurer or its authorized representatives in connection with the issuance of the policy.
- (c) Employing any device, scheme, or artifice to defraud in the business of life settlements.
- (d) In the solicitation, application or issuance of a life insurance policy, employing any device, scheme or artifice in violation of state insurable interest laws.

2. In the furtherance of a fraud or to prevent the detection of a fraud any person commits or permits its employees or its agents to;

(a) Remove, conceal, alter, destroy or sequester from the Commissioner the assets or records of a licensee or other person engaged in the business of life settlements;

(b) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer or other person;

(c) Transact the business of life settlements in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of life settlements;

(d) File with the Commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the Commissioner;

(e) Engage in embezzlement, theft, misappropriation or conversion of monies, funds, premiums, credits or other property of a Provider, insurer, insured, owner, insurance, policy owner or any other person engaged in the business of life settlements or insurance;

(f) Knowingly and with intent to defraud, enter into, broker, or otherwise deal in a Life Settlement Contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer;

(g) Attempt to commit, assist, aid or abet in the commission of, or conspiracy to commit the acts or omissions specified in this subsection; or

(h) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this Act for the purpose of evading or avoiding the provisions of this Act.

I. 'Insured' means the person covered under the policy being considered for sale in a Life Settlement Contract.

J. 'Life expectancy' means the arithmetic mean of the number of months the Insured under the life insurance policy to be settled can be expected to live as determined by a life expectancy company considering medical records and appropriate experiential data.

K. 'Life insurance producer' means any person licensed in this state as a resident or nonresident insurance producer who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to [insert reference to applicable producer licensing statute, with specific reference to a life insurance or equivalent line of authority].

L. 'Life Settlement Contract' means a written agreement entered into between a Provider and an Owner, establishing the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise or bequest of the death benefit or any portion of an insurance policy or certificate of insurance for compensation, provided, however, that the minimum value for a Life Settlement Contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a Life Settlement Contract. "Life Settlement Contract" also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract insures the life of a person residing in this State.

1. 'Life Settlement Contract' also includes

(a) a written agreement for a loan or other lending transaction, secured primarily by an individual or group life insurance policy; or

(b) a premium finance loan made for a policy on or before the date of issuance of the policy where:

(i.) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing; or

(ii.) The Owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy; or

(iii.) The Owner agrees on the date of the premium finance loan to sell the policy or any portion of its death benefit on any date following the issuance of the policy.

2. 'Life Settlement Contract' does not include:

(a) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider;

(b) A premium finance loan, as defined herein, or any loan made by a bank or other licensed financial institution, provided that neither default on such loan nor the transfer of the policy in connection with such default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this Act;

(c) A collateral assignment of a life insurance policy by an owner;

(d) A loan made by a lender that does not violate [insert reference to state's insurance premium finance law], provided such loan is not described in Paragraph (1) above, and is not otherwise within the definition of Life Settlement Contract;

(e) An agreement where all the parties [i] are closely related to the insured by blood or law or [ii] have a lawful substantial economic interest in the continued life, health and bodily safety of the person insured, or are trusts established primarily for the benefit of such parties;

(f) Any designation, consent or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or trust established by the employer, of life insurance on the life of the employee;

(g) A bona fide business succession planning arrangement:

(i.) Between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trust established by its shareholders;

(ii.) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trust established by its partners; or

(iii.) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trust established by its members;

(h) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business; or

(i) Any other contract, transaction or arrangement from the definition of Life Settlement Contract that the Commissioner determines is not of the type intended to be regulated by this Act.

M. 'Net death benefit' means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens.

N. 'Owner' means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a Life Settlement Contract. For the purposes of this article, an Owner shall not be limited to an Owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal or chronic illness or condition except where specifically addressed. The term 'Owner' does not include:

1. any Provider or other licensee under this Act;
2. a qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as amended;
3. a financing entity;
4. a special purpose entity; or
5. a related provider trust.

O. 'Patient identifying information' means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

P. 'Policy' means an individual or group policy, group certificate, contract or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

Q. 'Premium Finance Loan' is a loan made primarily for the purposes of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

R. 'Person' means any natural person or legal entity, including but not limited to, a partnership, Limited Liability Company, association, trust or corporation.

S. 'Provider' means a Person, other than an Owner, who enters into or effectuates a Life Settlement Contract with an Owner, A Provider does not include:

1. any bank, savings bank, savings and loan association, credit union;
2. a licensed lending institution or creditor or secured party pursuant to a Premium Finance Loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan;

3. the insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders under [refer to law or regulation implementing or accelerated death benefits provision] or cash surrender value;
4. any natural Person who enters into or effectuates no more than one agreement in a calendar year for the transfer of a life insurance policy or certificate issued pursuant to a group life insurance policy, for compensation or anything of value less than the expected death benefit payable under the policy;
5. a Purchaser;
6. any authorized or eligible insurer that provides stop loss coverage to a provider; purchaser, financing entity, special purpose entity, or related provider trust;
7. a Financing Entity;
8. a Special Purpose Entity;
9. a Related Provider Trust;
10. a Broker; or
11. an accredited investor or qualified institutional buyer as defined in respectively in regulation D, rule 501 or rule 144A of the federal securities act of 1933, as amended, who purchases a life settlement policy from a Provider.

T. 'Purchased Policy' means a policy or group certificate that has been acquired by a Provider pursuant to a Life Settlement Contract.

U. 'Purchaser' means a Person who pays compensation or anything of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a Life Settlement Contract.

V. 'Related Provider Trust' means a titling trust or other trust established by a licensed Provider or a Financing Entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a Financing Transaction. In order to qualify as a Related Provider Trust, the trust must have a written agreement with the licensed Provider under which the licensed Provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the Department of Insurance as if those records and files were maintained directly by the licensed Provider.

W. ‘Settled policy’ means a life insurance policy or certificate that has been acquired by a Provider pursuant to a Life Settlement Contract.

X. ‘Special Purpose Entity’ means a corporation, partnership, trust, limited liability company, or other legal entity formed solely to provide either directly or indirectly access to institutional capital markets:

1. for a financing entity or provider; or

(a) in connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a “qualified institutional buyer” as defined in Rule 144 promulgated under The Securities Act of 1933, as amended; or

(b) the securities pay a fixed rate of return commensurate with established asset- backed institutional capital markets.

Y. ‘Stranger-Originated Life Insurance’ or ‘STOLI’ is a practice or plan to initiate a life insurance policy for the benefit of a third party investor who, at the time of policy origination, has no insurable interest in the insured. STOLI practices include but are not limited to cases in which life insurance is purchased with resources or guarantees from or through a person, or entity, who, at the time of policy inception, could not lawfully initiate the policy himself or itself, and where, at the time of inception, there is an arrangement or agreement, whether verbal or written, to directly or indirectly transfer the ownership of the policy and/or the policy benefits to a third party. Trusts, that are created to give the appearance of insurable interest, and are used to initiate policies for investors, violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include those practices set forth in Section 2L(2) of this Act.

Z. ‘Terminally Ill’ means having an illness or sickness that can reasonably be expected to result in death in twenty-four (24) months or less.

Section 3. Licensing Requirements

A. No Person, wherever located, shall act as a Provider or Broker with an Owner or multiple Owners who is a resident of this state, without first having obtained a license from the Commissioner. If there is more than one owner on a single policy and the owners are residents of different states, the Life Settlement Contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all owners.

B. Application for a Provider, or Broker, license shall be made to the Commissioner by the applicant on a form prescribed by the Commissioner, and the application shall be accompanied by a fee in an amount established by the Commissioner, provided, however, that the license and renewal fees for a Provider license shall be reasonable and that the

license and renewal fees for a Broker license shall not exceed those established for an insurance producer, as such fees are otherwise provided for in this chapter.

C. A life insurance producer who has been duly licensed as a resident insurance producer with a life line of authority in this state or his or her home state for at least one year and is licensed as a nonresident producer in this state shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a Broker.

D. Not later than thirty (30) days from the first day of operating as a Broker, the life insurance producer shall notify the Commissioner that he or she is acting as a Broker on a form prescribed by the Commissioner, and shall pay any applicable fee to be determined by the Commissioner. Notification shall include an acknowledgement by the life insurance producer that he or she will operate as a Broker in accordance with this Act.

E. The insurer that issued the policy that is the subject of a Life Settlement Contract shall not be responsible for any act or omission of a Broker or Provider or Purchaser arising out of or in connection with the life settlement transaction, unless the insurer receives compensation for the placement of a Life Settlement Contract from the Provider or Purchaser or Broker in connection with the Life Settlement Contract.

F. A person licensed as an attorney, certified public accountant or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the Owner, whose compensation is not paid directly or indirectly by the Provider or Purchaser, may negotiate Life Settlement Contracts on behalf of the Owner without having to obtain a license as a Broker.

G. Licenses may be renewed every [INSERT NUMBER OF YEARS] on the anniversary date upon payment of the periodic renewal fee. As specified by subsection B of this section, the renewal fee for a Provider shall not exceed a reasonable fee. Failure to pay the fee within the terms prescribed shall result in the automatic revocation of the license requiring periodic renewal.

H. The term of a Provider license shall be equal to that of a domestic stock life insurance company and the term of a Broker license shall be equal to that of an insurance producer license. Licenses requiring periodic renewal may be renewed on their anniversary date upon payment of the periodic renewal fee as specified in subsection B of this section. Failure to pay the fees on or before the renewal date shall result in expiration of the license.

I. The applicant shall provide such information as the Commissioner may require on forms prepared by the Commissioner. The Commissioner shall have authority, at any time, to require such applicant to fully disclose the identity of its stockholders (except stockholders owning fewer than ten percent of the shares of an applicant whose shares are publicly traded), partners, officers and employees, and the Commissioner may, in the exercise of the Commissioner's sole discretion, refuse to issue such a license in the name of any Person if not satisfied that any officer, employee,

stockholder or partner thereof who may materially influence the applicant's conduct meets the standards of Sections 1 to 14 of this Act.

J. A license issued to a partnership, corporation or other entity authorizes all members, officers and designated employees to act as a licensee under the license, if those Persons are named in the application and any supplements to the application.

K. Upon the filing of an application and the payment of the license fee, the Commissioner shall make an investigation of each applicant and may issue a license if the Commissioner finds that the applicant:

1. if a Provider, has provided a detailed plan of operation;
2. is competent and trustworthy and intends to transact its business in good faith;
3. has a good business reputation and has had experience, training or education so as to be qualified in the business for which the license is applied;
4. if the applicant is a legal entity, is formed or organized pursuant to the laws of this state or is a foreign legal entity authorized to transact business in this state, or provides a certificate of good standing from the state of its domicile; and
5. has provided to the Commissioner an anti-fraud plan that meets the requirements of section 13 of this Act and includes:
 - (a) a description of the procedures for detecting and investigating possible fraudulent acts and procedures for resolving material inconsistencies between medical records and insurance applications;
 - (b) a description of the procedures for reporting fraudulent insurance acts to the Commissioner;
 - (c) a description of the plan for anti-fraud education and training of its underwriters and other personnel; and
 - (d) a written description or chart outlining the arrangement of the anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts and investigating unresolved material inconsistencies between medical records and insurance applications.

L. The Commissioner shall not issue any license to any nonresident applicant, unless a written designation of an agent for service of process is filed and maintained with the Commissioner or unless the applicant has filed with the Commissioner the applicant's written irrevocable consent that any action against the applicant may be commenced against the applicant by service of process on the Commissioner. M. Each licensee shall

file with the Commissioner on or before the first day of March of each year an annual statement containing such information as the Commissioner by rule may prescribe.

N. A Provider may not use any Person to perform the functions of a Broker as defined in this Act unless the Person holds a current, valid license as a Broker, and as provided in this Section.

O. A Broker may not use any Person to perform the functions of a Provider as defined in this Act unless such Person holds a current, valid license as a Provider, and as provided in this Section.

P. A Provider, or Broker shall provide to the Commissioner new or revised information about officers, ten percent or more stockholders, partners, directors, members or designated employees within thirty days of the change.

Q. An individual licensed as a Broker shall complete on a biennial basis fifteen (15) hours of training related to life settlements and life settlement transactions, as required by the Commissioner; provided, however, that a life insurance producer who is operating as a Broker pursuant to this Section shall not be subject to the requirements of this subsection. Any person failing to meet the requirements of this subsection shall be subject to the penalties imposed by the Commissioner.

Section 4. License Suspension, Revocation or Refusal to Renew

A. The Commissioner may suspend, revoke or refuse to renew the license of any licensee if the Commissioner finds that:

1. there was any material misrepresentation in the application for the license;
2. the licensee or any officer, partner, member or director has been guilty of fraudulent or dishonest practices, is subject to a final administrative action or is otherwise shown to be untrustworthy or incompetent to act as a licensee;
3. the Provider demonstrates a pattern of unreasonably withholding payments to policy Owners;
4. the licensee no longer meets the requirements for initial licensure;
5. the licensee or any officer, partner, member or director has been convicted of a felony, or of any misdemeanor of which criminal fraud is an element; or the licensee has pleaded guilty or nolo contendere with respect to any felony or any misdemeanor of which criminal fraud or moral turpitude is an element, regardless whether a judgment of conviction has been entered by the court;
6. the Provider has entered into any Life Settlement Contract that has not been approved pursuant to the Act;

7. the Provider has failed to honor contractual obligations set out in a Life Settlement Contract;

8. the Provider has assigned, transferred or pledged a settled policy to a person other than a Provider licensed in this state, a purchaser, an accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the Federal Securities Act of 1933, as amended, financing entity, special purpose entity, or related provider trust; or

9. the licensee or any officer, partner, member or key management personnel has violated any of the provisions of this Act.

B. Before the Commissioner denies a license application or suspends, revokes or refuses to renew the license of any licensee under this Act, the Commissioner shall conduct a hearing in accordance with this state's laws governing administrative hearings.

Section 5. Contract Requirements

A. No Person may use any form of Life Settlement Contract in this state unless it has been filed with and approved, if required, by the Commissioner in a manner that conforms with the filing procedures and any time restrictions or deeming provisions, if any, for life insurance forms, policies and contracts.

B. No insurer may, as a condition of responding to a request for verification of coverage or in connection with the transfer of a policy pursuant to a Life Settlement Contract, require that the Owner, Insured, Provider or Broker sign any form, disclosure, consent, waiver or acknowledgment that has not been expressly approved by the Commissioner for use in connection with Life Settlement Contracts in this state.

C. A Person shall not use a Life Settlement Contract form or provide to an Owner a disclosure statement form in this state unless first filed with and approved by the Commissioner. The Commissioner shall disapprove a Life Settlement Contract form or disclosure statement form if, in the Commissioner's opinion, the contract or provisions contained therein fail to meet the requirements of Sections 8, 9, 11 and 15B of this Act or are unreasonable, contrary to the interests of the public, or otherwise misleading or unfair to the Owner. At the Commissioner's discretion, the Commissioner may require the submission of advertising material.

Section 6. Reporting Requirements and Privacy

A. For any policy settled within five (5) years of policy issuance, each Provider shall file with the Commissioner on or before March 1 of each year an annual statement containing such information as the Commissioner may prescribe by regulation. In addition to any other requirements, the annual statement shall specify the total number, aggregate face amount and life settlement proceeds of policies settled during the immediately preceding

calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the Brokers that have settled said policies.

1. Such information shall be limited to only those transactions where the Insured is a resident of this state and shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the Owner or the Insured.

2. Every Provider that willfully fails to file an annual statement as required in this section, or willfully fails to reply within thirty days to a written inquiry by the Commissioner in connection therewith, shall, in addition to other penalties provided by this chapter, be subject, upon due notice and opportunity to be heard, to a penalty of up to two hundred fifty dollars per day of delay, not to exceed twenty-five thousand dollars in the aggregate, for each such failure.

B. Except as otherwise allowed or required by law, a Provider, Broker, insurance company, insurance producer, information bureau, rating agency or company, or any other person with actual knowledge of an insured's identity, shall not disclose the identity of an insured or information that there is a reasonable basis to believe could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure:

1. is necessary to effect a Life Settlement Contract between the owner and a Provider and the owner and insured have provided prior written consent to the disclosure;

2. is necessary to effectuate the sale of Life Settlement Contracts, or interests therein, as investments, provided the sale is conducted in accordance with applicable state and federal securities law and provided further that the Owner and the insured have both provided prior written consent to the disclosure;

3. is provided in response to an investigation or examination by the Commissioner or any other governmental officer or agency or pursuant to the requirements of Section 13;

4. is a term or condition to the transfer of a policy by one Provider to another Provider, in which case the receiving Provider shall be required to comply with the confidentiality requirements of Section 6B;

5. is necessary to allow the Provider or Broker or their authorized representatives to make contacts for the purpose of determining health status. For the purposes of this section, the term "authorized representative" shall not include any person who has or may have any financial interest in the settlement contract other than a Provider, licensed Broker, financing entity, related provider trust or special purpose entity; further, a Provider or Broker shall require its authorized

representative to agree in writing to adhere to the privacy provisions of this Act;
or

6. is required to purchase stop loss coverage.

[Drafting Note: In implementing this section, states should keep in mind privacy considerations of insureds. However, the language needs to be broad enough to allow licensed entities to notify Commissioners of unlicensed activity and for insurers to make necessary disclosures to insurers and in similar situations.]

C. Non-public personal information solicited or obtained in connection with a proposed or actual life settlement contract shall be subject to the provisions applicable to financial institutions under the federal Gramm Leach Bliley Act, P.L. 106-102 (1999), and all other state and federal laws relating to confidentiality of non-public personal information.

Section 7. Examination

[Drafting Note: NCOIL has established a Model Act for the examination of insurers. This Model should be applied to settlement companies. Where practicable, examination should be detailed in a rule adopted by the Commissioner under the authority of this law.]

A. The Commissioner may, when the Commissioner deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The Commissioner may order any licensee or applicant to produce any records, books, files or other information reasonably necessary to ascertain whether such licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

B. In lieu of an examination under this Act of any foreign or alien licensee licensed in this state, the Commissioner may, at the Commissioner's discretion, accept an examination report on the licensee as prepared by the Commissioner for the licensee's state of domicile or port-of-entry state.

C. Names of and individual identification data, or for all Owners and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner unless required by law.

D. Records of all consummated transactions and Life Settlement Contracts shall be maintained by the Provider for three years after the death of the insured and shall be available to the Commissioner for inspection during reasonable business hours.

E. Conduct of Examinations

1. Upon determining that an examination should be conducted, the Commissioner shall Issue an examination warrant appointing one or more examiners to perform the examination and instructing them as to the scope of the examination. In conducting the examination, the examiner shall use methods common to the examination of any life settlement licensee and should use those guidelines and procedures set forth in an examiners' handbook adopted by a national organization.
2. Every licensee or person from whom information is sought, its officers, directors and agents shall provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents, assets and computer or other recordings relating to the property, assets, business and affairs of the licensee being examined. The officers, directors, employees and agents of the licensee or person shall facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of a licensee, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the Commissioner shall be grounds for suspension or refusal of, or nonrenewal of any license or authority held by the licensee to engage in the life settlement business or other business subject to the Commissioner's jurisdiction. Any proceedings for suspension, revocation or refusal of any license or authority shall be conducted pursuant to Section [insert reference to cease and desist statute or other law having a post-order hearing mechanism].
3. The Commissioner shall have the power to issue subpoenas, to administer oaths and to examine under oath any person as to any matter pertinent to the examination. Upon the failure or refusal of a person to obey a subpoena, the Commissioner may petition a court of competent jurisdiction, and upon proper showing, the Court may enter an order compelling the witness to appear and testify or produce documentary evidence.
4. When making an examination under this Act, the Commissioner may retain attorneys, appraisers, independent actuaries, independent certified public accountants or other professionals and specialists as examiners, the reasonable cost of which shall be borne by the licensee that is the subject of the examination.
5. Nothing contained in this Act shall be construed to limit the Commissioner's authority to terminate or suspend an examination in order to pursue other legal or regulatory action pursuant to the insurance laws of this state. Findings of fact and conclusions made pursuant to any examination shall be prima facie evidence in any legal or regulatory action.
6. Nothing contained in this Act shall be construed to limit the Commissioner's authority to use and, if appropriate, to make public any final or preliminary examination report, any examiner or licensee work papers or other documents, or any other information discovered or developed during the course of any

examination in the furtherance of any legal or regulatory action which the Commissioner may, in his or her sole discretion, deem appropriate.

[Drafting Note: In many states examination work papers remain confidential. The previous paragraph should be adjusted to conform to state statute and practice.]

F. Examination Reports

1. Examination reports shall be comprised of only facts appearing upon the books, from the testimony of its officers or agents or other persons examined concerning its affairs, and such conclusions and recommendations as the examiners find reasonably warranted from the facts.
2. No later than sixty (60) days following completion of the examination, the examiner in charge shall file with the Commissioner a verified written report of examination under oath. Upon receipt of the verified report, the Commissioner shall transmit the report to the licensee examined, together with a notice that shall afford the licensee examined a reasonable opportunity of not more than thirty (30) days to make a written submission or rebuttal with respect to any matters contained in the examination report and which shall become part of the report or to request a hearing on any matter in dispute.
3. In the event the Commissioner determines that regulatory action is appropriate as a result of an examination, the Commissioner may initiate any proceedings or actions provided by law.

G. Confidentiality of Examination Information

1. Names and individual identification data for all owners, purchasers, and insureds shall be considered private and confidential information and shall not be disclosed by the Commissioner, unless the disclosure is to another regulator or is required by law.
2. Except as otherwise provided in this Act, all examination reports, working papers, recorded information, documents and copies thereof produced by, obtained by or disclosed to the Commissioner or any other person in the course of an examination made under this Act, or in the course of analysis or investigation by the Commissioner of the financial condition or market conduct of a licensee shall be confidential by law and privileged, shall not be subject to [INSERT OPEN RECORDS, FREEDOM OF INFORMATION, SUNSHINE OR OTHER APPROPRIATE PHRASE] shall not be subject to subpoena, and shall not be subject to discovery or admissible in evidence in any private civil action. The Commissioner is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as part of the Commissioner's official duties. The licensee being examined may have access to all documents used to make the report.

H. Conflict of Interest

1. An examiner may not be appointed by the Commissioner if the examiner, either directly or indirectly, has a conflict of interest or is affiliated with the management of or owns a pecuniary interest in any person subject to examination under this Act. This section shall not be construed to automatically preclude an examiner from being:

(a) an owner;

(b) an insured in a Life Settlement Contract or insurance policy; or

(c) a beneficiary in an insurance policy that is proposed for a Life Settlement Contract.

2. Notwithstanding the requirements of this clause, the Commissioner may retain from time to time, on an individual basis, qualified actuaries, certified public accountants, or other similar individuals who are independently practicing their professions, even though these persons may from time to time be similarly employed or retained by persons subject to examination under this Act.

I. Immunity from Liability

1. No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or any examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act.

2. No cause of action shall arise, nor shall any liability be imposed against any person for the act of communicating or delivering information or data to the Commissioner or the Commissioner's authorized representative or examiner pursuant to an examination made under this Act, if the act of communication or delivery was performed in good faith and without fraudulent intent or the intent to deceive. This paragraph does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person identified in Paragraph (1).

3. A person identified in Paragraph (1) or (2) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

J. Investigative Authority of the Commissioner

1. The Commissioner may investigate suspected Fraudulent Life Settlement Acts and persons engaged in the business of life settlements.

K. Cost of Examinations

[Drafting Note: The Insurance Department may have a funding mechanism for examinations and it should be inserted in this section and be consistent with other examination expenses.]

Section 8. Advertising

- A. A broker, or provider licensed pursuant to this act may conduct or participate in advertisements within this state. Such advertisements shall comply with all advertising and marketing laws [statutory cite] or rules and regulations promulgated by the Commissioner that are applicable to life insurers or to brokers, and providers licensed pursuant to this act.
- B. Advertisements shall be accurate, truthful and not misleading in fact or by implication.
- C. No person or trust shall:
 1. directly or indirectly, market, advertise, solicit or otherwise promote the purchase of a policy for the sole purpose of or with an emphasis on settling the policy; or
 2. use the words “free”, “no cost” or words of similar import in the marketing, advertising, soliciting or otherwise promoting of the purchase of a policy.

Section 9. Disclosures to Owners

- A. The Provider shall provide in writing, in a separate document that is signed by the Owner and Provider, the following information to the Owner no later than the date the Life Settlement Contract is signed by all parties:
 1. the fact that possible alternatives to Life Settlement Contracts exist, including, but not limited to, accelerated benefits offered by the issuer of the life insurance policy;
 2. the fact that some or all of the proceeds of a Life Settlement Contract may be taxable and that assistance should be sought from a professional tax advisor;
 3. the fact that the proceeds from a Life Settlement Contract could be subject to the claims of creditors;

4. the fact that receipt of proceeds from a Life Settlement Contract may adversely affect the recipients' eligibility for public assistance or other government benefits or entitlements and that advice should be obtained from the appropriate agencies;

5. the fact that the Owner has a right to terminate a Life Settlement Contract within fifteen (15) days of the date it is executed by all parties and the Owner has received the disclosures contained herein. Rescission, if exercised by the Owner, is effective only if both notice of the rescission is given, and the Owner repays all proceeds and any premiums, loans, and loan interest paid on account of the Provider within the rescission period. If the insured dies during the rescission period, the Contract shall be deemed to have been rescinded subject to repayment by the Owner or the Owner's estate of all proceeds and any premiums, loans, and loan interest to the Provider;

6. the fact that proceeds will be sent to the Owner within three (3) business days after the Provider has received the insurer or group administrator's acknowledgement that ownership of the policy or interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the Life Settlement Contract;

7. the fact that entering into a Life Settlement Contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited by the Owner and that assistance should be sought from a professional financial advisor;

8. the amount and method of calculating the compensation paid or to be paid to the Broker, or any other person acting for the Owner in connection with the transaction, wherein the term compensation includes anything of value paid or given;

9. the date by which the funds will be available to the Owner and the transmitter of the funds;

10. the fact that the Commissioner shall require delivery of a Buyer's Guide or a similar consumer advisory package in the form prescribed by the Commissioner to Owners during the solicitation process;

11. the disclosure document shall contain the following language: "all medical, financial or personal information solicited or obtained by a Provider or Broker about an insured, including the insured's identity or the identity of family members, a spouse or a significant other may be disclosed as necessary to effect the Life Settlement Contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure. The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years;

12. the fact that the Commissioner shall require Providers and Brokers to print separate signed fraud warnings on their applications and on their Life Settlement Contracts is as follows: “Any person who knowingly presents false information in an application for insurance or Life Settlement Contract is guilty of a crime and may be subject to fines and confinement in prison.”

13. the fact that the insured may be contacted by either the Provider or broker or its authorized representative for the purpose of determining the insured’s health status or to verify the insured’s address. This contact is limited to once every three (3) months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less;

14. the affiliation, if any, between the Provider and the issuer of the insurance policy to be settled;

15. that a Broker represents exclusively the Owner, and not the insurer or the Provider or any other person, and owes a fiduciary duty to the Owner, including a duty to act according to the Owner’s instructions and in the best interest of the Owner;

16. the document shall include the name, address and telephone number of the Provider;

17. the name, business address, and telephone number of the independent third party escrow agent, and the fact that the owner may inspect or receive copies of the relevant escrow or trust agreements or documents;

18. the fact that a change of ownership could in the future limit the insured’s ability to purchase future insurance on the insured’s life because there is a limit to how much coverage insurers will issue on one life;

B. The written disclosures shall be conspicuously displayed in any Life Settlement Contract furnished to the Owner by a Provider including any affiliations or contractual arrangements between the Provider and the Broker. C. A Broker shall provide the Owner and the Provider with at least the following disclosures no later than the date the Life Settlement Contract is signed by all parties. The disclosures shall be conspicuously displayed in the Life Settlement Contract or in a separate document signed by the Owner and provide the following information:

(1) The name, business address and telephone number of the Broker;

(2) A full, complete and accurate description of all the offers, counter-offers, acceptances and rejections relating to the proposed Life Settlement Contract;

(3) A written disclosure of any affiliations or contractual arrangements between the Broker and any person making an offer in connection with the proposed Life Settlement Contracts;

(4) The name of each Broker who receives compensation and the amount of compensation received by that broker, which compensation includes anything of value paid or given to the Broker in connection with the life settlement contract;

(5) A complete reconciliation of the gross offer or bid by the Provider to the net amount of proceeds or value to be received by the Owner. For the purpose of this section, gross offer or bid shall mean the total amount or value offered by the Provider for the purchase of one or more life insurance policies, inclusive of commissions and fees; and

(6) The failure to provide the disclosures or rights described in this Section 9 shall be deemed an Unfair Trade Practice pursuant to Section 17. Section 10.
Disclosure to Insurer

[Drafting Note: The provisions in this Section pertaining to premium finance arrangements and disclosures may be inserted into a state's premium finance law. If so, it is recommended that the disclosures be made to the borrower and/or insured by a lender which takes the policy as collateral for a premium finance loan.]

A. Without limiting the ability of an insurer from assessing the insurability of a policy applicant and determining whether or not to issue the policy, and in addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

1. If, as described in Section 2L, the loan provides funds which can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application shall be rejected as a violation of the Prohibited Practices in Section 13 of this Act.

2. If the financing does not violate Section 13 in this manner, the insurance carrier:

(a) may make disclosures, including but not limited to such as the following, to the applicant and the insured, either on the application or an amendment to the application to be completed no later than the delivery of the policy: "If you have entered into a loan arrangement where the policy is used as collateral, and the policy does change ownership at some point in the future in satisfaction of the loan, the following may be true:

(i.) a change of ownership could lead to a stranger owning an interest in the insured's life;

(ii.) a change of ownership could in the future limit your ability to purchase future insurance on the insured's life because there is a limit to how much coverage insurers will issue on one life;

(iii.) should there be a change of ownership and you wish to obtain more insurance coverage on the insured's life in the future, the insured's higher issue age, a change in health status, and/or other factors may reduce the ability to obtain coverage and/or may result in significantly higher premiums;

(iv.) you should consult a professional advisor, since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan;" and

(b) may require certifications, such as the following, from the applicant and/or the insured:

(i) I have not entered into any agreement or arrangement providing for the future sale of this life insurance policy;

(ii) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy; and

(iii) the borrower has an insurable interest in the insured."

Section 11. General Rules

A. A Provider entering into a Life Settlement Contract with any Owner of a policy, wherein the insured is terminally or chronically ill, shall first obtain:

1. if the Owner is the insured, a written statement from a licensed attending physician that the Owner is of sound mind and under no constraint or undue influence to enter into a settlement contract; and
2. a document in which the insured consents to the release of his medical records to a Provider, settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

B. The insurer shall respond to a request for verification of coverage submitted by a Provider, settlement broker, or life insurance producer not later than thirty calendar days of the date the request is received. The request for verification of coverage must be made on a form approved by the Commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

C. Before or at the time of execution of the settlement contract, the Provider shall obtain a witnessed document in which the Owner consents to the settlement contract, represents that the Owner has a full and complete understanding of the settlement contract, that the Owner has a full and complete understanding of the benefits of the policy, acknowledges that the Owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal or chronic illness or condition, acknowledges that the insured has a terminal or chronic illness and that the terminal or chronic illness or condition was diagnosed after the policy was issued.

D. The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any Life Settlement Contract lawfully entered into in this state or with a resident of this state.

E. If a settlement broker or life insurance producer performs any of these activities required of the Provider, the Provider is deemed to have fulfilled the requirements of this section.

F. If a Broker performs those verification of coverage activities required of the Provider, the provider is deemed to have fulfilled the requirements of section 9A.

G. Within twenty (20) days after an owner executes the Life Settlement Contract, the Provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a Life Settlement Contract. The notice shall be accompanied by the documents required by Section 10 A. (2).

H. All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information, if not otherwise provided in this Act.

I. All Life Settlement Contracts entered into in this state shall provide that the Owner may rescind the Contract on or before fifteen (15) days after the date it is executed by all parties thereto. Rescission, if exercised by the Owner, is effective only if both notice of the rescission is given, and the Owner repays all proceeds and any premiums, loans, and loan interest paid on account of the Provider within the rescission period. If the insured dies during the rescission period, the Contract shall be deemed to have been rescinded subject to repayment by the Owner or the Owner's estate of all proceeds and any premiums, loans, and loan interest to the Provider.

J. Within three business days after receipt from the Owner of documents to effect the transfer of the insurance policy, the Provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgement of the transfer by the issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the Owner within three business days of acknowledgement of the transfer from the insurer.

K. Failure to tender the Life Settlement Contract proceeds to the Owner by the date disclosed to the Owner renders the Contract voidable by the Owner for lack of consideration until the time the proceeds are tendered to and accepted by the Owner. A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until thirty days after the written notice of the right of rescission has been given.

L. Any fee paid by a Provider, party, individual, or an Owner to a Broker in exchange for services provided to the Owner pertaining to a Life Settlement Contract shall be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this Section shall be construed as prohibiting a Broker from reducing such Broker's fee below this percentage if the Broker so chooses.

M. The Broker shall disclose to the Owner anything of value paid or given to a Broker, which relate to a Life Settlement Contract.

N. No person at any time prior to, or at the time of, the application for, or issuance of, a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a Life Settlement regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest or surrender of the policy is to occur. This prohibition shall not apply if the Owner certifies to the Provider that:

1. the policy was issued upon the Owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least twenty-four months. The time covered under a group policy must be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship; or

2. the Owner submits independent evidence to the Provider that one or more of the following conditions have been met within the two-year period:

- (a) the Owner or insured is terminally or chronically ill;

- (b) the Owner or insured disposes of his ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued;

- (c) the Owner's spouse dies;
- (d) the Owner divorces his or her spouse;
- (e) the Owner retires from full-time employment;
- (f) the Owner becomes physically or mentally disabled and a physician determines that the disability prevents the Owner from maintaining full-time employment; or
- (g) a final order, judgment or decree is entered by a court of competent jurisdiction, on the application of a creditor of the Owner, adjudicating the Owner bankrupt or insolvent, or approving a petition seeking reorganization of the Owner or appointing a receiver, trustee or liquidator to all or a substantial part of the Owner's assets;

3. Copies of the independent evidence required by Section 11.N(2) shall be submitted to the insurer when the Provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the Provider that the copies are true and correct copies of the documents received by the Provider. Nothing in this Section shall prohibit an insurer from exercising its right to contest the validity of any policy;

4. If the Provider submits to the insurer a copy of independent evidence provided for in item (2)(a) when the Provider submits a request to the insurer to effect the transfer of the policy to the Provider, the copy is deemed to establish that the settlement contract satisfies the requirements of this section.

Section 12. Authority to Promulgate Regulations; Conflict of Laws

A. The Commissioner may:

- 1. promulgate regulations implementing Sections 1 to 18 of this Act and regulating the activities and relationships of Providers, Brokers, insurers and their agents, subject to statutory limitations on administrative rule making.

[Drafting Note: Fees need not be mentioned if the fee is set by statute.]

B. Conflict of Laws.

- 1. If there is more than one Owner on a single policy, and the Owners are residents of different states, the Life Settlement Contract shall be governed by the law of the state in which the Owner having the largest percentage ownership resides or, if the Owners hold equal ownership, the state of residence of one Owner agreed upon in writing by all of the Owners. The law of the state of the

Insured shall govern in the event that equal Owners fail to agree in writing upon a state of residence for jurisdictional purposes.

2. A Provider from this state who enters into a Life Settlement Contract with an Owner who is a resident of another state that has enacted statutes or adopted regulations governing Life Settlement Contracts, shall be governed in the effectuation of that Life Settlement Contract by the statutes and regulations of the Owner's state of residence. If the state in which the Owner is a resident has not enacted statutes or regulations governing Life Settlement Contracts, the Provider shall give the Owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the Provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the Department.

3. If there is a conflict in the laws that apply to an Owner and a Purchaser in any individual transaction, the laws of the state that apply to the Owner shall take precedence and the Provider shall comply with those laws.

Section 13. Prohibited Practices

A. IT IS UNLAWFUL FOR ANY PERSON TO:

1. enter into a Life Settlement Contract if such Person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive or misleading application for such policy;
2. engage in any transaction, practice or course of business if such Person knows or reasonably should have known that the intent was to avoid the notice requirements of this Section;
3. engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an Owner who is a resident of this state;
4. issue, solicit, market or otherwise promote the purchase of an insurance policy for the purpose of or with an emphasis on settling the policy;
5. enter into a premium finance agreement with any person or agency, or any person affiliated with such person or agency, pursuant to which such person shall receive any proceeds, fees or other consideration, directly or indirectly, from the policy or owner of the policy or any other person with respect to the premium finance agreement or any settlement contract or other transaction related to such policy that are in addition to the amounts required to pay the principal, interest and service charges related to policy premiums pursuant to the premium finance agreement or subsequent sale of such agreement; provided, further, that any payments, charges, fees or other amounts in

addition to the amounts required to pay the principal, interest and service charges related to policy premiums paid under the premium finance agreement shall be remitted to the original owner of the policy or to his or her estate if he or she is not living at the time of the determination of the overpayment;

6. with respect to any settlement contract or insurance policy and a Broker, knowingly solicit an offer from, effectuate a life settlement contract with or make a sale to any Provider, financing entity or related provider trust that is controlling, controlled by, or under common control with such Broker;

7. with respect to any Life Settlement Contract or insurance policy and a Provider, knowingly enter into a Life Settlement Contract with a Owner, if, in connection with such Life Settlement Contract, anything of value will be paid to a Broker that is controlling, controlled by, or under common control with such Provider or the financing entity or related Provider trust that is involved in such settlement contract;

8. with respect to a Provider, enter into a Life Settlement Contract unless the life settlement promotional, advertising and marketing materials, as may be prescribed by regulation, have been filed with the Commissioner. In no event shall any marketing materials expressly reference that the insurance is “free” for any period of time. The inclusion of any reference in the marketing materials that would cause an Owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of this Act; or

9. with respect to any life insurance producer, insurance company, Broker, or Provider make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

B. A violation of Section 13 shall be deemed a Fraudulent Life Settlement Act.

Section 14. Fraud Prevention and Control

A. Fraudulent Life Settlement Acts, Interference and Participation of Convicted Felons Prohibited.

1. A person shall not commit a Fraudulent Life Settlement Act.

2. A person shall not knowingly and intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

3. A person in the business of life settlements shall not knowingly or intentionally permit any person convicted of a felony involving dishonesty or breach of trust to participate in the business of life settlements.

B. Fraud Warning Required

1. Life Settlement Contracts and applications for Life Settlement Contracts, regardless of the form of transmission, shall contain the following statement or a substantially similar statement: “Any person who knowingly presents false information in an application for insurance or Life Settlement Contract is guilty of a crime and may be subject to fines and confinement in prison.”

2. The lack of a statement as required in Paragraph (1) of this subsection does not constitute a defense in any prosecution for a Fraudulent Life Settlement Act.

C. Mandatory Reporting of Fraudulent Life Settlement Acts

1. Any person engaged in the business of life settlements having knowledge or a reasonable belief that a Fraudulent Life Settlement Act is being, will be or has been committed shall provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

2. Any other person having knowledge or a reasonable belief that a Fraudulent Life Settlement Act is being, will be or has been committed may provide to the Commissioner the information required by, and in a manner prescribed by, the Commissioner.

D. Immunity from Liability

1. No civil liability shall be imposed on and no cause of action shall arise from a person’s furnishing information concerning suspected, anticipated or completed Fraudulent Life Settlement Acts or suspected or completed fraudulent insurance acts, if the information is provided to or received from:

(a) the Commissioner or the Commissioner’s employees, agents or representatives;

(b) federal, state or local law enforcement or regulatory officials or their employees, agents or representatives;

(c) a person involved in the prevention and detection of Fraudulent Life Settlement Acts or that person’s agents, employees or representatives;

(d) any regulatory body or their employees, agents or representatives, overseeing life insurance, life settlements, securities or investment fraud;

(e) the life insurer that issued the life insurance policy covering the life of the insured; or

(f) the licensee and any agents, employees or representatives.

2. Paragraph (1) of this subsection shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a Fraudulent Life Settlement Act or a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that Paragraph (1) does not apply because the person filing the report or furnishing the information did so with actual malice.

3. A person identified in Paragraph (1) shall be entitled to an award of attorney's fees and costs if he or she is the prevailing party in a civil cause of action for libel, slander or any other relevant tort arising out of activities in carrying out the provisions of this Act and the party bringing the action was not substantially justified in doing so. For purposes of this section a proceeding is "substantially justified" if it had a reasonable basis in law or fact at the time that it was initiated.

4. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Paragraph (1).

E. Confidentiality

1. The documents and evidence provided pursuant to Subsection D of this section or obtained by the Commissioner in an investigation of suspected or actual Fraudulent Life Settlement Acts shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

2. Paragraph (1) of this subsection does not prohibit release by the Commissioner of documents and evidence obtained in an investigation of suspected or actual Fraudulent Life Settlement Acts:

(a) in administrative or judicial proceedings to enforce laws administered by the Commissioner;

(b) to federal, state or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing Fraudulent Life Settlement Acts or to the NAIC; or

(c) at the discretion of the Commissioner, to a person in the business of life settlements that is aggrieved by a Fraudulent Life Settlement Act.

3. Release of documents and evidence under Paragraph (2) of this subsection does not abrogate or modify the privilege granted in Paragraph (1).

F. Other Law Enforcement or Regulatory Authority. This Act shall not:

1. preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law;
2. preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder;
3. prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the insurance department; or
4. limit the powers granted elsewhere by the laws of this state to the Commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

G. Life Settlement Antifraud Initiatives.

1. Providers and Brokers shall have in place antifraud initiatives reasonably calculated to detect, prosecute and prevent Fraudulent Life Settlement Acts. At the discretion of the Commissioner, the Commissioner may order, or a licensee may request and the Commissioner may grant, such modifications of the following required initiatives as necessary to ensure an effective antifraud program. The modifications may be more or less restrictive than the required initiatives so long as the modifications may reasonably be expected to accomplish the purpose of this section. Antifraud initiatives shall include:
 2. Fraud investigators, who may be Provider or Broker employees or independent contractors; and
 3. An antifraud plan, which shall be submitted to the Commissioner. The antifraud plan shall include, but not be limited to:
 - (a) a description of the procedures for detecting and investigating possible Fraudulent Life Settlement Acts and procedures for resolving material inconsistencies between medical records and insurance applications;
 - (b) a description of the procedures for reporting possible Fraudulent Life Settlement Acts to the Commissioner;
 - (c) a description of the plan for antifraud education and training of underwriters and other personnel; and
 - (d) a description or chart outlining the organizational arrangement of the antifraud personnel who are responsible for the investigation and reporting of possible Fraudulent Life Settlement Acts and investigating unresolved

material inconsistencies between medical records and insurance applications.

4. Antifraud plans submitted to the Commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Section 15. Injunctions; Civil Remedies; Cease and Desist

A. In addition to the penalties and other enforcement provisions of this Act, if any Person violates this Act or any rule implementing this Act, the Commissioner may seek an injunction in a court of competent jurisdiction in the county where the Person resides or has a principal place of business and may apply for temporary and permanent orders that the Commissioner determines necessary to restrain the Person from further committing the violation.

B. Any Person damaged by the acts of another Person in violation of this Act or any rule or regulation implementing this Act, may bring a civil action for damages against the Person committing the violation in a court of competent jurisdiction.

C. The Commissioner may issue a cease and desist order upon a Person who violates any provision of this part, any rule or order adopted by the Commissioner, or any written agreement entered into with the Commissioner, in accordance with this State's Act governing administrative procedures.

D. When the Commissioner finds that such an action presents an immediate danger to the public and requires an immediate final order, he may issue an emergency cease and desist order reciting with particularity the facts underlying such findings. The emergency cease and desist order is effective immediately upon service of a copy of the order on the respondent and remains effective for 90 days. If the department begins non-emergency cease and desist proceedings under paragraph A, the emergency cease and desist order remains effective, absent an order by an appellate court of competent jurisdiction pursuant to [cite the state's administrative procedure Act]. In the event of a willful violation of this Act, the trial court may award statutory damages in addition to actual damages in an additional amount up to three times the actual damage award. The provisions of this Act may not be waived by agreement. No choice of law provision may be utilized to prevent the application of this Act to any settlement in which a party to the settlement is a resident of this state.

Section 16. Penalties

A. It is a violation of this Act for any Person, Provider, Broker, or any other party related to the business of life settlements, to commit a Fraudulent Life Settlement Act.

B. For criminal liability purposes, a person that commits a Fraudulent Life Settlement Act is guilty of committing insurance fraud and shall be subject to additional penalties under [insert State statute regarding insurance fraud].

C. The Commissioner shall be empowered to levy a civil penalty not exceeding [insert appropriate State fine] and the amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this Act, who is found to have committed a Fraudulent Life Settlement Act or violated any other provision of this Act.

D. The license of a person licensed under this Act that commits a Fraudulent Life Settlement Act shall be revoked for a period of at least [insert appropriate State penalty].

Section 17. Unfair Trade Practices

A violation of Sections 1 to 16 of this Act shall be considered an unfair trade practice pursuant to state law and subject to the penalties provided by state law.

Section 18. Effective Date

A. A Provider lawfully transacting business in this state prior to the effective date of this Act may continue to do so pending approval or disapproval of that person's application for a license as long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for licensure of Providers. If the publication of the application form and instructions is prior to the effective date of this chapter, then the filing of the application shall not be later than 30 days after the effective date of this Act. During the time that such an application is pending with the Commissioner, the applicant may use any form of Life Settlement Contract that has been filed with the Commissioner pending approval thereof, provided that such form is otherwise in compliance with the provisions of this Act. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this Act.

B. A person who has lawfully negotiated Life Settlement Contracts between any Owner residing in this state and one or more Providers for at least one year immediately prior to the effective date of this Act may continue to do so pending approval or disapproval of that person's application for a license as long as the application is filed with the Commissioner not later than 30 days after publication by the Commissioner of an application form and instructions for licensure of Brokers. If the publication of the application form and instructions is prior to the effective date of this chapter, then the filing of the application shall not be later than 30 days after the effective date of this Act. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this Act.

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National Council of Insurance Legislators (NCOIL)

Model Workers' Compensation Drug Formulary Act

**Sponsored by Rep. Matt Lehman (IN)*

**Initial Discussion Draft. To be discussed during the Workers' Compensation Insurance Committee on Saturday, March 16th, 2019*

Drafting Note: The following language is based on Indiana SB 369 (enacted on March 25, 2018) and is meant for initial discussion for development of an NCOIL Model Workers' Compensation Drug Formulary Act. This topic will be discussed throughout 2019 and the language below could change significantly depending on which drug formulary is referenced in the Model.

Table of Contents

Section 1.	Short Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Reimbursement and Prescribing Procedures for an "N" Drug
Section 5.	Rules
Section 6.	Effective Date

Section 1. Short Title

This Act shall be known as the "Model Workers' Compensation Drug Formulary Act"

Section 2. Purpose

The purpose of this Act shall be to require the establishment of a drug formulary for use in a state's workers' compensation system.

Section 3. Definitions

“Formulary” means the Official Disability Guidelines (ODG) Workers’ Compensation Drug Formulary Appendix A published by MCG Health [or another nationally available workers’ compensation drug formulary].

“Medical emergency” means the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected to result in:

- (1) serious jeopardy to the employee's health or bodily functions; or
- (2) serious dysfunction of a body part or organ.

Section 4. Reimbursement and Prescribing Procedures for an “N” Drug

(a) Beginning [January 1, 2019/insert date] reimbursement is not permitted for a claim for payment for a drug that:

- (1) is prescribed for use by an employee who files a notice of injury under this chapter; and
- (2) according to the formulary, is an "N" drug, unless the employee begins use of the “N” drug before [January 1, 2018], and the use continues after [January 1, 2019/insert date]
- (3) If the employee begins use of the “N” drug before [July 1, 2018/insert date], and the use continues after [January 1, 2019/insert date], reimbursement is permitted for the “N” drug until [January 1, 2020/insert date].

(b) If a prescribing physician submits to an employer a request to permit use of an "N" drug described in subsection (a), including the prescribing physician's reason for requesting use of an "N" drug, and the employer approves the request, the prescribing physician may prescribe the "N" drug for use by the injured employee.

(c) If the employer does not approve the prescribing physician's request under subsection (b) to permit use of an "N" drug, the employer shall:

- (1) send the request to a third party that is certified by the [Utilization Review Accreditation Commission/another Accreditation Organization] to make a determination concerning the request; and
- (2) notify the prescribing physician and the injured employee of the third party's determination not more than five (5) business days after receiving the request.

(d) If an employer fails to provide the notice required by subsection (c)(2), the prescribing physician's request under subsection (b) is considered approved, and reimbursement of the "N" drug prescribed for use by the injured employee is authorized.

(e) If the third party's determination under subsection (c) is to deny the prescribing physician's request to permit the use of an "N" drug:

(1) the employer shall notify the prescribing physician and the injured employee;
and

(2) the injured employee may apply to the [worker's compensation board] for a final determination concerning the third party's determination under subsection (c).

(f) Notwithstanding subsections (a) through (e), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is an "N" drug according to the formulary.

Section 5. Rules

The [state department] shall promulgate rules for the implementation of the formulary.

Section 6. Effective Date

This Act shall take effect [xxx days] following enactment.

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 Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting health insurance and long-term care.
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 & Multi-Lines Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting financial services and matters which cross multiple lines of insurance.
7. 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. 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. 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. 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. 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 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 & Multi-Lines Issues 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;
Amended Annual Meeting, Oklahoma City, Oklahoma, December 8, 2018.

© National Council of Insurance Legislators

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2317 Route 34, Suite 2B
Manasquan, NJ 08726
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine



PRESIDENT: Sen. Dan "Blade" Morrish, LA
VICE PRESIDENT: Rep. Matt Lehman, IN
TREASURER: Asm. Ken Cooley, CA
SECRETARY: Asm. Kevin Cahill, NY

IMMEDIATE PAST PRESIDENTS:
Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

National Council of Insurance Legislators (NCOIL)

Model Act Regarding Interpretation of an Insurance Policy

**To be discussed during the Property & Casualty Insurance Committee on March 17th, 2019*

Drafting Note: The language below is based on Tennessee HB 1977 – enacted on March 22, 2018 – and is meant to set forth in statute the settled law regarding the “plain meaning rule” as applied to interpretation of insurance policies. States should work with stakeholders and the insurance department to amend the appropriate portion of insurance code to reflect the language below in order to avoid the “Restatement of the Law, Liability Insurance” that was approved at the 2018 Annual Meeting of the American Law Institute being construed as the state’s settled law on this issue.

Section 1. Title

This Act shall be known as the “Model Act Regarding Interpretation of an Insurance Policy.”

Section 2. Insurance Policy Interpretation

- (a) A policy of insurance is a contract and the rules of construction used to interpret a policy of insurance are the same as any other contract.
- (b) A policy of insurance must be interpreted fairly and reasonably, giving the language of the policy of insurance its ordinary meaning.
- (c) A policy of insurance must be construed reasonably and logically as a whole.
- (d) An insurance company's duty to defend depends solely on the allegations contained in the underlying complaint describing acts or events covered by the policy of insurance. This subsection (d) does not impose a duty to defend on an insurance company that has no duty to defend pursuant to this Act or that has an express exclusion of the duty to defend in the policy of insurance.

Section 3. Effective Date

This Act shall take effect immediately.

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National Council of Insurance Legislators (NCOIL)

Guidance for States Responding to the American Law Institute's Restatement of the Law: Liability Insurance

**To be discussed during the Property & Casualty Insurance Committee on March 17th, 2019*

Drafting Note: While the majority of the Restatement of the Law: Liability Insurance (Restatement) that was approved at the 2018 annual meeting of the American Law Institute is noncontroversial and reflects settled rules and principles of insurance law, it does contain several provisions that depart from those rules and principles both substantively and significantly. This document is meant to serve as guidance for states seeking to respond to those provisions by means of enacting legislation to prevent court adoption of new legal principles set forth in the Restatement. Below are specific issues that states should consider as the basis for such legislation, either in the form of an omnibus bill or separate bills. States should work with stakeholders and the insurance department to amend the appropriate portion of insurance code to reflect the settled law on the issues below in order to avoid the Restatement being construed as the state's settled law on those issues.

- 1.) Insurers have no independent duty to screen defense counsel for impairment or otherwise second-guess the competency of counsel who has been determined fit to practice law by the [governing licensing body in the applicable state].
- 2.) For those states in which the legislatures have considered and rejected a "tort" of bad faith as well as a private right of action under that state's Unfair Claim Practices Act, the legislature should affirmatively enact legislation stating that the terms and conditions of an insurance contract and the contractual obligation of good faith and fair dealing govern the duties between insurer and insured.
- 3.) Insurance contracts shall be governed by the same standards as other contracts, and thus not have a separate set of standards under the law. Accordingly, existing standards relating to rescission shall apply and additional requirements such as a new "substantiality" test shall not be superimposed on the requirements of a misrepresentation under the contract.

4.) Policy language requiring a claim to be made and reported during the policy period will be enforced if the policyholder does not purchase an extended reporting period.

5.) Any party seeking recovery under a contract – including an insurance contract – has a duty to mitigate its damages and cannot recover for loss it could have avoided without undue risk.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 7, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Friday, December 7, 2018 at 5:00 p.m.

Representative Martin Carbaugh of Indiana, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Sen. Jason Rapert (AR)	Sen. Dan "Blade" Morrish (LA)
Sen. Travis Holdman (IN)	Asm. Andrew Garbarino (NY)
Rep. Matt Lehman (IN)	
Rep. Steve Riggs (KY)	

Other legislators present were:

Asm. Ken Cooley (CA)	Asw. Pamela Hunter (NY)
Sen. Gary Dahms (MN)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Utke (MN)	Rep. Joe Schmick (WA)
Sen. Jerry Klein (ND)	

Also in attendance were:

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

DISCUSSION/CONSIDERATION OF PROPOSED AMENDMENTS TO ARTICLES OF ORGANIZATION & BYLAWS

Commissioner Tom Considine, NCOIL CEO, stated that since he began his time as NCOIL CEO, the State-Federal Relations Committee and International Insurance Issues Committee have met jointly at every national meeting. Accordingly, amendments are proposed to the bylaws to have the bylaws reflect that reality; specifically, Section III.B.1. is proposed to be amended; Section III.B.7 is proposed to be deleted; and Section III.B. will have to be re-numbered accordingly to reflect the merging of those two committees. Cmsr. Considine then stated that an amendment is proposed to re-name the Health, Long Term Care and Health Retirement Issues Committee to the Health Insurance and Long Term Care Issues Committee. The reasoning for the re-naming of that Committee is that for a committee to have under its jurisdiction health issues, long term care issues and retirement issues is a lot to handle. Additionally, retirement issues generally fall under "financial planning" and therefore it is better for retirement issues to be dealt with in the current Life Insurance & Financial Planning Committee.

Cmsr. Considine then stated that an amendment is proposed to Section III.G.1.

regarding clarification of the 30-day rules. The purpose of the 30-day rule is to eliminate the notion of surprise so that people know what the issues being discussed will be. However, the rules read literally require a supermajority for any floor amendment to pass no matter how minor the amendment is. Therefore, the proposed amendments simply clarify the purpose of the 30-day rules by stating: "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."

Lastly, Cmsr. Considine stated that an amendment is proposed to Section VI.B. consistent with the aforementioned proposal to merge the State-Federal Relations and International Insurance Issues Committees.

Upon a Motion made by Sen. Travis Holdman (IN) – NCOIL Immediate Past President – and seconded by Asm. Andrew Garbarino (NY), the Committee voted without opposition by way of a voice vote to adopt the amendments to the bylaws.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
OKLAHOMA CITY, OK
DECEMBER 8, 2018

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Renaissance Oklahoma City, on Saturday, December 8 at 10:20 a.m.

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

MEMBERS OF THE COMMITTEE PRESENT:

Sen. Dan "Blade" Morrish, Vice President, LA
Rep. Matt Lehman, Treasurer, IN
Asm. Ken Cooley, Secretary, CA
Rep. Steve Riggs, Immediate Past
President, KY
Sen. Travis Holdman, Immediate Past
President, IN
Rep. Sam Kito, AK

Rep. Deborah Ferguson, AR
Rep. Martin Carbaugh, IN
Sen. Jerry Klein, ND
Rep. Bart Rowland, KY
Asm. Kevin Cahill, NY
Asm. Andrew Garbarino, NY
Rep. Lewis Moore, OK
Rep. Tom Oliverson, TX

OTHER LEGISLATORS PRESENT:

Sen. Gary Dahm, MN
Sen. Paul Utke, MN
Asw. Pamela Hunter, NY

ALSO PRESENT:

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

Sen. Rapert called the meeting to order and asked for a motion to waive the quorum which was made, seconded and carried on a voice vote.

MINUTES

A motion was made by Sen. Morrish and seconded by Sen. Holdman to approve the minutes of the July 15th Executive Committee meeting minutes.

FUTURE LOCATIONS

Commissioner Considine discussed having the 2021 spring meeting in either Denver or District of Columbia from March 11-14 or March 18-21 at the Denver Westin or Metro Center DC.

Sen. Rapert stated that it's been a long time since NCOIL has met in DC and suggested going there.

Sen. Holdman stated that earlier in March is better since spring break is a bit later that year.

Rep. Lehman stated NCOIL has not been to DC for a meeting since 2013 and thought that DC is the better choice. Commissioner Considine stated it's the will consensus of the body for March 11 – 14 in DC at the Marriott Metro Center.

ADMINISTRATION

Commissioner Considine noted that there were 271 registrants for the annual meeting, 40, legislators and participants from 24 states. 6 legislators participated via ILF scholarship. 4 Commissioners and 1 Commissioner-elect, and 9 insurance departments were present.

Paul Penna gave the 2018 unaudited financial report through September 30, 2018 that showed \$826,803.68 in revenue and \$658,419.85 in expenses for a net operating revenue of \$168,383.83. A motion to accept financials was made by Asm. Garbarino and seconded by Rep. Kito. It passed on voice vote

Commissioner Considine asked that the committee continue to use Collins and Co as auditor.

Rep. Riggs made a motion that was seconded by Rep. Lehman and it passed on a voice vote.

CONSENT CALENDAR

Sen. Rapert asked if any member had an item to take off the consent calendar. No member did so a motion was made by Sen. Klein to accept the consent calendar and seconded by Asm. Garbarino. The motion carried on a voice vote.

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

Asm. Cooley asked for consideration of his model and stated this is the 4th time it's been discussed. It instructs insurance departments to brief the legislature on –

- the state of law in insurance and the accreditation process.
- Issues of documentation by the department where it confers delegation to act.
- regulatory actions based on delegation of authority.

Asm. Cooley noted that the NAIC is not a government body and this model puts the spotlight where legislators gave the NAIC authority and bring back to legislature for authority. It asks for more informed legislature and training periodically. Items need to be publicly available on the internet. Believe there is consensus to do this now.

Asm. Cooley made a motion to adopt and Asm. Garbarino seconded. Passed on voice vote

Rep Riggs stated that this is groundbreaking idea it will help send people to NCOIL meetings to be more informed. It's beneficial to have more informed legislators. Rapert said staff will disseminate to states, department and interested parties.

OTHER SESSIONS

Sen. Rapert noted that OK Gov. Mary Fallin and former Gov. Frank Keating were both informative and interesting and noted the other sessions:

The Institutes Griffith Insurance Education Foundation luncheon featured a primer on catastrophe modeling by Dr. Brenda Wells for public policy makers.

The three General Sessions:

- Examining the Role of ERISA in the State Based System of Insurance Regulation: Can Meaningful State Reforms be Achieved in an ERISA-Dominated Marketplace?
- Reverse Preemption – Can States Preempt Federal Insurance Laws and Regulations through use of the McCarran-Ferguson Act?
- Understanding InsurTech and FinTech – What Legislators and Regulators Can do to Promote Innovation in the Insurance and Financial Services Industries.

NOMINATING COMMITTEE REPORT

Rep Riggs gave the Nominating Committee report and stated that NY Asm. Kevin Cahill has been selected to serve as Secretary. All other officers moved up a position. Motion to accept was made by Rep. Riggs and seconded by Rep. Lehman. Motion carried on voice vote

OTHER BUSINESS

Sen. Rapert noted that per the bylaws, MO Sen. Paul Wieland, as chair of the insurance committee in his state is elevated to the Executive Committee as he has attended his second NCOIL meeting.

Asm. Garbarino made a motion to elect Asw. Pam Hunter from NY to the Executive Committee. Asm. Cahill seconded. Motion carried on a voice vote.

Commissioner Considine asked for a moment of personal privilege to personally thank Sen. Rapert you for all he's done this year as NCOIL President. He noted that he was a pleasure to work with over the last year and was an "Energizer Bunny" with endless enthusiasm and energy as an ambassador for NCOIL.

Sen. Rapert noted that it's been quite an honor. Getting involved with NCOIL after his first election was one of the best decisions he made. He noted pride in the growth in states and revenue. He thanked Considine for the leadership that he's shown and noted that as many people are depending on him. Sen. Rapert continued that enjoyed serving NCOIL very much and has come to think a great deal of Considine and noted that Considine operates with dignity under pressure. People feel welcome at NCOIL. He concluded with a "Thanks to all", specifically noting the staff.

Rapert recognized Sen Morrish as the next NCOIL president. He noted that Morrish stepped in when he was needed even though it was not in his plan to do so. He introduced Morrish who presented Sen. Rapert with a ceremonial gavel on behalf of NCOIL to thank him for his term as President and his years of service.

ADJOURNMENT

There being no further business, the committee adjourned at 11 am.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 6, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Thursday, December 6, 2018 at 2:15 p.m.

Representative Sam Kito of Alaska, Vice Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Steve Riggs (KY)
Rep. Edmond Jordan (LA)

Sen. Dan "Blade" Morrish (LA)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asm. Andrew Garbarino (NY)
Asw. Pamela Hunter (NY)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Gary Dahms (MN)
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

A motion was first made by Rep. Tom Oliverson, M.D. (TX) and seconded by Sen. Jerry Klein (ND) to waive the quorum requirement which the Committee approved without objection by way of a voice vote. Upon a motion made by Asm. Ken Cooley (CA) and seconded by Rep. Joseph Fischer (KY), the Committee approved without objection by way of a voice vote the minutes of its July 13, 2018 meeting in Salt Lake City, UT.

UPDATE ON DATA SECURITY AND BREACH NOTIFICATION LAWS

Paul Ferrillo of GreenbergTraurig, LLP, stated that the current state of cybersecurity is not good, particularly with the very recent news regarding the Marriott and Quora breaches. The only way things are going to get better is by continuing the dialogue surrounding cybersecurity. In the past month alone, there have probably been approximately one billion records hacked or stolen. Mr. Ferrillo stated that he worked on some of the big third party vendor media hacks in addition to several others. Legislation is not working well because whenever we have a piece of legislation introduced it seems like it takes six or seven years to actually sign it into law.

One big issue on almost everyone's mind is the national data breach notification rule. For those in the different industries and different states, there are several different rules and guidelines that must be met relating to breach notification requirements. Some people are talking about whether or not there should be federal guidance that preempts state laws. An example of that is H.R. 6743 – The Consumer Information Notification Requirement Act – sponsored by Congressmen Luetkemeyer. Mr. Ferrillo stated that in his opinion, none of it really matters. Whether you must report a breach in one day or 72 hours is not going to matter.

Mr. Ferrillo stated that he spent on behalf of one client easily \$20,000 in attorney time giving notifications of a huge data breach to all 50 states and 37 countries. Something does not make much sense when you are talking about that much money being spent when millions of pieces of personally identifiable information (PII) had already been obtained. Mr. Ferrillo stated that, in the spirit of a conversation held earlier during which the National Association of Insurance Commissioners (NAIC) was the focus, something that would go against the NAIC's wishes would be if states adopted the NIST Cybersecurity Framework, which is actually Federal guidance but a common sense framework that you may or may not know has been incorporated in many different state regimes and federal laws, in addition to the new General Data Protection Regulation (GDPR) in the EU if you look "under the hood" of that regulation.

Mr. Ferrillo stated that the NIST framework is a document that will get the U.S. "out of jail" and "out of the doghouse." Mr. Ferrillo urged the legislators present to adopt the NIST framework in each of their states because you can have any genius stand up and tell you what is wrong with the state of cybersecurity and they will all be wrong. They can be right by adopting the NIST framework. With regard to incident responses, Mr. Ferrillo stated that they are a big problem. You must report an incident affecting consumers of a particular magnitude and the magnitude differs from state to state and the reporting requirements also differ depending on the type of information obtained in the incident. Mr. Ferrillo stated that the big problem with cybersecurity today is that no one is talking about how to fix something; everyone is talking about remedial actions. Mr. Ferrillo stated that one of the biggest problems today related to cybersecurity is also aging infrastructure. You cannot run a state or a business effectively using Windows XP or Windows 7. Software needs to be updated but paying for it is of course an issue. There will be no end in cybersecurity attacks unless we all take the bull by the horns and do something that actually makes sense. We will not be able to sustain this country when we're dealing with 47 parts of the U.S. government that are unconnected to each other and not protected by the NSA or other large government body.

Justin Brookman, Director of Consumer Privacy and Technology at ConsumersUnion, stated that, just like the current state of cybersecurity, the current state of data privacy is also not good at all. The recent news of Facebook accessing consumer's call logs without notice in order to suggest friends affirms that statement. Mr. Brookman stated that U.S. law on privacy is a relatively new concept and has evolved slowly since Justice Brandeis raised concerns in 1890. Sectoral specific laws have emerged, which have done a good job of protecting types of data, such as the Fair Credit Reporting Act (FCRA); Children's Online Privacy Protection Act (COPPA); Health Information Portability and Accountability Act (HIPAA); and the Video Privacy Protection Act (VPPA). However, a lot of your personal information is not well protected.

Mr. Brookman stated that many of the aforementioned laws look somewhat similar and

have similar principles based on the Fair Information Practice Principles. The problem is that most data is not covered by those laws which is unusual because most countries around the world have basic privacy protections for all information. Since 1995, Europe has had such legislation and the EU also just passed the GDPR, designed to be a more rigorous version of their existing law. Mr. Brookman stated that in the U.S., the Federal Trade Commission (FTC) is the default privacy regulator but they don't have a privacy law, but rather broad prohibitions on "deceptive" and "unfair" business practices set forth in Section 5 of the FTC Act. "Deception" is a good standard, but the Act doesn't say much beyond "don't lie" which means privacy policies tend to be very vague. It is also unclear as to what is "unfair" in the privacy space since the Act was not really designed to address the privacy issues we deal with today.

Mr. Brookman stated that states have historically taken the lead on privacy and security issues. States have constitutional protections surrounding personal information. New Hampshire recently passed a ballot initiative to approve an amendment to the state's constitution: "An individual's right to live free from governmental intrusion in private or personal information is natural, essential, and inherent." The federal government still has not caught up with states regarding breach notification laws and almost half the states have data security laws.

Mr. Brookman stated that the recently passed California Consumer Privacy Act of 2018 (CCPA) is the most sweeping and ambitious privacy law passed in the U.S. The CCPA came about very suddenly in that a real estate developer, Alastair MacTaggart, started having conversations with his friends from Silicon Valley and realized that a comprehensive privacy law was needed due to their complex activities. Mr. MacTaggart then sponsored a ballot initiative and was not sure if it was going to advance but then the Facebook-Cambridge Analytica story broke and that spurred the initiative forward. California legislators thought that ballot initiatives were not the best way to make laws dealing with data security and technology, so they worked out a deal whereby the legislature would pass a law that could be amended more easily if Mr. MacTaggart dropped the ballot initiative.

The entire process went very quickly and the CCPA reads as such as there are many inconsistencies. Some amendments have already been introduced in an effort to clean it up, but the process is nowhere near finished. The CCPA applies to all entities doing business in California that make more than \$25 million in annual revenue, have personal data on 50,000 or more people, or data brokers, which is what the Act was really designed to "get to" – data brokers who get information about you and sell that information. It is unclear whether the CCPA applies to non-profits but it is clear that it covers a very broad amount of information: essentially any information that could relate to you.

Mr. Brookman stated that the CCPA adds four new rights for individuals: transparency; access to data; opt-out of sharing; and deletion. Regarding transparency, privacy policies don't really say much today. Some states require privacy policies, but the laws don't really state what the policy must contain. Accordingly, the CCPA tries to set forth what must be in privacy policies. Regarding access to data, the CCPA permits a consumer, twice per year, to request specific pieces of information from any covered business. That is certainly a feature of European privacy laws. Regarding opting-out of sharing information, if you go to the grocery store and they generated a profile of all of the groceries you bought, you can tell them to not sell it to data brokers. There are

important exceptions to that right, notably for sharing limited information for “business purposes” to service providers, but it nonetheless is a very broad right. However, it is not clear how that right will apply to online advertisement (and other third-party) tracking and that is an issue that may be addressed through amendments. Regarding deletion, you can direct a company to delete any data it has about you, with certain exceptions.

Mr. Brookman stated that the CCPA prohibits the selling of information about minors under 16 years of age without affirmative consent from the parent or minor, depending on the age of the minor. One of the controversial parts of the CCPA deals with whether a company can charge an individual more or offer lower quality to someone who exercises their privacy rights and opts out of sharing their information. Mr. Brookman stated that he understands the arguments on both sides of that issue. The language in the ballot initiative prohibited companies from doing so but the language that passed states that the company can offer the individual an incentive to allow them to sell your information or they can charge the individual more if it reasonably relates to the value that the data provides. No one is quite sure what that means.

Regarding enforcement, Mr. Brookman stated that the CCPA provides for a penalty of up to \$7,500 per violation which can be incredibly onerous particularly for companies like Facebook that has billions of users. The enforcement provisions were somewhat watered down in the final version. There was a whistleblower provision, municipality enforcement provisions, and provisions providing for a private cause of action but those are all by and large removed from the statute as enacted. In 2019, the CA Attorney General will be promulgating regulations to clarify certain outstanding issues such as who exactly is covered under the CCPA, how do you obtain verifiable consent from an individual and how do you make the opt-out provisions work at scale.

Mr. Brookman stated that in some ways the CCPA does not address all the concerns raised by privacy advocates as the focus is more on small data brokers rather than large companies like Google and Facebook. Some privacy advocates have called for provisions that require companies to only collect the data that they need, and that require companies to obtain permission for certain things rather than putting the burden on the user to tell the company to stop collecting and selling data. Nevertheless, Mr. Brookman stated that the CCPA is a significant advancement in privacy protections. The CCPA probably will not get repealed, but a big fight is in store for those in California in 2019 as amendments are expected to be considered and litigation is underway with plaintiffs raising concerns related to the Commerce Clause and the 1st Amendment, among others.

Mr. Brookman stated that with regard to security legislation, about half of the states have such legislation that states if you have information, reasonable procedures need to be in place to ensure it is not stolen. The legislation is roughly consistent with authority the FTC has asserted under its Unfair, Deceptive or Abusive Acts and Practices (UDAP) authority. One new development in California last year was the enactment of cybersecurity legislation which does not deal with information security but rather with protecting certain things such as “smart” washing machines so that they cannot be hacked and manipulated. Mr. Brookman further stated that there is also a tremendous amount of interest in these issues at the federal level but he is not optimistic of seeing anything passed anytime soon.

Michael Gugig, Vice President of State Gov’t Relations & Assoc. General Counsel at

Transamerica began by stating that his remarks today are on behalf of the American Council of Life Insurers (ACLI). Mr. Gugig stated that there is a fundamental need to secure policyholder information. Life insurers have a long history of dealing with highly sensitive personal information from their customers. Much of that is medical information, which life insurers need. Without that information, underwriting cannot occur and claims cannot be paid because life insurers need to be able to get the information both at the start of the sales process and when it comes time to pay the claim. Life insurers are acutely aware of the type of data that they have and the need to secure it.

Mr. Gugig stated that life insurers have been strong supporters of carefully thought through state and federal laws that together comprise a broad and rigorous regulatory framework that requires life insurers to protect both the privacy and security of customer information. Mr. Gugig then discussed some differences between security and privacy laws. Security laws and regulations tell us how our systems have to be protected so that hackers cannot steal information. Privacy laws and regulations tell us what companies can do with the information once they have it. The CCPA is an example of a privacy law. Many people conflate those two types of laws but it is important to recognize the differences.

Mr. Gugig stated that virtually every state has multiple laws in place that govern how insurers, particularly life insurers, are required to safeguard customer information. With regard to the CCPA, it is important to note that insurers are in a unique position because they need certain information from customers; insurers are not just gathering information so that they can sell it to others. Insurers are gathering information in order to conduct the business of insurance. The CCPA was passed in a very short period of time and was literally in the legislature for only a few days. There was a lot of brokering behind closed doors and no consideration as to how the law might affect regulated industries like the insurance business as there are already multiple CA laws and regulations that insurers must comply with. Accordingly, when laws like the CCPA are passed without thoughtful consideration of how it might affect certain industries, the impact can be profound. Mr. Gugig also noted that there are federal laws in place that insurers must comply with such as Gramm-Leach-Bliley, the Fair Credit Reporting Act, and HIPAA.

Mr. Gugig further stated that the main point is that the life insurance industry believes fundamentally in the need for uniformity and harmonization. Think for a moment of the difficulty that a 50-state business encounters when having to utilize computer systems and secure them in 50 different ways subject to different laws and regulations within each state. It also becomes extraordinarily difficult to know which law and rule is working and which ones are not working because some of the laws and rules have been enacted without enough consultation as to how some unintended consequences might arise. Insurers generally keep data on systems on a national level, not on a state-by-state basis. In the absence of a uniform privacy and data security protocol, insurers that conduct business across the country end up defaulting to the most draconian standard because in theory they will then be complying with all laws. By forcing the industry to act in such a manner, public policy agendas will not be satisfied.

Going back to the CCPA, Mr. Gugig stated that it is a generally applicable law. Without thoughtful consideration of how it will impact all covered entities, it is going to be extraordinarily difficult for there to be an understandable comprehensive data security and data privacy system. The complexity of the current regulatory structure and new and growing privacy and security challenges make careful and thoughtful consideration

necessary regarding the need for and substance of any new privacy or security law applicable to life insurers. We need to be thinking about these issues on an industry-by-industry analysis. The hope is that insurers will not be subject to any more breaches, but the fear is that they might be, and without a uniform system of data security and data privacy, the likelihood of breaches will grow.

Rep. Sam Kito (AK) – Vice Chair of the Committee – stated that with regard to the problem of regulating these issues state-by-state, are there any industries and organizations seeking to enact a national standard? Mr. Gugig stated that there is an appetite in Congress for federal preemptive legislation. The life insurance industry strongly supports state regulation of insurance and wants there to be uniformity between the states and wants state insurance regulators to regulate how insurers protect consumer's data as opposed to Attorneys General. The fear is that if that does not prove to be workable, a federal standard will be enacted.

Asm. Ken Cooley (CA) – NCOIL Secretary – noted that the basic path of the CCPA was a ballot initiative which means the drafters of the law “did their own thing” and it was exceedingly stringent and on the November ballot. A facet of CA law is that if you qualify something to go on the ballot, if the legislature passes something similar that the mover of the initiative is agreeable to, the legislation can be passed and the initiative can be pulled. Accordingly, a bill was then drafted quickly as an alternative to the more stringent ballot version and the legislature now has until January 1, 2020, to implement the bill.

DISCUSSION/CONSIDERATION OF RESOLUTION IN SUPPORT OF STATE REGULATED HEALTH SAVINGS ACCOUNT-BASED COVERAGE

Rep. Steve Riggs (KY) – NCOIL Immediate Past President – provided some background on a proposed “Resolution in Support of State Regulated Health Savings Account-Based Coverage” which he and Sen. Jerry Klein (ND) co-sponsored for consideration. Health savings accounts (HSAs) have become the fastest growing product in the insurance market. The Resolution aims to inform states to essentially avoid the actions that certain states such as Illinois, Maryland, Oregon, and Vermont undertook relating to enacting laws requiring fully-insured plans issued within their borders to cover male sterilization benefits without application of the plan deductible, copays or coinsurance. Those laws effectively made HSAs inoperable in those states because the laws go beyond a clear understanding of what the IRS considers “preventive care services” that could be exempt from the deductible. HSAs are linked to high deductible health plans (HDHPs), which must meet certain requirements, most notably that the plan deductible must apply to all covered benefits received from in-network providers – the only exception being for “preventive care services” as defined by the IRS.

Sen. Klein stated that the Resolution is an important step in making sure those with HSAs are able to continue making contributions to such accounts. Sen. Klein stated that he discussed the Resolution with ND Insurance Cmsr, Jon Godfread, who supported it. Kevin McKechnie of the American Bankers Association (ABA) stated that the issue the Resolution deals with is very easy to understand. HSAs and qualified insurance are defined under IRS code but in the individual, fully-insured market, HSA-qualified insurance is insurance that adheres to IRS code and the many rules of each state. Accordingly, when those two qualifiers conflict, everyone in the conflicting state with an HSA becomes ineligible to contribute to their HSA and must find replacement coverage.

The Resolution therefore is in support of states respecting federal IRS code and when a state chooses to enact a mandate, there is no issue with what the mandate is, people who have HSA-qualified insurance can keep that coverage. More specifically, the Resolution encourages to follow the path of what Vermont did which was to adopt language that exempts HSA-qualified insurance from having to meet a certain first-dollar coverage requirement.

Upon a Motion made by Rep. Riggs and seconded by Sen. Klein, the Committee voted without opposition to adopt the Resolution as amended by way of a voice vote. The amendment served to add to the list of recipients that the Resolution directs NCOIL staff to send to.

DISCUSSION/CONSIDERATION OF RESOLUTION ASSERTING MCCARRANFERGUSON REVERSE PREEMPTION OVER THE SUPERVISION OF INSURANCE COMPANIES BY THE FEDERAL RESERVE BOARD AND ITS EXAMINERS

Paul Martin, Regional Vice President, Southwestern Region, of the National Association of Mutual Insurance Companies (NAMIC) spoke in support of a 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) – NCOIL Vice President.

Mr. Martin stated that the McCarran-Ferguson Act was passed by Congress in 1945 in response to a U.S. Supreme Court decision that held that insurance was commerce and therefore should be regulated by Congress. The McCarran-Ferguson Act has allowed insurance companies and consumers to greatly benefit. Insurance companies are allowed to, in a very limited sense, share information and work together on forms and create different types of products that are available and affordable for consumers. This process has worked well for the marketplace, however, there has recently been some incremental encroachment by the Federal Reserve by seeking and asking for information that is already being regulated by state regulators. Mr. Martin stated that NAMIC feels very passionately that state regulation is the best option for the insurance industry. The Resolution is necessary to send a message to Congress and the Federal Reserve that current Federal law puts state regulation of insurance at the forefront.

Sen. Morrish pointed to the Resolution’s penultimate paragraph which states that the actions which the Resolution calls for are not only consistent with the McCarran-Ferguson Act, but with the Gramm-Leach-Bliley Act, and the Dodd-Frank Act. The Federal Reserve should stay out of state regulated insurance operations, regardless of the insurer’s affiliations with federally-regulated financial institutions.

Upon a Motion made by Sen. Morrish and seconded by Sen. Klein, the Committee voted without opposition to adopt the Resolution by way of a voice vote.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH, LONG TERM CARE AND HEALTH RETIREMENT ISSUES COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 8, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health, Long Term Care and Health Retirement Issues Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Saturday, December 8, 2018 at 8:30 a.m.

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

Other members of the Committees present were:

Rep. Sam Kito (AK)	Sen. Dan "Blade" Morrish (LA)
Rep. Deborah Ferguson (AR)	Rep. Michael Webber (MI)
Sen. Jason Rapert (AR)	Sen. Jerry Klein (ND)
Asm. Ken Cooley (CA)	Asm. Andrew Garbarino (NY)
Rep. Lois Landgraf (CO)	Asw. Pam Hunter (NY)
Rep. Martin Carbaugh (IN)	Rep. Tom Oliverson, M.D. (TX)
Rep. Matt Lehman (IN)	
Rep. Bart Rowland (KY)	

Other legislators present were:

Sen. Travis Holdman (IN)	Sen. Paul Utke (MN)
Rep. Steve Riggs (KY)	Sen. Paul Wieland (MO)
Sen. Gary Dahms (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

A motion was first made by Asw. Pam Hunter (NY) and seconded by Rep. Tom Oliverson, M.D. (TX) to waive the quorum requirement which the Committee approved without objection by way of a voice vote. Upon a Motion made by Asw. Hunter and seconded by Rep. Oliverson, the Committee approved without objection by way of a voice vote the minutes of its July 14, 2018 meeting in Salt Lake City, UT. Upon a motion made by Rep. Deborah Ferguson (AR) and seconded by Sen. Jason Rapert (AR) – NCOIL President – the Committee approved without objection by way of a voice vote the minutes of its Oct. 25, 2018 interim conference call committee minutes.

DISCUSSION/CONSIDERATION OF NCOIL PHARMACY BENEFIT MANAGER LICENSURE AND REGULATION MODEL ACT

Sen. Rapert – sponsor of the NCOIL Pharmacy Benefit Managers Licensure and

Regulation Model Act (Model) began by offering two sponsor's amendments to the current version of the Model. The first amendment serves to delete the language in Section 8(c) and replace it with: "Nothing in this Act is intended or shall be construed to be in conflict with existing relevant federal law." Sen. Rapert stated that the purpose of that amendment is to avoid any issues related to preemption and the Employee Retirement Income and Security Act of 1974 (ERISA). The second amendment serves to delete the drafting note following Section 8 and preceding Section 9 in its entirety. Sen. Rapert noted that said drafting note dealt with the proposed independent dispute resolution (IDR) system and that after discussing that issue with stakeholders he thought it was best to remove the language from the Model and leave it up to the Committee to decide if it would like to discuss the issue separately in a more thorough manner at a later time.

Josh Keeps, Regional Director of State Affairs for America's Health Insurance Plans (AHIP), stated that AHIP appreciates Sen. Rapert's decision to remove the drafting note related to IDR. AHIP does have some issues with the remaining drafting notes and removal of those drafting notes would remove AHIP's opposition to the Model and that is why AHIP has supported the Committee going back to the prior version of the Model that the Committee discussed in October.

Melodie Shrader, Senior Director of State Affairs for the Pharmaceutical Care Management Association (PCMA), stated that PCMA supports the two amendments offered by Sen. Rapert today and that PCMA's primary remaining concern is the drafting note in Section 7 that lists issues without any context. PCMA has grave concerns that there is not enough guidance in that drafting note for states to understand what this committee means for them to do. Ms. Shrader also stated that PCMA continues to have concerns related to the Model and ERISA-preemption, and that PCMA looks forward to working with members of the committee going forward if the Model is introduced in any of the committee member's states.

Ronna Hauser, PharmD, Vice President of Pharmacy Policy & Regulatory Affairs for the National Community Pharmacists Association (NCPA), stated that since the Committee met in July in Salt Lake City, Ohio has found that their PBMs have pocketed \$224 million dollars in spread while simultaneously underpaying pharmacies by over \$350 million dollars. Pennsylvania's Auditor General is currently investigating PBMs' use of tax dollars in PA and his report will be released in the upcoming days. In addition, West Virginia will soon release data showing extraordinary savings by taking management of their Medicaid pharmacy program away from PBMs and putting it back into the state's hands.

Ms. Hauser stated that NCPA believes that the Model is a very positive step in the right direction to address these PBM practices. NCPA requests that the exemption for self-funded plans be removed from the Model and therefore supports the amendment to Section 8 offered by Sen. Rapert this morning. The extent to which federal law will permit the regulation of self-funded plans is a determination that is best made by the states. Currently, 32 state Attorneys General have filed an amicus brief in the U.S. Supreme Court defending state's rights to regulate PBMs. The states are fighting to get the U.S. Supreme Court to overturn an 8th Circuit ruling (PCMA v. Rutledge) that prevented Arkansas from regulating PBMs. The states are arguing that the 8th Circuit interpreted ERISA too broadly in deciding that ERISA preempted Arkansas state law. Ms. Hauser stated that if the 8th Circuit's ruling became the law of the land, states might

not be able to provide a check on PBM reimbursement and billing practices, at a time when those practices have raised significant concerns about healthcare affordability and access.

Ms. Hauser closed by stating that the drafting note in Section 7 of the Model is consistent with the spirit of the Model which is to provide a framework to the state insurance commissioner to draft rules, and the drafting note is completely permissive in nature. NCPA supports the committee's adoption of the Model, as amended, and believes that the Model is a robust chassis that will put state insurance commissioners in a better position to regulate PBMs.

Sen. Rapert stated that he appreciates everyone's comments on this issue since the discussion started earlier this year. Sen. Rapert stated that, as many are probably aware, Arkansas passed a comprehensive PBM law earlier this year that actually contains much of what is seen in the drafting note in Section 7. Sen. Rapert further stated that he is pleased that the news was shared of 32 state Attorneys General challenging the PCMA v Rutledge decision. Sen. Rapert then made a Motion to move adoption of the Model, as amended, which was seconded by Rep. Oliverson. Asm. Cahill then opened up the discussion on the Model to any legislators present.

Rep. Lois Landgraf (CO) asked if Section 6(b)(1) of the Model could possibly be a Health Insurance Portability and Accountability Act (HIPAA) violation since the provision permits the state insurance commissioner to have access to people's medical records. Ms. Shrader stated that she understands how the provisions could raise questions related to HIPAA but that she would have to defer to a HIPAA expert as to whether the language was in fact problematic. Rep. Oliverson stated that, from a clinician's perspective who has to be HIPAA-trained every year, the statute states that the person who is entitled to have access to protected health information that is necessary in order for them to do their job is bound by the conditions to protect the privacy of that information. Rep. Oliverson stated that the only change that he could potentially envision is if the insurance commissioner was suddenly having access to protected health information in a situation where they previously did not have access to any such information which he would find hard to believe; and even in that scenario, there is no issue so long as the person handling, who has been authorized to handle, breaches the duty to protect the information.

Asm. Cahill also noted that Section 6(b)(2)(A) and (B) state that "the information or data acquired during an examination under subdivision (b)(1) of this section is: (A) Considered proprietary and confidential; and (B) Not subject to the [Freedom of Information Act] of this State." The Honorable Tom Considine, NCOIL CEO, stated that it is a daily ongoing function at insurance departments around the country as part of their examination functions to, when examining all types of health insurers, come into contact with HIPAA-protected information, so the referenced provision in the Model is consistent with their functions.

Asm. Ken Cooley (CA) – NCOIL Secretary – stated that Section 6(b)(1) is very limited in that it simply lets the insurance commissioner enforce the Model to determine compliance with the Model and agrees that it is consistent with how things are done all the time. Asm. Cooley stated that as a lawyer looking at that provision, and if he were advising the legislature as to whether the provision constituted a sound practice, he would state that the power of enforcement cannot be created without providing the

capacity to enforce, and those two concepts are in alignment in Section 6(b)(1) as it is not overbroad at all. Asm. Cooley stated that if an examiner was trying to gain access to information that went beyond trying to simply enforce compliance with the Model, then an argument of over broadness could be proffered, but that is outside the framework of the Model.

Asm. Cooley then asked the panelists if any of them had ever been in a state and been in a fight with a regulator whom they thought was acting in an overbroad manner beyond the scope of their authority. Mr. Keepes stated that type of dispute has come up from time to time but not on this particular issue. Ms. Shrader stated that in her previous life she had represented health plans for about 15 years, in only 1 state, but there was always a concern when working with legislators about what gets put in writing to make sure that they had enough guidance so that they did not overstep their authority. Ms. Shrader stated that oftentimes when she is working with legislators, she will discuss how the current insurance commissioner would never do certain things, but then note that it is important to legislate for the future.

Asm. Cooley stated that as someone who has advised CA lawmakers on public policy for decades, he has a personal philosophy that the National Association of Insurance Commissioners (NAIC) passes model regulations and laws, and he would always advise lawmakers that even if the NAIC adopts a model regulation, it should be adopted in CA by statute; it should never be a wide-open tool in the regulator's hands to let them do whatever they want. That sort of philosophy is protective of the inherent powers of a legislative body.

Accordingly, Asm. Cooley stated that he believes objections to the drafting note in Section 7 is misguided because the drafting note is a message to legislators that they may wish to give specific guidance in these areas, rather than just giving regulators a broad general grant of authority by saying "you may adopt rules not inconsistent with this Act", which actually is a very expansive phrase. Asm. Cooley stated that the drafting note tells legislators that if they think there are some companion ideas from the areas in the list, direction may be provided to regulators.

Asm. Cooley stated that if he was in the position of a state advocate, he would be returning home to tell his colleagues and members that they should be educating lawmakers as to why they have a stake in these issues and that the rules are balanced. If in any given state, the regulators start pushing ahead in an area that a group believes is improper, the group can then discuss with legislators that they should provide specific guidance. Asm. Cooley's belief is that regulators are code administrators and it is the legislature that writes the code. Therefore, the drafting note is actually an advantageous provision for those concerned that a regulator could get "creative" and enact overbroad regulations.

Ms. Hauser stated that while NCPA would like to see the language in the drafting note in Section 7 be part of the Model, NCPA still fully supports the language in drafting noteform. Ms. Shrader stated that she agrees with Asm. Cooley in that she would want a lot of context and language in legislation in order to tell regulators how to regulate certain issues. Ms. Shrader stated that her point was that she was concerned that the drafting note in Section 7 would be given to states as an open-ended list of regulatory topics without any specific guidance from this Committee. Asm. Cooley stated that the drafting note is actually an "arrow in your quiver" for the reasons he previously stated. Ms.

Shrader stated that her experience has been that there are typically very specific issues that arise from state to state and that it is better to have an organic conversation as opposed to a laundry list of regulatory topics in a statute that may not be appropriate in certain states.

Rep. Landgraf stated that she is concerned that Section (b)(1) is very broad in that it does not provide any specifics on when the books and records of a PBM can be examined or audited. Rep. Landgraf asked Asm. Cooley if he was concerned about that because a drafting note in that section could offer guidance on such specifics. Asm. Cahill answered as Chair of the Cmte and stated that the concept of the current version of the Model is very different from the original version introduced earlier this year. The original version was a comprehensive, exhaustive approach to regulating PBMs. Over the course of the year, through discussions and debate, Sen. Rapert decided to go with a “chassis” approach, which is what the current version reflects. The chassis approach takes the form of guidance and a signal to state legislatures across the country that NCOIL is taking the position that there should be regulation and licensure of PBMs. Additionally, Sen. Rapert made sure that each state would have the flexibility to address it as they see fit.

Asm. Cahill noted that the point made by Rep. Landgraf regarding the specifics of PBM examinations and audits has been brought up in NY and he has discussed it with the NY Dep’t of Financial Services (NY DFS). Asm. Cahill noted that he intends on debating the issue with the NY DFS and that is the beauty of a chassis Model law approach. If the Model set forth specific audit requirements, then you run into the situation of straying from the Model as opposed to providing states with a signal that it is time to license and regulate PBMs and the states can take into account their unique needs. Asm. Cooley agreed with Asm. Cahill and noted that Section 6(b)(1) is permissive since it states “may” as opposed to “shall” and it also incorporates the option of an examination which is less stringent than an audit. Overall, Asm. Cooley stated that the Model provides for state flexibility and is not overbearing.

There being no further comments, Asm. Cahill then returned to the Motion made by Sen. Rapert and seconded by Rep. Oliverson to adopt the Model, as amended. Asm. Cahill asked if anyone objected to the vote being in the form of a voice vote. Hearing no objections, the Committee voted affirmatively to adopt the Model by voice vote with Rep. Landgraf being the only voice in opposition.

Sen. Rapert thanked everyone for their comments throughout the entire process and stated that he is proud of NCOIL for providing leadership on these issues and that he is very appreciative to all of the supporters of the Model.

DISCUSSION ON EFFORTS TO OFFER MORE AFFORDABLE INSURANCE OPTIONS TO CONSUMERS

Randy Pate, Director of the Center for Consumer Information and Insurance Oversight (CCIO), and Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS), stated that CMS supports high-quality patient care, competition, and a meaningful move away from fee-for-service and towards value. Value-based care isn’t something CMS would just like to do, it is something that must be done. By 2026, 1 in every 5 dollars spent in the U.S. economy will be spent on healthcare. The current trajectory for healthcare spending must be addressed and improvements to the

sustainability of our healthcare system must be made. Over the past year and half, CMS has introduced several initiatives including Patients over Paperwork, Meaningful Measures, and MyHealthEData aimed at doing the things necessary to finally achieve the long-talked about goal of value-based and patient-centered care. If the final steps are going to be taken, patients must be activated as they are the most powerful force in our healthcare system for creating value. Patients must be at the center of cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families.

Mr. Pate stated that in the area of Medicaid, CMS' vision for the future is to reset the federal-state relationship and restore the partnership, while at the same time modernizing the program to deliver better outcomes for the people it serves. CMS and the current Administration wishes to empower all states to advance the next wave of innovative solutions to Medicaid's challenges – solutions that focus on improving quality, accessibility, and outcomes in the most cost-effective manner. In the area of drug pricing, lowering prescription drug prices is a top priority for the Trump Administration. In the "American Patients First" Blueprint, President Trump has outlined a sweeping set of policies to lower drug prices, which fall under four goals: Lowering list prices, reducing out-of-pocket costs, increasing competition, and strengthening negotiations. CMS has already taken a number of steps to promote drug price transparency and lower drug prices. CMS will continue to execute on President Trump's blueprint, including to encourage value-based purchasing. Drug pricing is a particularly acute issue for CMS. Combined, Medicare and Medicaid represent 40% of the U.S. drug market – making CMS the largest purchaser of prescription drugs in the country and maybe the world. The Medicare program must be protected and strengthened for current and future beneficiaries. In 2012, Medicare spent 17% of its total budget, or \$109 billion, on prescription drugs. Four years later in 2016, this had increased to 23%, or \$173 billion. That is an increase of \$64 billion in just four years. This is not sustainable. As we see innovation in biomedicine, it is incumbent to also modernize payment policies. Over the past year CMS has been evaluating existing value-based payment models in order to assess performance and identify opportunities for improvement.

Mr. Pate then transitioned to discussing the work of the Center he directs—CCIIO. CCIIO's primary focus is on the individual market; but it also has oversight authority over small group. The individual market is often thought of as a residual market where people go when they don't get another offer of coverage through an employer or public program. However, the individual market plays a very important role in the economy—particularly for seasonal workers, retail workers, people in the gig economy, entrepreneurs, and so on. That's why CCIIO is working so hard to make sure this market works for the approximately 16 million people who rely on it. Mr. Pate noted that CCIIO is making progress on bringing competition to the markets around the country. Issuer participation in the Exchanges has increased with 155 total state level issuers in plan year 2019, up from 132 in plan year '18. Five states in plan year '19 will have only one issuer; down from eight states in plan year '18. CCIIO is pursuing policies across the board to reduce barriers to entry, provide more flexibility to states, and encourage competition.

Mr. Pate stated that 20% of current enrollees will have only one issuer to choose from, down from 29% in plan year '18. The average number of qualified health plans (QHPs) available to enrollees is 26 for plan year '19, up from 25 in plan year '18. As you can see from the graph, while there is a positive uptick in the number of issuers overall

between 2018 and 2019, there continue to be disparities in the number of issuers available between rural and Counties with Extreme Access Considerations (CEAC) areas and metropolitan areas. CCIIO will continue to focus efforts to close this gap. The average monthly premium for the second-lowest cost silver plan (SLCSP), also called the benchmark plan, for a 27-year-old decreased by 1.8% from plan year '18 to plan year '19. This year is the first time that CCIIO has seen the premium for SLCSP decrease nationally. That obviously varies from state to state, but it's a great sign for the future. Mr. Pate stated that a big part of the impact on premiums decreasing comes from state innovation. The impact of the reinsurance 1332 waivers that have been approved in 7 states now has been significant and the waivers are having an impact on rates and people's ability to purchase coverage. But, CCIIO still sees this as an area where everyone has lots of work to do.

Mr. Pate noted that on October 12, 2017, President Trump issued the executive order (EO) "Promoting Healthcare Choice and Competition Across the United States." The executive order aimed to address the failings of the ACA, which limited the choice of healthcare options available to many Americans and produced large premium increases in many state individual markets for health insurance. Among the many areas where previously issued regulations limited choice and competition, the EO focused on the following: association health plans (AHPs); short-term, limited-duration insurance (STLDI); and health reimbursement arrangements (HRAs).

With regard to AHPs, Mr. Pate stated that on June 21, 2018, the Department of Labor (DOL) issued a final rule to expand access to affordable health coverage options for America's small businesses and their employees through AHPs. This reform allows small employers—many of whom are facing much higher premiums and fewer coverage options—a greater ability to join together and gain many of the regulatory advantages enjoyed by large employers. Under the rule, AHPs can serve employers in a city, county, state, or a multi-state metropolitan area, or a particular industry nationwide. Working owners of businesses, such as sole proprietors, who meet certain criteria, as well as their families, will be permitted to join such plans. In addition to providing more choice, the new rule can make insurance more affordable for small businesses. Just like plans for large employers, these plans will be customizable to tailor benefit design to small businesses' needs. These plans will also be able to reduce administrative costs, strengthen negotiating power with health care providers, and achieve greater economies of scale.

With regard to STLDI, Mr. Pate stated that on August 3, 2018, the Departments of Health and Human Services (HHS), Labor, and the Treasury issued a final rule to help Americans struggling to afford health coverage find new, more affordable options. The rule allows for the sale and renewal of STLDI plans that cover longer periods than the previous maximum period of less than three months. Such coverage can now cover an initial period of less than 12 months, and, taking into account any extensions, a maximum duration of no longer than 36 months total. This action will help increase choices for Americans faced with escalating premiums and dwindling options in the individual insurance market.

With regard to HRAs, Mr. Pate stated that on October 29, 2018, HHS, Labor, and the Treasury issued a proposed rule that would expand the usability of HRAs, which give working Americans greater control over their healthcare by providing an additional way for employers to finance quality, affordable health insurance. HRAs allow employers to

reimburse their employees for medical expenses in a tax-favored way. Current regulations prohibit employers from using HRAs to reimburse employees for the cost of individual health insurance coverage. Because medical expense reimbursements from HRAs are tax-preferred, HRAs provide the same tax advantage enjoyed by traditional employer-sponsored coverage. The proposal would not alter the tax treatment of traditional employer-sponsored coverage. It would merely create a new tax-preferred option for employers of any size to use when funding employee health coverage. While the employer would fund the cost of individual health insurance coverage, the employee would own the coverage, allowing the employee to keep the coverage even if he or she left the employer and was no longer covered by the HRA.

With regard to 1332 waiver guidance, Mr. Pated stated that on October 22, 2018, CMS and Treasury released new guidance related to section 1332 of the ACA. This action was taken so states can increase choice and competition within their insurance market. The guidance gives states more flexibility to address problems caused by the ACA and to give Americans more options to get health coverage that better meets their needs. Under this new guidance, states will be able to pursue waivers to improve their individual insurance markets, increase affordable coverage options for their residents, and ensure that people with pre-existing conditions are protected. Specifically, the guidance provides information about the requirements that must be met for the approval of these waivers, including the Secretaries' application review procedures, the calculation of pass-through funding, certain analytical requirements, and operational considerations. This new guidance replaces the guidance related to section 1332 of the ACA that was previously published on December 16, 2015 (80 FR 78131).

Mr. Pate further stated that on November 29, 2018, CMS released four waiver concepts for states' use to promote more affordable, flexible health insurance coverage options through State Relief and Empowerment Waivers (SREW). The concepts illustrate ideas that the Administration supports and fit within the framework outlined in section 1332 of the ACA.

The four waiver concepts are: a.) Account-Based Subsidies - Under this waiver concept, a state can direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay for health insurance premiums or other health care expenses. The account could be funded with pass-through funding made available by waiving the Premium Tax Credit (PTC) under section 36B of the Internal Revenue Code (IRC) or the small business health care tax credit under section 45R of the IRC. The account could also allow individuals to aggregate funding from additional sources, including individual and employer contributions. An account-based approach could give beneficiaries more choices and require them to take responsibility for managing their health care spending. This approach could also allow a consumer greater ability to select a plan based on the individual's or their family's needs, including a higher deductible plan with lower premiums;

b.) State-Specific Premium Assistance - States can use the State-Specific Premium Assistance waiver concept to create a new, state-administered subsidy program. A state may design a subsidy structure that meets the unique needs of its population in order to provide more affordable health care options to a wider range of individuals, attract more young and healthy consumers into their market, or to address structural issues that create perverse incentives, such as the subsidy cliff. States may receive federal pass-through funding by waiving the PTC under section 36B of the IRC to help

fund the state subsidy program;

c.) Adjusted Plan Options - under this waiver concept, states would be able to provide financial assistance for different types of health insurance plans, including non-QHPs, potentially increasing consumer choice and making coverage more affordable for individuals. For example, states could choose to expand the availability of catastrophic plans beyond the current eligibility limitations by waiving section 1302(e)(2) of the ACA. Used in conjunction with the Account-based Subsidy waiver concept, states could provide subsidies in the form of contributions to accounts, allowing individuals to use the funds to purchase coverage that is right for them and use any remaining funds in the account to offset out-of-pocket health care expenses; and

d.) Risk Stabilization Strategies - to address risk associated with individuals with high health care costs, this waiver concept gives states more flexibility to implement reinsurance programs or high-risk pools. For example, a state can implement a state operated reinsurance program or high-risk pool by waiving the single risk pool requirement under section 1312(c)(1) of the ACA. Reinsurance programs have lowered premiums for consumers, improved market stability, and increased consumer choice. To date, States have chosen to use a variety of models to operate their state-based reinsurance programs, using flexibility available under section 1332. These models include a claims cost-based model, a conditions-based model, and a hybrid conditions and claims cost-based model. If the state shows an expected reduction in federal spending on PTC, the state can receive federal pass-through funding to help fund the state's high risk pool/reinsurance program.

Mr. Pate closed by urging states interested in applying for section 1332 waivers to reach out to HHS and Treasury as soon as possible – the sooner the better – and to e-mail stateinnovationwaivers@cms.hhs.gov for assistance in formulating and enacting a plan that meets the requirements of Section 1332.

Asm. Cahill asked how the 2018 premium increases compare to 2011, 2012 and 2013 – right after the ACA was put in place. Mr. Pate stated that the premiums from 2014 – when the ACA's main provisions went into effect – up until 2018 increased by over 100%. Asm. Cahill then asked Mr. Pate if he has any opinions on whether there should be some sort of waiver process for ERISA, considering that such a process exists for the ACA in 1332 waivers, and for other laws. Mr. Pate stated that he would defer to the DOL on that question. Asm. Cahill re-phrased the question to ask Mr. Pate if he agreed that there are impediments to states in enacting health reforms because we cannot have waivers under ERISA. Mr. Pate stated that he is not an ERISA expert but for purposes of a 1332 waiver, if a state wants to assess its insured lives to fund the program, the reinsurance program under a 1332 waiver is blind to how a state goes about getting that funding, and that CMS and CCIIO are supportive of state flexibility.

INTRODUCTION OF NCOIL MODEL LAW FRAMEWORK ON DRUG PRICING TRANSPARENCY

Rep. Oliverson – prime sponsor of the NCOIL Model Law on Drug Pricing Transparency - stated that for those that are new to this topic, the introduction of it actually dates back to the NCOIL Spring Meeting earlier this year in Atlanta where then NCOIL Vice President, Vermont Representative Bill Botzow, and current NCOIL Secretary, Asm. Cooley, had introduced laws from their respective states for distribution to the

Committee. Their legislation focused on reporting and notification requirements for prescription drug manufacturers. The idea at the time was for those laws to serve as the starting point of an NCOIL Drug Pricing Transparency Model Law drafting discussion. However, after that meeting, with the departure of Rep. Botzow from the legislature, it took some time to put pen to paper and arrive at a starting point for what a framework of an NCOIL Drug Pricing Transparency Model Law should look like. Rep. Oliverson stated that over the course of the summer, after discussions with Sen. Morrish, he eventually landed upon the drug pricing transparency bill that had passed in Louisiana as what should be used to start this committee's drafting discussion. However, in an effort to follow the NCOIL tradition of bi-partisanship, Rep. Oliverson stated that he looked for another successful drug pricing transparency law from a predominantly Democratic state and accordingly decided to incorporate some language from Connecticut's law into the document that is before the Committee.

Before opening up the topic for discussion, Rep. Oliverson noted that the draft language seeks to shed light on drug prices and manufacturer investment, the flow of manufacturer rebates and other discounts through PBMs, and the impact of drugs on insurance premiums. Rep. Oliverson noted that it is important to do this right which means that we have to look at the entire drug supply chain so we can identify where the cost increases are coming from and why they are occurring. All of the information submitted by manufacturers, PBMs and insurers must be posted publicly by the insurance department. The information submitted will be aggregated and include additional protections against disclosure of confidential or proprietary information, as needed.

Rep. Oliverson stated that Section 4, which primarily applies to the drug manufacturers, requires them to: report wholesale acquisition cost (WAC) information for all of their products on a quarterly basis; report information following a price increase of 50% or more, including the price change, date of the price change, company-wide R&D spending, and history of new drugs that were approved by the FDA and that lost exclusivity over the previous 5 years; and notify the state within 3 days of the launch of a high-priced drug. Section 5 applies to PBMs and requires them to report the annual aggregated amount of rebates, fees and other payments collected from manufacturers; and report the amount of such payments that is passed through to insurers and the amount passed to patients. Section 6 applies to insurers and requires them to: report the top most frequently prescribed drugs; report the increase in net spending on prescription drugs and their contribution to premium increases; and report utilization management requirements for specialty drugs and their contribution to premium decreases.

Asm. Cahill then noted that a representative from the Pharmaceutical and Manufacturers Association of America (PhRMA) had intended to be here for the discussion but had to unexpectedly leave the conference early. A copy of PhRMA's comment letter on the draft framework can be found on the conference app and on the NCOIL website. Ms. Shrader thanked Rep. Oliverson for his leadership on this issue and stated that PCMA agrees that the high cost of drugs is an issue that everyone is dealing with, not just as companies, but as individuals and consumers. Ms. Shrader then noted that a publication from the American Academy of Actuaries (AAA) stated that in 2016, the U.S. spent \$3,337 billion (\$3.337 trillion) dollars, or 17% of the U.S. GDP, on healthcare alone, and of that number \$329 billion was spent on prescription drugs. The publication then discusses the cost-drivers which are the high cost of drugs, increasing utilization, and the changes in drug mix. PCMA looks forward to working with the committee on the

draft framework and noted that the reason PBMs came into existence is because their clients, health plans, wanted an expert in holding down the cost of drugs and that is what PBMs do in the supply chain.

Mr. Keepes stated that the high cost of drugs is one of the most pressing issues facing consumers, health plans, PBMs, and pharmaceutical companies. Of all the issues impacting the healthcare system, this spans the entire spectrum. AHIP has been very active with these issues on the state level and has supported transparency bills in several states. AHIP has been supportive of legislation requiring reporting of general costs of drugs as well as cost increases. AHIP does have some changes it would like to see made to the draft framework but they are meant to be tweaks to the underlying substance and AHIP looks forward to working with the committee. Mr. Keepes also noted that AHIP is pleased that PhRMA has been engaged in this process and looks forward to working with them. Lastly, Mr. Keepes noted that the committee should keep in mind the language contained in the recently adopted NCOIL PBM Model when considering the PBM reporting requirements set forth in Rep. Oliverson and Sen. Morrish's draft framework.

Rep. Matt Lehman (IN) – NCOIL Treasurer – pointed to Section 4(b)(1) which requires drug manufacturers to report an increase in WAC of 50% or greater for a drug with a WAC of \$100 or more for a 30-day supply, and asked how the figure of 50% was decided upon. Rep. Oliverson stated that percentage was chosen simply because it comes from the LA law and that was a fight and negotiation that had already been completed. Accordingly, 50% is simply a starting point for the Model and it is certainly ultimately up to the will of the Committee as to what percentage should be in the Model.

Rep. Lehman thanked Rep. Oliverson and stated that he looks forward to discussing that issue as it is somewhat ironic that there would be riots in the streets if there was a 20% increase to auto insurance premiums, but 40% increases to drugs are not viewed the same by everyone. Rep. Lehman further stated that a lot of the problems that arise from drug pricing stem from what is built into the wholesale cost. Part of it is tort reform because it seems as if every other commercial on TV is providing legal remedies to those who have taken certain drugs. Rep. Lehman would like to know what PhRMA's members spend in tort claims.

Rep. Oliverson thanked Rep. Lehman for his comments and stated that his intent with the Model is not to enact any form of price controls, but to rather promote transparency and get a better understanding of why the prices of drugs are increasing; class action lawsuits and multi-million-dollar settlements may very well be a cause for the increases. Rep. Lehman applauded Rep. Oliverson and Sen. Morrish for bringing this Model forth. Rep. Oliverson stated that he and Sen. Morrish look forward to working with everyone throughout 2019 and that they urge committee members and stakeholders to contact them and NCOIL staff with any other comments or suggestions.

ANY OTHER BUSINESS

Asm. Cahill stated that during Thursday's general session titled: "Examining the Role of ERISA in the State Based System of Insurance Regulation: Can Meaningful State Reforms be Achieved in an ERISA-Dominated Marketplace?" – Prof. Elizabeth McCuskey of the Univ. of Toledo College of Law indicated a number of ways to deal with the preemption issues associated with ERISA, and one of her proposals was having an

ERISA waiver-process for states to utilize.

Asm. Cahill stated that Prof. McCuskey's waiver proposal will be circulated to Committee members and posted on the NCOIL website. Asm. Cahill further stated that he hopes that the Committee can further discuss the waiver concept for purposes of improving and expanding state flexibility and economy at the NCOIL Spring Meeting in Nashville.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES
COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 7, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) State-Federal Relations and International Insurance Issues Committees met jointly at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Friday, December 7, 2018 at 3:30 p.m.

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

Other members of the Committees present were:

Rep. Sam Kito (AK)	Rep. Steve Riggs (KY)
Asm. Ken Cooley (CA)	Rep. Lewis Moore (OK)
Sen. Travis Holdman (IN)	Rep. Tom Oliverson, M.D. (TX)
Rep. Matt Lehman (IN)	

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Paul Utke (MN)
Rep. Martin Carbaugh (IN)	Asm. Kevin Cahill (NY)
Sen. Gary Dahms (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

After a motion was made by Rep. Matt Lehman (IN) – NCOIL Treasurer - and seconded by Asm. Ken Cooley (CA) – NCOIL Secretary - to waive the quorum requirement, the Committee unanimously approved the minutes of its July 12, 2018 meeting in Salt Lake City, UT upon a separate motion made by Rep. Michael Webber (MI) and seconded by Sen. Jason Rapert (AR) – NCOIL President.

DISCUSSION ON CHANGES TO THE 1332 WAIVER PROGRAM – WILL STATE RELIEF AND EMPOWERMENT WAIVERS (SREW) HELP CONSUMERS?

Randy Pate, Director of the Center for Consumer Information and Insurance Oversight (CCIO) and Deputy Administrator for the Centers for Medicare and Medicaid Services (CMS), stated that CMS is committed to promoting healthcare choice and has been very busy over the past year in trying to make headway in that area, with significant progress being made particularly in the area of state flexibility. Mr. Pate stated that the 1332 waivers have been re-branded with a new direction in calling them SREW's. CMS

issued guidance at the end of October that replaced prior guidance that had been in place since Dec. 25, 2015 that CMS believes will open up more possibilities for states. CMS also just last week released 4 SREW concepts in collaboration with Treasury that aim to spur conversations with state policymakers.

Mr. Pate stated that, as a refresher, under §1332 of the ACA, a state can apply for a waiver from certain ACA requirements, allowing a state to implement innovative ways to improve their health insurance market and provide access to quality care. For a waiver to be approved under the statute, it has to meet 4 guardrails which means that for each year of the waiver, the application must compare measures of coverage, comprehensiveness, affordability, and must also take into account the impact on the federal deficit, absent the waiver, the baseline scenario being “absent the waiver.” Waivers can be granted for a period of up to 5 years under the statute. Mr. Pate stated that the new guidance released in October replaces the prior guidance and outlines 4 principles that are going to be important to the Secretaries in evaluating waivers. Those principles are: empowering states to innovate in ways that will strengthen their markets; expanding coverage choices; targeting public resources to those that are most in need, including low-income and high-cost individuals in order to meet unique circumstances in each state; and lowering barriers to innovation in states seeking to reform their health insurance markets.

Mr. Pate stated that states can use both the guidance released in October and the waiver concepts, but emphasized that CMS welcomes additional ideas and wants states to be thinking of their own directions as CMS views the guidance as concepts as conversations-starters. CMS welcomes comments on the guidance and concepts. Mr. Pate stated that many people at CMS have had multiple conversations with states and regulators and heard a lot of feedback on §1332 waivers, the guidance issued, and what the barriers states were seeing and what they would like to see changed. CMS tried to reflect that feedback in the guidance it issued to address those concerns. With regard to the statutory guardrails, CMS heard from states that the prior guidance had interpreted the guardrails as making anything other than a waiver that provided the exact same ACA subsidy structure out of the question. CMS also heard from states that they wanted to seek innovative ways to stabilize their markets and develop more effective approaches to increase choice. CMS further heard from states that the 2015 guidance imposed additional hurdles on states in terms of meeting the guardrails in terms of microanalysis and simulations that were really difficult.

Mr. Pate stated that in the new guidance, CMS sought to loosen some of those restrictions while still maintaining the requirements of the statute. Under the guidance, the focus is on whether the waiver provides access to coverage that is at least as comprehensive and affordable under the waiver when compared to coverage available without the waiver. CMS believes that is going to enable states to provide access to new health insurance coverage options at different price points and benefit levels so long as people retain access to coverage options that are just as comprehensive and affordable as before. So the idea is that states are free to open up new options that may be more affordable and less comprehensive as long as they are preserving access to the same level of affordable and comprehensive coverage as was there prior to the waiver. The guidance surrounding the coverage guardrail specifically continues to consider the number of state residents who are actually receiving coverage. So as long as a comparable number of residents are projected to be covered as would have been covered absent the waiver the coverage guardrail will be met. Mr. Pate stated that CMS

also expanded the definition of what coverage is under the guardrail; the prior definition was minimum essential coverage but the new definition is minimum essential coverage plus the federal definition of health insurance coverage under the Public Health Service Act. That change allows STLDs to count under the coverage definition for §1332 waivers as well as other types of health insurance coverage.

Mr. Pate further stated that CMS now focuses on the aggregate affects of the waiver rather than requiring that the guardrails be met for specific sub-populations, which CMS had heard was a barrier for states in having their waiver approved. While CMS is looking at the aggregate affect of the waiver, applications should address how the waiver will impact those with low incomes or high healthcare costs in alignment with the guardrail analysis. Mr. Pate stated that another issue that CMS heard a lot of feedback from states on related to operational options. For states that are using the healthcare.gov platform, CMS wants to work with them to accommodate backend support to design a new system with a different eligibility and enrollment regime for example, potentially allowing new data sharing functionality and the ability to leverage state designs with private sector operational assistance. That is something that CMS can talk to states about further as they get further into the details.

Mr. Pate stated that surrounding the state legislative requirement in the statute, CMS had heard that the previous interpretation was challenging for many states especially when many state legislatures meet infrequently. States and other stakeholders requested additional information on how the departments would assess their applications based on the statutory requirements and other review criteria. Accordingly, the new guidance clarifies that states may use their existing state legislation or existing state authority if it provides statutory authority to enforce ACA provisions and the state waiver plan combined with a duly enacted state regulation or executive order in order to satisfy the statutory requirement. Under this new approach, states can use different combinations of legislative authority to meet the state law requirement to pursue a waiver. The guidance does not eliminate the requirement for a state to enact a law or encourage state executives to bypass their legislatures by any means; it simply recognizes that state legislation can come in different forms.

Mr. Pate stated that in discussing the review timeline, CMS heard from states that the timelines can create challenges for states to come up with ideas and have their applications approved in time for them to be implemented. Accordingly, under the new guidance CMS is reiterating encouragement to states to reach out to CMS as early as possible in the process to discuss specific ideas and get feedback along the way so the departments and states can enter into a conversation early on which CMS thinks is very important. The amount of time it would take to develop and review a wavier application and to implement a waiver depends heavily on the specific content of that waiver. CMS received positive feedback from most of the states it currently works with on its current approach in the 7 waivers that have been approved and CMS has been able to be responsive to states under the review timelines. Mr. Pate stated that the departments reviewed all 2019 waiver applications well before the 180 day timeline for federal review. Mr. Pate stated that he and his team are happy to work with states to ensure there is a reasonable timeline implemented for a waiver.

Mr. Pate stated that states also asked CMS for more clarity on how it evaluates the waivers it received. Accordingly, the guidance clarifies that the Secretaries will consider favorably waiver applications that advance some or all of the 5 principles: providing

increased access to affordable private market coverage; encouraging sustainable spending growth; fostering state innovation; supporting and empowering those in need; and promoting consumer-driven healthcare. Mr. Pate noted that states had asked for model waiver ideas that would fit within the framework of §1332 and that is exactly what CMS released last week: 4 waiver concepts to start a discussion with state policymakers. Each of the concepts illustrate ideas that the Administration supports and fit within the framework outlined in §1332.

Mr. Pate noted that the first concept is an account-based subsidy. Under that waiver concept a state can direct public subsidies into a defined contribution consumer-directed account that an individual can use to pay for their health insurance premiums or other healthcare expenses. The account can be funded with pass-through funding made available under §1332 by waiving the premium tax credit under section 36b of the Internal Revenue Code, or the small business healthcare tax credit under section 45r of the IRC. The account could also allow individuals to aggregate funding from additional sources including individual and employer contributions. Mr. Pate stated that an account-based approach could give beneficiaries more choices and could also help them to take more responsibility for managing their healthcare costs. The approach could also allow greater consumer ability to select a plan based on the individual's or family's personal needs including a higher deductible plan with lower premiums. Mr. Pate stated that the second concept is called state specific premium assistance. Under that concept, states can create a new state administered subsidy program. A state can design a subsidy structure that meets the unique needs of its population in order to provide more affordable coverage options to a wider range of individuals or they can use it to attract younger and healthier consumers into their market, or to address structural issues that create some perverse incentives such as the subsidy cliff. States may receive federal pass-through funding by waiving premium tax credits to help fund the state subsidy program.

The third concept is called adjusted plan options. Under that concept, states would be able to provide financial assistance to different types of health insurance plans including non-qualified health plans, potentially increasing choice in the market and making coverage more affordable for individuals. For example, states could choose to expand the availability of catastrophic plans beyond the current eligibility rules by waiving section 1302(e)(2) of the ACA. Used in conjunction with the account-based subsidy waiver concept, states can provide subsidies in the form of contributions to accounts, allowing individuals to use these funds to purchase coverage that is right for them and use any remaining funds in the account to pay for their out of pocket healthcare expenses.

Mr. Pate stated that the final concept is called risk stabilization strategies and is really a bundle of concepts to help states address high cost individuals. That concept gives states more flexibility to implement reinsurance programs or high risk pools. For example, a state can implement a state operated reinsurance program or high risk pool by waiving the single risk pool requirement under section 1312(c)(1) of the ACA. Reinsurance programs have lowered premiums for consumers in many states, improved market stability and increased consumer choice. To date, states have chosen to use a variety of models to operate their state based reinsurance programs, using flexibility available under section 1332. Such models include a claims-based cost model; a conditions based model; and a hybrid conditions and claims cost model. If a state can show an expected reduction in federal spending on premium tax credits, the state can receive federal pass-through funding to help fund the state's high risk pool or

reinsurance program. Mr. Pate stated that states are not required to use those concepts; states can use them in pieces in conjunction with others. CMS is committed to working with states on waiver requests. As with all waiver requests, a state must ensure that the waiver plan meets the 4 statutory guardrails relating to comprehensiveness, affordability, coverage, and deficit neutrality.

Mr. Pate then discussed some things that have not changed in light of the new guidance and model waiver concepts. It is important to note that the new flexibilities do not impact the ACA's protections relating to pre-existing conditions which are not waivable. Also, the requirement for states to provide for a meaningful level of public input and comment prior to submitting an application has not changed. Mr. Pate closed by reiterating that CMS is committed to working with states to stabilize their markets and urged states to reach out as early in the process as possible even if states are not sure if they want to pursue certain options.

Sen. Klein asked if it is fair to say that the concepts issued by CMS enable states to "fill in the blanks" and therefore speed up the waiver process. Mr. Pate stated that he would term the concepts more so as discussion papers, but CMS plans to issue more specific templates and checklists, which is something they did for reinsurance waivers that states found helpful. CMS was focused on getting the concepts initially distributed in advance of upcoming legislative sessions and to start discussions with states. Sen. Klein stated that ND Insurance Commissioner, Jon Godfread, was excited about the concepts because they have some ideas that could do more with less and provide opportunities to certain individuals.

Sen. Gary Dahms (MN) asked for an expected timeline for when CMS would receive and approve an application for reinsurance. Mr. Pate stated that under the statute there is a 180 day review period that the federal government has once a waiver has been submitted. However, with reinsurance waivers in particular since CMS has received several of them now, that timeline can be reduced significantly but the earlier a state beings a dialogue with CMS the better.

Rep. Lewis Moore (OK) asked if the checklists and forms mentioned by Mr. Pate are accessible somewhere. Mr. Pate stated that the only checklists issued thus far have been for reinsurance which is available on the CCIO website, but CMS plans to issue similar checklists and templates for the waiver concepts. Rep. Moore asked if under a waiver a state could expand Medicaid or have a catastrophic plan introduced. Mr. Pate stated that the waivers do not specifically address expanding Medicaid as a state would not need a waiver to do that. If a state wanted expand tax credits to an expanded population that is something that a state could look to do under a 1332 waiver. In that circumstance, under the deficit neutrality guardrail, a state would have to do something else in its waiver to trigger the pass-through savings to the federal government that would create the amount of money that a state could use to for example provide subsidies for private coverage for those under 100% of the federal poverty line. To draw a clear line of delineation, 1332 waivers do not speak to Medicaid expansion as that can be done outside the waiver process.

Rep. Moore asked if the waivers were a return of federal dollars that came from the state. Mr. Pate stated that the way the analysis works is that a state's waiver will do something to alter the rules previously mentioned and in order to receive a pass-through those changes will have to trigger a reduction in the premium tax credits or small

business tax credits that would otherwise flow into the state. CMS runs micro-simulations that take all of the assumptions into account and will forecast what the next year's market will look like without the waiver, and then plug in the waiver's triggers for the premium or small business tax credits to examine if it creates a savings for the federal government. That would be the amount of money the state would get to implement its plan.

Rep. Deborah Ferguson (AR) stated that considering insurance rates across the country have stabilized, is it likely that a state would get approved for a reinsurance waiver at this point. Mr. Pate stated that with the reinsurance waivers that have been approved thus far there is a set of parameters that a state comes up with regarding a reinsurance program such as what they want the attachment point to be, the cap, and coinsurance rate. Those issues are examined in addition to what the anticipated premiums and enrollment will be in that state and the issuers come back with the rates and all of that is plugged into an actuarial analysis which states what will happen to premiums if you take into account the reinsurance program's parameters, which can then trigger the passthrough amount that the state would get if the program lowers premiums. Mr. Pate added that under a reinsurance waiver, a state does have to put in some of their own money. Under the reinsurance waiver there are savings to the federal tax credits but for the reinsurance program to apply across the whole market the state has to plug in some money for the unsubsidized portion of the market that is not getting premium tax credits.

Rep. Ferguson stated that Arkansas has looked at reinsurance waivers for the Medicaid population and asked if the reinsurance waivers in states such as Alaska and Minnesota have been for Medicaid. Mr. Pate stated that for AK and MN and for all reinsurance waivers approved, they have all been for the individual health insurance market.

Sen. Dahms stated that MN was the second state to obtain a reinsurance waiver back in 2017 and the original estimate that MN was expected to receive back under the 1332 waiver was approximately \$184 million dollars. In the past 10 days or so MN received notice that the amount would be \$80 million dollars. Accordingly, Sen. Dahms asked what the changes were that led to that disparity. Mr. Pate stated that MN was the third state to obtain a reinsurance waiver so at that time CMS had not done many of them. The way the process operated was that Treasury would run a microsimulation model to figure out how much pass-through the state will get under the waiver. When Treasury sends the letter to the state, it gives a 5 year projection but clearly states that the projections need to be re-examined every year based upon changes in law or changes in the market. The microsimulation is done every year for every state that has a reinsurance waiver. With MN, there had been changes in the market as premiums have decreased and there are many different factors that Treasury looks at in its microsimulations.

Sen. Dahms asked Mr. Pate if he is essentially saying that because the reinsurance program was successful and caused premiums to go down, that resulted in MN being penalized. Mr. Pate stated that he would not characterize it that way as he is not a statistician or an actuary but again noted that Treasury takes into account several different factors when running its simulations, not just whether premiums decreased, but other factors such as what enrollment is going to look like. There is no arbitrary decision made by anyone to decrease the amount of money a state receives.

Sen. Dahms asked if MN submitted another application for another reinsurance program, or to extend the current program, can it assume that the program would be subject to the same disparity from year to year. Mr. Pate stated that the document a state receives with the 5 year projection clearly states that if the assumptions on which the microsimulations were based upon change, which often do depending on marketplace realities, the projections can then change.

Sen. Paul Utke (MN) asked if the MN Commerce Dept's statement that they are not aware of any state's right to appeal any decisions relating to the aforementioned projection figures is accurate. Mr. Pate stated that there will always be phone calls and meetings and conversations with Treasury and a state to make sure the assumptions are correct although it is not a formal appeal process. Also, there are actually 3 points each year at which Treasury calculates the numbers for the pass-through payment amounts, the first being when the initial rates are filed, the second when the final rates come in, and the third when the final enrollment numbers come in. Each projection of the first two points is an estimate and there is always a dialogue with Treasury after those estimates are received to review everything.

The Honorable Jessica Altman, Pennsylvania Insurance Commissioner, stated that the old saying relating to once you know one state's health insurance market, you know one state's health insurance market, is especially true in individual health insurance markets today which are in very different places and have many different problems and therefore may warrant very different solutions. States believe that they are in the best position to identify what those solutions should be – collectively among state insurance regulators and legislators. Cmsr. Altman stated that she believes state flexibility is needed and most state regulators are pleased to see the new flexibility in the form of new guidance and concepts issued from CMS. The new guidance takes a positive step in allowing state insurance regulators to use the full authority that their state laws already grant them. If a state legislature has already chosen to grant the insurance commissioner the authority to fully implement the ACA or otherwise pursue a state waiver, the commissioner can now use that authority without further action from the state legislature which can help with the timing of a waiver application but does not mean that a Governor or insurance commissioner can act on their own as the state would need an Executive Order or duly enacted regulations to define it waiver plan and if state funds are need, the legislature would most likely need to appropriate such funds in addition those appropriated in the original legislation.

Cmsr. Altman stated that the new interpretation of waiver guardrails will also allow for wider availability of short term plans and other alternative coverage types in fulfilling the law's requirements for states that choose to pursue such a waiver. States very much differ on how much they want such plans to be a part of their market and what their approach to them is and will be but any state that chooses to propose a waiver will have to look closely on the effects on the risk pool because coverage is not the only guardrail.

A state's waiver must make available to state residents coverage that is as comprehensive and affordable as ACA plans even if some residents choose a less comprehensive plan. A waiver must also not increase the federal deficit. Cmsr. Altman stated that if the availability of short term or other less comprehensive plans makes coverage more expensive on the exchange due to risk pool effects, the federal gov't's cost for tax credits could potentially increase meaning that the state could have trouble meeting the federal deficit neutrality guardrail. Such a scenario might also not meet the

affordability guardrail either since exchange plans would be more expensive than the without-waiver scenario.

In addition to the 5 principles that Mr. Pate reviewed, the Administration released last week a discussion paper outlining 4 concepts that states could pursue under the new waiver guidance which many states are reviewing. One of the concepts is a reinsurance mechanism which a number of states have already chosen to pursue and are wellversed in. Cmsr. Altman stated that, overall, it is good to have some additional direction in this area and the principles are fairly broad but state insurance regulators would not want to see the Administration use the principles to limit state flexibility and innovation. Waiver proposals should be judged against how they meet the law's requirements and not whether they serve any particular Administration's ideological goals. In particular, sustainable spending growth should not be interpreted more narrowly than it has to date; federal costs under a waiver should be compared to the expected federal costs in the absence of the waiver; anything lower than or equal to the expected without-waiver cost should be allowable. The principle of increased access to affordable private market coverage should not get in the way of a state that wanted to, for instance, develop a Medicare buy-in option or other public option. Such a waiver could certainly fulfill the principles of fostering state innovation, limiting spending growth, and supporting those in need as well.

Cmsr. Altman stated that the revised guidance opens the door a little wider for states to pursue different strategies but it remains to be seen if the additional flexibility is truly useful for states and how many will take advantage of it and what they will do in doing so. A number of states have successfully used waivers under the old guidance to develop reinsurance mechanisms but other types of waivers have not yet come to fruition widely. The Administration acknowledges that the concepts are intended to be the beginning of discussions with states, as they should be since this is a state-specific endeavor. The concepts provide a set of important questions for states to think about in designing and operationalizing waivers but they do not include the detail required to be evaluated as a complete proposal so state insurance regulators look forward to the additional information that Mr. Pate stated is on the way. Cmsr. stated that overall, more flexibility is good but it remains to be seen how states will choose to move forward with that additional flexibility.

The Honorable Gordon Ito, Hawaii Insurance Commissioner and NAIC Vice President, stated that Hawaii was the first state to be granted a 1332 waiver but it was significantly different from the high-risk reinsurance program that many states have created. In 1974, HI passed the Prepaid Healthcare Act which was an employer mandate and therefore HI had a separate system for small and large businesses to purchase insurance on behalf of their employees. HI's waiver was to waive out of the Small Business Health Options Program (SHOP) provisions and not have the middle levels applicable to small businesses that purchase ACA plans. Cmsr. Ito stated that HI is interested in pursuing a second 1332 waiver to create a high-risk reinsurance program. To put things into context, in HI's microsimulations, HI has about 16,000 individuals that effectuated plans through the ACA marketplace, and about 10,000 off the exchange. For those 16,000 individuals, in the microsimulation to effect the 10% reduction in premiums, the state portion would be about \$9.4 million.

DISCUSSION ON FEDERAL INSURANCE OFFICE (FIO) PRIORITIES

The Honorable Tom Considine, NCOIL CEO, stated that it seems to be an interesting at FIO. Steven Dreyer, who had committed to speak at this meeting and whose attendance would have marked the first time a FIO Director spoke at an NCOIL meeting in some time, recently resigned suddenly. Cmsr. Considine stated that the relationship between FIO and NCOIL was never better than it was under Dir. Dreyer's leadership as he had reached out to NCOIL in a way that FIO never had before when it became clear that the U.S. was going to pursue another covered agreement with the UK. NCOIL believes that the UK should not be disadvantaged by not having a covered agreement. Since the UK would be a beneficiary while they are in the EU, they should have those same benefits when not in the EU. Cmsr. Considine stated that does not change the fact that NCOIL does not favor the elimination of collateral but understands the political realities of the need for a substantially similar covered agreement with the UK. If it were to happen that the UK covered agreement departed substantially from the EU covered agreement, then collateral would be one of the issues that would need to be put back on the table. Cmsr. closed by noting that Steve Seitz is once again Acting FIO Director and we had reached out via e-mail, letter and phone to invite him to this meeting but we did not hear back.

DISCUSSION ON OKLAHOMA INSURANCE BUSINESS TRANSFER (IBT) LAW: IS THIS THE BASIS FOR A MODEL?

Luann Petrellis, Managing Director at PricewaterhouseCoopers, LLP (PWC), stated that in many countries worldwide IBT mechanisms are used to transfer legal liability of a contract or a group of contracts to another carrier without the need for policyholder consent. As a restructuring tool, IBT can allow companies to more effectively respond to changing regulatory environments; can allow companies to balance overall capital between different lines of business to bring finality to business or to release excess capital. For example, in Europe, IBTs were a key restructuring tool that was utilized by carriers to respond to the requirements of Solvency II. In order to create a vibrant and healthy market, insurers need to be able to respond to different challenges and in order to do that they need effective tools to restructure so that they can achieve capital, operational, and administrative efficiencies, as well as develop strategies and plans to deal with non-core or discontinued business.

Ms. Petrellis stated that because of the limited availability of effective restructuring tools in the U.S., U.S. companies are somewhat challenged to achieve these objectives. The most frequently used restructuring options in this country are sale and reinsurance or limited portfolio transfers (LPTs) but those options are limited in their scope and effect. A sale can bring finality but many times run-off is embedded with live business and there is no mechanism to segregate the discontinued business from the active business, making a sale unattractive. Similarly, LPTs and reinsurance provide some economic relief but no legal finality because the ultimate liability remains with the original insurer. Also, LPTs and reinsurance may not be attractive because of counterparty credit risk that can be tied to long duration liabilities. Presently, the only way to transfer blocks of business is by way of a policy novation process but that process in the U.S. is inconsistent among the states and very cumbersome, expensive and time consuming. And in most instances, companies will not be able to obtain positive consent from all policyholders, especially for older books of business.

Ms. Petrellis stated that PWC did a recent survey of the global run-off insurance market

and it was estimated that U.S. non-life run-off liabilities are \$335 billion and the life runoff market is estimated to be even larger than that. Companies need tools to be able to manage these liabilities to achieve their objectives as well as to address concerns of regulators. An IBT allows an insurer to transfer some or all of its business underwritten to another insurer. For example, enabling a company to segregate run-off from live business. This can be used within a group or to a third party. The approval process itself is a multi-layered transparent review that includes multiple safeguards to protect policyholders. IBT requires regulatory and judicial review and it is the court order that will implement the novation of the contracts and it will include the attaching reinsurance. One of the key features of the process is that it does bring complete legal finality to the transferring company for the transferred business. Since it came into effect in 2001, the U.K.'s IBT mechanism, that is commonly called the part VII transfer, has become a core restructuring tool for companies look to restructure their operations or utilize capital more efficiently. Presently, the UK part VII transfer is the most frequently utilized legal mechanism to move blocks of insurance business in the UK.

Ms. Petrellis stated that since the part VII transfer was enacted there have been hundreds of successfully completed part VII transfers of life and non-life portfolios, none of which encountered subsequent financial difficulties. Many of the transfers have been to reorganize business within large insurance groups but the process is equally applicable to transfers between third parties and there has been hundreds of billions of dollars in liabilities transferred since the legislation was enacted.

Ms. Petrellis stated that the part VII transfer is part of a broader European landscape that provides for a harmonized and cooperative approach to the supervision of insurance business and the transfer of insurance business between members of the EU. In continental Europe, in addition the aforementioned transfers, there have been about 140 successfully completed transfers. The part VII transfer and its wider equivalents in the EU are the mechanisms most frequently used to move business, especially run-off blocks of business. Unlike most modern jurisdictions, until very recently, the U.S. has not had an IBT mechanism but we are starting to see some states pass IBT legislation. The first state that attempted to pass IBT legislation was Vermont by passing the Legacy Insurance Management Act but that was not a true IBT but rather a regulatory process but it did result in a novation of the business. The first true IBT legislation was enacted in Rhode Island in August 2015 when the Div. of Business Regulation introduced regulation 68 that did provide an IBT mechanism. It allowed the transfer of blocks of commercial P&C run-off business from any insurer into a RI domiciled carrier. In May of this year, Oklahoma passed its IBT law that became effective on Nov. 1. The OK IBT law is currently the most direct reflection of the UK part VII legislation but in both RI and OK, the transfer results in a court-sanctioned novation of policies from one carrier to another carrier without the need for policyholder consent.

Ms. Petrellis stated that the transfer results in complete finality for the transferring company. Because of the non-consensual nature of this process, the process is designed with certain checks and balances that protect the position of policyholders which include: notification to all stakeholders, including policyholders; an independent expert report that evaluates the impact of the transfer on affected policyholders; review and approval from regulators in the transferring and assuming company's state of domicile; a court hearing and an opportunity for stakeholders – including policyholders - to be heard; and judicial review and approval. The court must find that policyholders are not adversely impacted. The process before approval is robust and thorough in

requiring both the regulators from the receiving and the transferring company's to be involved and no process is complete without a court order. Policyholder protection is a key driver in any IBT approval process and it is rightly the driver for the approving regulators and the court. The regulators and the court need to be satisfied that the policyholders will be protected in the hands of the new owner. The regulators will only approve a transfer if they are satisfied that the policyholders will be just as protected, if not better protected, after the transfer. It is also up to the acquiring insurer to show its own solvency pre and post transfer.

Ms. Petrellis stated that a key element of the review is the independent expert report. Every IBT process will include an independent expert report that will focus on security provided to policyholders. The independent expert will be approved by the regulator and will be charged with providing assistance to the regulator and the court to ensure that the transfer is sound. The report itself will consider all affected parties in the transfer and is a very important element in the process to determine whether the transfer is sound and it is what is used in the part VII transfer process. Ms. Petrellis noted that the IBT itself has many different applications and its flexibility is what makes it so useful. It can be used for internal restructuring and many times in the UK and continental Europe it was used for just that. A company can consolidate business from one or more subsidiary, putting it all in one company to achieve regulatory, capital, and administrative efficiency. It can also be used by a company to segregate business - to segregate live from run-off business - or to position a company for a future sale. Because you can segregate live from discontinued business, it's more effective than a sale because it can involve just the portion you want to sell. It can also be used to transfer business between third party entities.

Ms. Petrellis stated that the UK part VII transfer, which serves as the model for the OK IBT law, is a successful business model that has been used throughout the world for decades. In continental Europe, 28 countries have worked together to establish guidelines so that all countries recognize the transfers in every other country. The process varies from country to country but each country recognizes the transfers of the other countries. Ms. Petrellis stated that over time as more states pass IBT legislation it is possible that the U.S. could enact a similar recognition process that works within the U.S. regulatory and legal framework.

Buddy Combs, Oklahoma Deputy Commissioner of IBTs, stated that he served as the legislative liaison for the OK Insurance Dep't as it attempted to get the OK IBT law passed and it is also his job now to implement the law in his current position. Mr. Combs stated that the process surrounding enactment of the OK IBT law started at the 2016 NAIC Fall National Meeting via conversations with people in the industry who mentioned that there are several restructuring options overseas that are very successful and some states have dabbled in the area but have not been successful in getting it off the ground. OK Insurance Cmsr. John Doak and others were very intrigued by the IBT concept and therefore in 2017, SB 606 was introduced. SB 606 was very similar to the RI IBT law where there is a commutation plan filed along with the IBT and limited to only P&C commercial business and run-off business. SB 606 was met with strong opposition, mainly due to the commutation provisions, the idea of transferring business and then severing the contractual relationships and buy-off claimants or policyholders. The RAA, AIA, NAMIC and almost every trade association opposed the bill very strongly and a decision was made to go back to the drawing board. Accordingly, an interim study was conducted in the Summer of 2017 to study the issue more.

Mr. Combs stated that a lot of lessons were learned from introducing SB 606, the main one being that the RI IBT law was not necessarily the model for other states to use. Some of that has changed since RI passed a new law this year that pulls back some of the problematic elements of their IBT law, specifically, there was an interpretation that the commutation portion of their law was required and they have since clarified that it is not necessarily required although it is still an optional part of their legislation. Mr. Combs stated that he and others in OK learned that the UK part VII transfer is the model to look at. Policyholder protection is essential and SB 606 did not have enough procedural safeguards and due process protections for policyholders. After taking time to step back and analyze, it was clear that it needed to be fixed. Also, legal finality was a must because the way SB 606 was drafted, it was a commissioner-only review in that only the cmsr. would receive an IBT application and review and sign-off on it. There was a worry that the legal finality for that was not high enough and therefore courts needed to be involved to make sure there is a court order that novates the policies.

Accordingly, during the 2018 OK legislative session, a revised version of SB 606 was introduced – SB 1101 – which passed that was modeled much more after UK part VII transfer. Mr. Combs noted that they are currently in the early stages of the first IBT transaction at the OK insurance dep't and insurance cmsr. has selected the independent expert for the first transaction. Everyone is confident in the expert's qualifications and will be review not only the actuarial and financial information, but how the new company will be able to handle claims and administer the policies, and opine on whether there is a material adverse impact on policyholders after the transfer. The OK IBT Law allows for all lines of business to be transferred while the RI IBT law is only commercial P&C. The OK IBT law is also not limited to run-off business while the RI IBT law only allows transfer of policies that have no new premiums within the last 60 months. The OK IBT law also requires insurance commissioner and court approval, and there is no commutation provisions.

Mr. Combs stated that the OK IBT law allows for the transfer and novation of the policies. A novation is a legal term for exchanging one party to a contract with another party. Under the OK IBT law, the assuming insurer must be domiciled in OK and the hope is that such a provision brings business to the state. Also, in addition to the OK insurance cmsr. signing off on the IBT, the chief insurance regulator of the domiciliary state of the transferring company has to either approve or not object to it in a letter. Lastly, after that review, the insurance cmsr. then permits the parties to go to court and obtain a court order, representing the legal finality that those involved were looking for.

Mr. Combs stated that policyholder protection is the most important thing to consider when discussing the OK IBT law because novation is very serious since you are switching parties to a contract, against the policyholder's consent in some instances. Therefore it is important to ensure that policyholders have their day in court and can appear to explain why they object to the novation. In the OK IBT law, when the commissioner signs off on transfer to go to court, that triggers a hearing date to be set which triggers a 60 day comment period. That comment period occurs after all policyholders are notified in writing. Also, the guaranty funds in any state the companies have ever done business in are notified, as are reinsurers, claimants, and the insurance regulators in the states where the companies have ever been licensed. Any policyholder or interested party has the ability to not only object in writing but to appear in court and explain why. The other policyholder protections in place include the two step approval process involving the insurance regulators and the court; and the role of the independent

expert, who also have a duty to the court to advise as to whether it is a good transaction or not.

Mr. Combs stated that those involved with the OK IBT law believe that it is not only good for OK, but also good for the industry. To make an analogy, OK can serve as a regulatory sandbox for IBTs, and while the RI IBT law is currently in place, those involved with the OK IBT law are very excited and believe that they can be the first state to get a full-fledged deal done.

Adam Kerns, Vice President – State Relations of the Reinsurance Assoc. of America (RAA), stated that RAA believes adoption of a Model IBT Law using the OK IBT law as the basis is premature given that only a few states have adopted laws like the OK IBT law or a similar law that is called a domestic stock insured division law, and also because it is RAA's understanding that there have not been any deals completed under any such laws so, at least in the U.S., there has not been an opportunity to examine any deals. There are also many unanswered procedural questions as to how an IBT would occur. The mechanism of transferring assets and obligations is untested and requires more debate and discussion before moving towards an IBT model law. One question is what happens if the new entity fails? If the new entity fails, the guaranty fund in the solvent insurer's state would be held responsible for the resulting obligations of the new entity if that new entity didn't have sufficient assets to cover its obligations and its liabilities. It is also not clear which state law would provide the best framework for development of an IBT law as they all have slightly different variations.

Mr. Kerns stated that another issue is that the IBT laws are potentially suspect as violative of U.S. constitutional protections against the alteration of contracts. The fundamental terms of the insurance contract are changed along with the original promise to the consumer and other third parties such as reinsurers; no consumer or reinsurer consent is required under any of these laws. Certain state laws specifically dealing with contracts would not apply even though the decision is being made by another state. Mr. Kerns stated that the NAIC is just starting to discuss IBTs and during the most recent discussion, CA Insurance Cmsr. Dave Jones questioned the constitutionality of IBT laws, based on a legal opinion given to him from the general counsel of the CA insurance dep't. Mr. Kerns noted that said opinion has not yet been publicly released.

The RAA supports state-based regulation and IBT laws bring that concept into question as a single state would make decisions that would affect consumers in other states, thereby creating similarities to a federal regulator. The consumers and the reinsurers in the other states would have no mechanism to challenge the divisions and are essentially forced to accept the decision that is made by another state. Overall, given the many unanswered questions, Mr. Kerns stated that RAA urges NCOIL to continue the dialogue on IBTs before moving towards an IBT model law as this is the first time it has been on a meeting agenda, and since other states are likely to introduce IBT bills in the near future.

Sen. Klein asked Mr. Kerns what the biggest concern was during negotiations surrounding the OK IBT law. Mr. Kerns stated that RAA's position on IBTs has evolved, mainly due to political realities, both internally with members who want to use IBTs as a business opportunity, and externally. RAA became more comfortable with the OK IBT bill towards the end of the process and RAA does not necessarily oppose it. Rather, RAA believes that more discussion is warranted before moving towards development of an IBT model law.

BALANCE BILLING: IS A FEDERAL SOLUTION IN SIGHT AND IS IT RIGHT?

Erin Trish, PhD., Assoc. Dir. of Health Policy at the USC Schaeffer Center for Health Policy and Economics, stated that in a standard, functioning healthcare market, healthcare providers are negotiating with private health insurers over the terms of essentially constructing contracted rates and forming provider networks. What that means is that those providers are willing to accept lower than their billed charges as payment in full in exchange for being included in those health insurer's networks. Providers do so because they ultimately believe that it will drive a bigger volume of patients to those providers because insurers are able to use their benefit design to incentivize and steer patients to in-network physicians. However, the insurers contract separately with healthcare facilities such as hospitals or emergency rooms so there is no guarantee that the facilities are going to be in the same insurer's networks as the physicians that work in those facilities. That means that the patient can be caught in the scenario where, with an elective in-patient procedure, the patient dutifully sought out an insurer that the hospital in which the procedure is going to occur is in their insurer's network, that the primary surgeon is in the network, but they largely have no control over the ancillary physicians that might see them throughout the course of that operation such as the anesthesiologist, pathologist, radiologist, or emergency medicine physician. The patient isn't choosing or shopping for those types of physicians and sometimes they can be out-of-network (OON).

Dr. Trish stated that in such a scenario, the patient can be liable, so for example, the anesthesiologist can send the patient a bill for their full billed charges since there is no contracted rate in such a scenario. The health plan may pay a portion of that bill if there is an OON benefit but ultimately, there typically is a big gap between the provider's full billed charges and what, if anything, the plan will pay. That gap, or balance, is something that the provider can send directly to the patient and in instances where it results from the patient being treated by an ancillary, OON provider that the patient did not choose and was unaware of, it is called a surprise balance bill (SBB). Dr. Trish stated that in the healthcare setting we have today, SBB's are common. Depending on the type of healthcare episode being discussed – an emergency setting or in-patient admission, either electively or through the ED – it ranges from a 1 in 5 to 1 in 10 chance that the patient will be treated by an OON physician and receive a SBB.

Dr. Trish stated that there has been a lot of national attention surrounding SBBs since they can be potentially financially ruinous for those that receive them, ultimately because there is no cap on what OON providers can bill or charge the patients. This represents a market failure because in standard, well-functioning healthcare markets, providers face a trade-off of being willing to accept a contracted rate less than billed charges in exchange for a larger volume of patients, but for some types of ancillary providers that the patient has no role in choosing, they have no incentive to be in-network since what drives the volume is the main providers such as surgeons and hospitals being in-network. Therefore, since traditional contracting dynamics are not at play, this represents a market failure since the ancillary physicians have an incentive to stay OON. Such a market failure cries out for a policy intervention.

Dr. Trish stated that a comprehensive policy solution for surprise medical bills requires a multi-faceted approach to truly protect patients across the board. First, it is important to take the patient out of the middle, which can be done by limiting patient cost-sharing to the amount they would owe to an in-network provider and prohibiting OON providers

from balance billing patients. However, that leaves a discussion point regarding what the provider can charge the insurer who is now on the hook since the patient is out of the middle. If there is no guidance on an appropriate payment rate a scenario is created where providers have a huge amount of market power where they can essentially bill the insurer whatever they want and the insurer must pay that amount, thereby ultimately raising healthcare costs for everyone involved, including consumers. Therefore, a policy solution must involve setting a payment standard regarding what insurers owe providers in these situations.

Dr. Trish noted that many states have taken action to protect consumers that include the aforementioned policy measures, especially in recent years, but current laws do not apply to the self-insured market due to ERISA preemption which has put pressure on federal policymakers to craft a broad solution. This Fall, there were two proposals on balance billing introduced, one being a bi-partisan discussion draft titled the "Protecting Patients from Surprise Medical Bills Act" and the second titled the "No More Surprise Medical Bills Act of 2018." Both proposals take the patient out of the middle by prohibiting balance billing and limiting patient cost-sharing to in-network rates for OON care and OON care delivered at an in-network facility. That applies to all OON emergency care, both the physician side and the facility side, as well as to all OON care delivered at in-network facilities.

Dr. Trish noted, however, that the proposals differ in their approach to determining the OON provider payment rate. The bi-partisan draft follows an approach similar to what has been enacted in CA and CT which essentially calls on the policymakers or regulators to determine what are reasonable or fair payments. The bi-partisan draft gives states or localities the authority to determine at the local market level what the appropriate payment rate is that an insurer must be required to pay a provider in these types of scenarios. But if a state or locality does not come up with a payment methodology, then it defaults to the federal schedule which is currently the greater of the median in-network contracted rate, or 125% of the average allowed amount. It is not clear why both of those figures are included because the latter will essentially always be higher than the former and that is a big concern because it begs the question of why a provider would go in-network if they know they are guaranteed 125% of the average allowed amount.

Dr. Trish stated that the alternative approach in the other proposal sets up binding arbitration process to determine appropriate payment rates. The goal is to have the parties settle beforehand as to what an appropriate amount of payment should be and if they cannot agree, they go to baseball style arbitration which means that each party submits an offer and the arbiter must choose one or the other. Dr. Trish stated that in some ways it allows for more flexibility and more understanding of fair rates in particular situations but ultimately it is more complex even though the goal is that, as the arbiter's decisions are made public, both sides will come to learn what amount the arbiter will choose and they will settle before entering arbitration. Dr. Trish stated that such a system can be complex and administratively costly and the arbiter must still be provided guidance as to what to consider in making a decision. The federal proposal instructs the arbiter to consider Medicare and negotiated network rates (but not charges) when making their determination. The proposal also permits states to establish own arbitration process or elect a defined payment standard (capped at 125% Medicare) instead.

Dr. Trish believes that this is an issue where many can coalesce around taking the

patient out of the middle. Determining the rate at which the providers should be paid is the challenging part which is where the two federal proposals differ and is where it will be difficult to see the proposals advance. Arbitration arguably provides more flexibility but determining a payment rate, particularly one that is tied to the Medicare rate, provides more certainty and is attractive to insurers who have actuaries who are setting premiums. Dr. Trish also noted an alternative policy approach is to require the hospital to contract with insurers for all ancillary physician services and, in turn, pay physicians as that would be more market-oriented, but it is a considerable change from the status quo. That policy may be attractive from a state perspective because since the providers are being regulated rather than the insurers, the self-insured market might be able to be regulated. Dr. Trish closed by stating that in large part the two federal proposals are positive developments and would provide strong consumer protections. Some small tweaks need to be made but the big issue is going to be the determination of appropriate provider payment rates.

Additionally, in terms of federal intervention, Dr. Trish stated that federal law is needed to protect the self-insured under current common billing policies. This is also an example of a targeted market-correction effort from the federal level and is not representative of a federal takeover of insurance regulation. There is precedent for Congress to step into insurance regulation when it sees the need and state flexibility is likely with any federal proposals on these issues.

Rep. Tom Oliverson, M.D. (TX) stated that he agreed with most of Dr. Trish's statements but the vast majority of hospital-based physicians in America would prefer to be in-network rather than OON. There are reasons besides having a larger book of business as to why a hospital-based physician would want to be in the same network as the hospital and the surgeon, most notably the fact that you don't want to be the only person in that healthcare transaction who is OON. There is tremendous pressure that is put on hospital-based physicians to be in-network and rightly so. Insurers also exploit that by trying to entice such physicians to take a lower reimbursement to be in-network by suddenly terminating a contract and then calling the CEO or chief-of-staff and stating that their anesthesia is OON and you may want to think about replacing them or convincing them to take their best offer. Hospital-based physicians would prefer to be in-network primarily center around prompt-pay issues and if someone has the ability to get paid within 30 days as opposed to going through a difficult process of billing the insurer and getting paid 15% of what they would get paid as an in-network physician, and then bill the patient for the remainder, they would choose the former.

Rep. Oliverson stated that these issues arise primarily because of gaps in coverage and inadequate networks. It is no surprise that the majority of inadequate network issues, at least in Texas, relate to hospital-based physicians. Rep. Oliverson stated that is not necessarily or exclusively the provider's fault. There is definitely financial incentives for keeping hospital-based providers out-of-networks if you can dump that cost onto the backs of the patients and then let them fight with providers. The solution is to get the patient out of the middle and it is unfortunate that putting the patient in the cross-hairs as become somewhat of a business practice.

Rep. Oliverson further stated that the issue with trying to lump everyone together under a standard payment and then deal only with the hospital and let them figure it out is that the job of the physician is to speak for the interest of the patient and when there are dollars and cents attached to tests and procedures and things that get ordered on the

patient, if the doctor and the hospital's incentives are in alignment, who speaks for the best interest of the patient? It is conceivable that a patient may get an MRI when a chest x-ray would suffice if that doctor is in danger of not meeting his quota from the hospital in terms of making his bonus payment for that quarter. Dr. Trish noted that there are a lot of issues surrounding state corporate practice of medicine laws that create issues for certain type of payment structures.

Rep. Ferguson asked if any states have passed a law that deals with balance billing arbitration. Dr. Trish stated that NY, NJ, and IL have but it is her understanding that it has not been used yet in IL. Rep. Ferguson then asked whether those states use the innetwork rate or a lower rate. Dr. Trish stated that in NY does not make its decisions public but the recently passed NJ law requires the decisions to be made public so there will be an opportunity to examine the specific numbers in the decisions.

Debra Judy, Policy Director at the Colorado Consumer Health Initiative (CCHI), stated that CCHI recently launched a consumer assistance program to help individuals navigate their claims and billing issues one of the issues CCHI hears from consumers about the most relates to surprise balance bills. Ms. Judy stated that CO has a hold harmless provision in current law relating to such bills but it has been determined that such a law alone does not do enough for consumers. After more than 5 years in trying to get balance billing legislation passed, it is everyone's hope that 2019 will be the year that something is enacted that will help consumers. Ms. Judy noted the results from a Kaiser Family Foundation poll in 2018 which stated that almost 70% of respondents stated that they were concerned about being able to pay for an unexpected medical bill, which ranked above the polled concerns of paying for a mortgage, insurance premiums, and prescription drugs. The poll also stated that almost 40% of respondents stated that they had received an unexpected medical bill in the past 12 months, 10% of which said the bill was from an OON provider.

Ms. Judy further stated that several studies have shown that almost 20% of emergency room visits have resulted involved surprise bills. Additionally, a Kaiser study focused on large employer health plans noted that about 18% of hospital stays included an OON claim. A recent study involving ambulance transports found that ambulances were OON about 50% of the time. Ms. Judy agreed that the main goal is to get the patient out of the middle because a 2016 survey on medical debt stated that among consumers with OON bills that they could not afford, almost 70% did not know that the provider was OON at the time of service which relates to issues relating to notice. Moreover, the average balance bill in that study was over \$622 but nearly half of Americans do not have the means to pay an unexpected \$400 charge without incurring debt.

Ms. Judy stated that from a consumer perspective, they do not want to get balance billed from providers when they had no choice and they want to be the ping pong ball between the provider and the carrier when trying to resolve the dispute. At the same time, consumers want their coverage to be affordable and as a consumer advocacy organization, CCHI wants to ensure that carriers are paying fair and reasonable rates but not exorbitant amounts as one example in CO has shown that there was a payment of almost 1,200% of Medicare. The NJ Policy Perspective conducted an analysis of the impact of involuntary OON billing in NJ and found that as a result of the billing practice, NJ citizens pay higher premiums to the tune of about \$957 million statewide.

Ms. Judy stated that CCHI believes that it is vitally important that consumers are held

harmless by the carriers and that the providers are prohibited from balance billing. It is important to have both of those protections in place because in CO it has become clear that it does not work to just have one. Such protections also need to apply to both emergency room services and in-network facilities. CCHI has recognized that there are some situations where consumers intentionally go OON and CCHI is deliberating on how to craft legislation to respect that choice. Ms. Judy also stated that notice protections are particularly important in states where only partial balance billing protections exist. Past legislative attempts in CO have all required, at a minimum, notice by carriers, facilities and providers that there are existing consumer protections in CO already. It is also important for each of those entities to coordinate because it is important that the consumer receive consistent information. CCHI also supports transparency and notice about a provider's OON status and possible charges in planned, non-emergency situations, which is particularly helpful to those who have self-funded plans or if a state is unable to adopt any other protections. To be clear, however, notice alone is not enough to solve the balance billing problem.

With regard to the benchmark rate which providers should be paid at, Ms. Judy stated that is the biggest stumbling block and suggestions such as a multiple of Medicare; a percentile of billed charges; the average in-network rate; a usual and customary rate; a reasonable rate; or some combination. Ms. Judy stated that CCHI is opposed to billed charges as being the rate and Medicare makes more sense as a starting point for a transparent reference point, although CCHI is open to looking at other suggestions such as using data on in-network rates and allowed amounts from the CO APCD. With regard to the federal proposals discussed by Dr. Trish, Ms. Judy stated that CCHI sees value in them since they regulate self-funded plans since about 1/3 of covered lives in CO are in self-funded plans and CCHI has been unsuccessful in crafting legislation to regulate self-funded plans. Additionally, the federal proposals take the patient out of the middle, apply to emergency settings, and address the in-network OON provider situation. Ms. Judy stated that she prefers the bi-partisan proposal since it limits the cost-sharing and has a prohibition on balance billing. Ms. Judy is more concerned about the other proposal since it has an opt-out provision if notice is provided at least 24 hours before the procedure as that is problematic for a consumer who has planned for a procedure well in-advance only to be informed of that information the day prior to the procedure.

Ms. Judy stated that CCHI prefers having a benchmark rate amount as opposed to arbitration because the arbitration system could be costly administratively and for consumers through higher premiums. Ms. Judy noted that some of the conversations on the state level when discussing arbitration dealt with what type of fiscal note that would require depending on how it is set up.

Ms. Judy closed by stating that some other issues that have been discussed in CO relate to who will enforce the requirements at the end of the day; the insurance dep't; the medical service board; or another agency. Additionally, what should happen if a consumer erroneously pays a balance bill; should there be an obligation of provider repayment? Lastly, with regard to ambulances, they are almost never in-network and that issued needs to be resolved to protect consumers.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE AND FINANCIAL PLANNING COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 6, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Thursday, December 6, 2018 at 10:15 a.m.

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

Other members of the Committees present were:

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Joseph Fischer (KY)
Rep. Steve Riggs (KY)
Rep. Edmond Jordan (LA)

Sen. Dan "Blade" Morrish (LA)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asm. Andrew Garbarino (NY)
Asw. Pamela Hunter (NY)

Other legislators present were:

Rep. Sam Kito (AK)
Rep. Larry Liston (CO)
Sen. Gary Dahms (MN)
Sen. Paul Utke (MN)
Sen. Paul Wieland (MO)

Asm. Kevin Cahill (NY)
Rep. Marcus McEntire (OK)
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

After a motion was made by Sen. Jerry Klein (ND) and seconded by Asm. Andrew Garbarino (NY) to waive the quorum requirement, the Committee unanimously approved the minutes of its July 12, 2018 meeting in Salt Lake City, UT upon a motion made by Rep. George Keiser (ND) and seconded by Rep. Joseph Fischer (KY).

EXAMINING PRESIDENT TRUMP'S EXECUTIVE ORDER ON RETIREMENT PLANNING

Michael Kreps, Esq., of Groom Law Group, stated that President Trump signed an Executive Order (EO) in September of this year on retirement security. The September EO was actually President Trump's second on retirement security, but the first to actually propose a path forward on affirmative new policy regulations. The September EO actually does not implement anything but rather calls on certain federal agencies to perform certain actions. The September EO contained three key issues that President

Trump wanted to focus on, the first being to encourage retirement savings, particularly through employer provided plans and small businesses by liberalizing the rules related to how employers can pool their resources and participate in a single plan.

The September EO also seeks to streamline some of the federally required disclosure and notice requirements and consider moving to an electronic based delivery system. Finally, the September EO directs the Treasury Department to look at retirement accounts and the rules related to required minimum distributions. Those rules essentially state that at 70.5 years of age, you must start taking money out of your retirement account, and the rules have not been updated in a long time. Many people are still working at age 70.5 and there is a desire to potentially change the age threshold account in order to let the money stay in a tax-favored retirement account longer. Mr. Kreps stated that the Department of Labor (DOL) and Treasury have not moved forward yet with any concrete actions relating to either the disclosure and notice requirements and the RMDs although they are expected to do so at some point in 2019.

However, the Administration has moved forward with a proposed regulation on multiple employer plans (MEPs). The concept of MEPs has been around for a long time and in Oklahoma and this part of the country there are a lot of cooperative plans that essentially have an association that runs an employee benefit plan – whether it's a traditional pension or 401k – and members participate in that plan by virtue of being part of the association. In many cases, it was found that such plans allowed small businesses to provide a benefit that they otherwise would not have been able to provide, both in terms of the level of sophistication needed to run the benefit, particularly with respect to traditional pensions, and in terms of time and energy. It's difficult for owners of a shoe shop to spend time monitoring and overseeing a retirement plan.

Accordingly, the Administration proposed a regulation that is intended to ease up on some of the DOL's prior rulings with respect to MEPs by allowing more people to sponsor and participate in MEPs with the goal of achieving economies of scale, pooling assets, and obtaining efficiencies. The regulation was proposed by DOL (83 Fed. Reg. 53534) a couple of months ago and the comment period closes on December 24. Mr. Kreps stated that in general, the DOL has taken a very restrictive view of who can participate in MEPs, and that was not because of concerns over retirement policy but rather to some concerns on the health side. The Employee Retirement and Income Security Act (ERISA) has broad preemption provisions and in the past there had been arrangements that had been started in states to provide health insurance through Multiple Employer Welfare Arrangements (MEWAs) that had taken advantage of ERISA's preemption provisions to preempt many state health insurance protections and when the premiums collected were not sufficient to pay benefits, the plan essentially disappeared leaving people in a bad position.

Regulatory steps were then taken to prevent that from happening again including the DOL tightening its rules to state that MEPs need to be fairly limited. The Administration, on the retirement side of things, has chosen to do something different and loosen those rules, recognizing that the health plan concerns are not necessarily intended for retirement plans. The Administration has essentially stated that more entities that are legitimate associations can sponsor MEPs. Rules are also sought to be liberalized to allow professional employment organizations (PEOs) to sponsor MEPs. Many PEOs currently sponsor such plans but they never had a set standard.

Mr. Kreps stated that while the proposed rules are a positive development, they do not go very far in the grand scheme of things. There is still a lot more that can be done to liberalize the system and allow more small businesses to provide retirement plans to their employees. The DOL could always expand the rules when it finalizes its proposal after receiving comments, but more importantly, Congress is examining these issues and legislation is expected.

Bruce Ferguson of the American Council of Life Insurers (ACLI) stated that retirement security is an issue that has been brewing for many years and the good news is that we are on the brink of potentially historic legislation passing at a time when it is needed the most. The good news is that Americans are living longer and healthier lives, but the bad news is that a significant percentage of Americans are woefully under-saved for their retirement years which could last up to 30 or more years. It is very important that national policy is now catching up to these issues.

Mr. Ferguson stated that the September EO Mr. Kreps discussed was very important because it sent the right message at the right time – that the Administration was serious about retirement security - but through regulations the Administration can only go so far. Mr. Ferguson stated that the Retirement Enhancement Savings Act (RESA) is a legislative proposal that has been under consideration and development for some time but now enjoys bi-partisan and bi-cameral support. The Act could very well pass the lame duck session of Congress through different vehicles such as a tax-extension piece of legislation or a year-end funding bill. Mr. Ferguson encouraged the legislators present to contact their Congressional delegations to encourage them to adopt RESA.

Mr. Ferguson stated that MEPs would be a key and essential part of RESA. Other key attributes of RESA relate to annuities – the only type of private sector product that can guarantee a lifetime income stream. If RESA were to be signed into law, it would signal to the American population that is trying to save for retirement that they now have options at the federal level for taking advantage of the economies of scale of MEPs and other enhancements regarding auto-enrolling in retirement plans.

Mr. Ferguson also thanked NCOIL for its leadership relating to enhancing the standard of care for annuities through adopting a Resolution opposing the DOL's Fiduciary Rule – sponsored by Sen. Jason Rapert (AR) – NCOIL President. The Fiduciary Rule was the product of the Obama Administration and it sought to impose a Fiduciary standard on all financial sales professionals. Mr. Ferguson stated that even though the Rule had only been partially implemented, we saw the dramatic effect it had on the market. The losers under that rule were the low to moderate income savers that would be deprived of access to advice and to products. The movement away from commission-based sales to fee-based sales would deprive a significant segment of the population of advice and products at a time when the needed it.

Mr. Ferguson stated that there is a movement under way at the Securities and Exchange Commission (SEC) and the National Association of Insurance Commissioners (NAIC) to right-size and enhance the "standard of care" to add additional key consumer protections but in a very responsible way. Mr. Ferguson stated that such action can be done by changes to existing state laws and regulations that deal with annuity suitability requirements. Mr. Ferguson stated that the legislators present should expect to see such legislation introduced in their states soon.

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, stated that reserves are what life insurance companies put aside to satisfy their future policyholder obligations. Reserves are based on a projection of what the claims and benefits would be. Projections are based on assumptions about mortality, longevity, interest rates, and equity performance. Up until now, the reserve calculation was very formulaic, highly prescribed, static, and interest rates would be locked in over the life of the policy. PBR brings us to a more guided framework which takes into account the unique risks and features of products, even products that don't exist in the marketplace today.

Ms. Kuklinski stated that PBR is important because the older calculations would often be overly conservative which would have an impact on consumers and lead to companies looking to reduce that burden by putting their business into a captive insurance company which reduced transparency and created an unlevel playing field. Ms. Kuklinski stated that there were issues with formulaic reserves being too low but that is countered by practices such as cashflow testing and asset adequacy analysis that actuaries must conduct and sign off on every year to make sure reserves are adequate. PBR “right sizes” reserves by accounting for moderately adverse conditions, product features, and company data.

Ms. Kuklinski stated that PBR for life products is based on the NAIC Valuation Manual 20 (VM 20); VM 21 deals with variable annuities; and VM 31 deals with PBR Actuarial Report Requirements for Businesses Subject to a PBR Valuation. The VM is adopted state by state and there can be some state specific variations. New York's adoption of the VM is still pending (note: On Dec. 7, 2018, NY Governor Andrew Cuomo signed into law PBR enabling legislation. The NY DFS promptly responded with an emergency regulation to begin the implementation of PBR to become effective on January 1, 2020 - <https://www.dfs.ny.gov/about/press/pr1812101.htm>). Life insurance VM 20 implementation is already live and in effect, so companies had the first opportunity to introduce it in 2017 with new issues in 2018 and 2019 – there is a three-year implementation period. VM 20 applies to new issues so we will see the impact of it slowly as each year of new issues comes into play and is reserved for under VM 20. Ms. Kuklinski stated that a very limited number of companies implemented VM 20 in 2017, mostly with term products. More companies are starting to bring it in 2018. In terms of implementing PBR and introducing products that incorporate the latest mortality tables, it is a multi-year process. Companies have also made a significant investment in modeling. The VM 20 reserve includes a net-premium reserve, a deterministic single-scenario reserve, and perhaps the most onerous is the stochastic reserve where benefits are projected out over thousands of interest rate and equity scenarios to understand the different dynamics.

Assumption setting is also a key factor because PBR looks at a company's own data for their products and statistical credibility measures and allows them blending with industry experience if needed. Ms. Kuklinski stated that financial reporting under PBR has to do with the analysis and attribution of those reserves. Ms. Kuklinski further stated that in addition to VM guidance, there has also been a significant effort by the industry to comply with PBR such as the American Academy of Actuaries (AAA) implementing the actuarial standards of practice (ASOPs) which set out the standards of professionalism

for the qualified actuary that signs off on the reserves. The AAA also promulgates Practice Notes.

Ms. Kuklinski stated that she sees communication with the state regulator as a very positive benefit of PBR because the disclosure and documentation requirements starts a dialogue. At least 80% of the industry has had at least one or two discussions with their state regulator and that will probably increase going forward. Ms. Kuklinski further stated that under the prior standards – actuarial guidelines 38 and 48 – reserves were well in excess of the economic reserve, what you would hold on a fair value basis. PBR has decreased what we're seeing as the redundant level of reserves that were compelling companies to form captives. Roughly 1/3 of the companies are seeing that reserves are "right-sized", another 1/3 are seeing that reserves are perhaps in excess of the economic reserve but not to the level where they have to seek alternatives, and the remainder are seeing redundancy and that perhaps reserve financing would be pursued.

Ms. Kuklinski stated that VM 21 reform is going to have a very large impact as variable annuity assets for the industry are in the trillions and the reserves associated with the guarantees can be substantial. When the variable annuity framework is implemented – it has not been passed yet – it will impact both new and in force business. Variable annuities were the first foray into PBR with the actuarial guidelines 43 standard and the reserve that was introduced over 10 years ago and the industry recognized some flaws in that it allowed for diversity in company practice and an un-level playing field. The reserve framework was complicated and there is a standard scenario that is meant to be a flood but ended up dominating a lot of the time which had impacts on company's hedging programs and caused some counter-intuitive movements.

Ms. Kuklinski stated that she was part of an industry effort that worked on two quantitative impact studies looking at different possibilities to change the reserve framework and what has been proposed is still being drafted but the industry seems to be comfortable with it as the standard scenario truly exists to catch outliers and company's that have very different properties and assumptions. Having industry policyholder behavior assumptions will need to be refreshed and having economic assumptions that are consistent with VM 20 for life insurance. Ms. Kuklinski stated that VM 31- the actuarial report – has been evolving over time. Each year, it is updated to standardize the format, eliminate redundancies and clarify certain issues.

With regard to next steps, Ms. Kuklinski stated that almost every company is looking at different ways to accelerate underwriting to use big data and public information to take the underwriting process, which is very onerous today, and provide consumers with their policies faster. The problem is that there are not mortality tables which reflect that type of underwriting, so the industry is looking to come up with guidance and find what is appropriate and that is something where as we see experience emerge and become credible, it will be used over time. State-specific guidance from states such as New York and how that will impact products will also need to be examined. Ms. Kuklinski stated that fixed indexed annuities have experienced a lot of growth and those reserve standards will need to be re-examined, probably in 2021. Ms. Kuklinski closed by stating that the industry has welcomed the changes she discussed and appreciates the opportunity to have a dialogue over issues such as creating a level playing field and right-sizing reserves. The opportunity to discuss these issues with regulators provides for a stronger solvency framework. PBR will undoubtedly evolve but Ms. Kuklinski stated that industry believes it will stand the test of time.

DISCUSSION ON THE USE OF GENETIC TESTING IN INSURANCE UNDERWRITING

Prof. Anya Prince of the University of Iowa College of Law stated that she will be discussing research she has done under a National Institutes of Health grant that looks at whether or not we should have regulation on insurer use of genetic information in life, long term care, and disability insurance. Prof. Prince stated that in 2008, the Genetic Information and Nondiscrimination Act (GINA) was passed which prohibits discrimination on the basis of genetic information with respect to health insurance and employment. In many ways we never got to see what the impacts of that were because just two years later the Affordable Care Act (ACA) was passed which changed risk classification in the health insurance realm. Accordingly, we missed out on the data on what it means to have insurers not take into account genetic information.

Prof. Prince stated that GINA does not cover life, long term care or disability insurance so the question becomes should we ban insurer's use of genetic information? There are two sides to the argument. From the social perspective, it is very important to have access to insurance, to have privacy, and to assuage fear of genetic discrimination. There is empirical evidence that people do not participate in genetic research and do not get clinically recommended genetic testing for fear of how that information will be used by life, long term care and disability insurers. Therefore, there are people who, if they had undergone that testing, could take preventive measures to better their health. Failure to do so is of course bad for them, but also bad for the insurers who insure them.

Prof. Prince stated that she believes some regulation is needed in this area. On the other hand, from the insurer perspective, genetic tests can tell you a lot about risk factors so in order to assess actuarially fair premiums the argument is that insurers need to be able to access information about predictive genetic tests, and avoid adverse selection whereby someone may know they are at risk for breast cancer by means of a genetic test but the insurer cannot take that information into account. Prof. Prince stated that much of her research deals with how to balance those two perspectives. More succinctly, should we have a GINA 2.0 that expands beyond just health information? The issue has been brought up at the federal level, but it has never gained traction.

Prof. Prince stated that regulatory options fall into two main categories right now: ban life, LTC and disability insurer use of genetic information, or permit it. Prof. Prince stated that she believes there should be some regulation so if choosing between those options she would choose to ban insurer use. However, there are other regulatory options abroad that can serve as models for how to regulate, not ban, insurer usage. Some policy constraints that have been implemented in other countries are monetary limits and independent review. For monetary limit policy, such policy states that under a certain threshold amount, insurers are not able to take into account genetic information, i.e. any life insurance policy under \$500,000 cannot take into account predictive genetic information. Prof. Prince stated that such a policy is a balance that helps to mitigate fears about adverse selection because you can model out the impact up to that monetary limit, make adjustments to those pools, and avoid consumers taking out huge policies with knowledge of certain genetic information.

Independent review policy constraints consist of an independent body viewing the actuarial evidence of a genetic condition and listing out those genetic conditions that meet actuarial review. That is an interesting policy because most genetic information at this point in time is not particularly helpful in assessing risk. There are very few genetic

conditions that actually have high enough penetrants and will happen to be important to life insurers. Accordingly, there is a disconnect between when somebody goes to get a genetic test and is scared off because in their informed consent documents it says “life insurers may use this information...”, and the actuality that the information the insurer obtains through the genetic test will be helpful to them is quite slim.

Accordingly, some countries look at each genetic condition piece-by-piece. Modeling currently being done by the Society of Actuaries (SOA) and the Canadian Institute of Actuaries lists 13 genetic conditions that are relevant for life insurers. Being able to review those conditions and state that those are the conditions life insurers can take into account would give much clearer information for genetic counselors, genetic researchers, the medical community, and advocacy groups to tell patients in order to help assuage the fear patients have of insurers using all genetic information with no restrictions.

Insurers in the U.K. have voluntarily agreed to bar use of most predictive genetic test results. Such policy started in 2000 and every 3 to 5 years it has been renewed. Prof. Prince stated that in her discussions with insurers and genetic researchers in the U.K., they agree that the policy is working well. In October 2018, the voluntarily policy was converted into an open-ended code where there will continuously be such a policy. There is a monetary limit: over 500,000 £ for life insurance; and there is also an independent review. The only genetic test that has been approved by the relevant government body in the U.K., which is actually now defunct because there were not enough applications, is Huntington’s disease for life insurance policies.

Prof. Prince stated that another important consideration is how to define genetic information. GINA defined the term to include family medical history so if a state implemented a law relating to genetic information and life insurance, using the GINA definition would have a much greater impact on the life insurance filed as opposed to only including predictive genetic testing or genetic testing that is both predictive and diagnostic. It is also important to keep up to speed with scientific advancements in the understanding of both risk and the preventive measures available. As those treatment advancements happen, it will change the risk classification and change the risk somebody has. There are also issues to consider as to the implications across different lines of insurance in terms of how prohibiting the use of genetic testing in underwriting would impact life insurers vs. LTC insurers and disability insurers. Additionally, considering who has the information relating to a genetic test is important: a policy constraint that comes into play there is one that states insurers can obtain information about a genetic test that is currently in someone’s medical records or done pursuant to direct-to-consumer testing. Also important to consider is the question of whether insurers can require someone to undergo genetic testing.

Rep. Keiser stated that Prof. Prince did not talk about any policy constraints directed toward the consumer. Rep. Keiser stated that based on his parents and siblings living well into their 80s, he believes he is a good risk for insurers and would therefore like a cheaper premium and be able to sign a waiver that permits insurers to use genetic testing information. Rep. Keiser stated that he believes good risks like he and his siblings are subsidizing the unhealthy population. Accordingly, Rep. Keiser asked when will we give power back to consumers? Prof. Prince stated that in the U.K., the code that was developed with the insurers allows individuals to give information about favorable genetic information. Also, Oregon law states that favorable genetic

information cannot be used for inducement of insurance and the reasoning behind that is if you allow people to use favorable genetic information, insurers may then backend into who has an adverse genetic test. Using Huntington's disease as an example, you have a 50/50 chance of having that mutation if you have a family history of it. If those with a negative test can show it to the insurer, the insurer will assume that everyone who did not show the test has the disease. Rep. Keiser stated that such a policy is adverse selection in reverse and is not fair.

Rep. Joe Schmick (WA) asked Prof. Prince if she has actually seen rates go down, or only go up when the genetic information is used. Rep. Schmick stated that it seems a way to drive rates up under the guise of being an appropriate risk, but those that do not have the risk would not see the benefit. Prof. Prince stated that it is delicate balance. In the U.K., where for 18 years insurers have not been able to take into account predictive genetic information, they have not seen much adverse selection. There has been some raising of premiums but to the extent that they have tried to model it, they have not seen much of an increase. There has been other modeling done by the Canadian Institute of Actuaries and the SOA to take into account that premiums will go up and there is some risk-pooling will happen with people with more favorable genetic information will be subsidizing people without such information. The modeling varies depending on what assumptions you put into the model.

Prof. Prince stated that she believes it comes down to whether or not we expect that we should have some pooling. There are other factors that have been legislated that acknowledge the actuarial impact but are not permitted to be used by life insurers such as race and being the victim of domestic violence. The underlying questions become: does genetics fall into those categories? Do we want to encourage people to get tested? If that is a social value that we hold dear, we are going to have to take on some adverse selection and have an increase in premiums across the board.

Rep. Schmick asked again if Prof. Prince has seen rates go down and the consumer benefit during her research. Prof. Prince stated she has not seen a specific example of a consumer providing the information and the rate going down, but actuaries in the room and Mr. Margolis may be able to answer that question.

Bruce Margolis, Chair of the ACLI's Risk Classification Cmte., stated that the process of underwriting for individual life, LTC, and disability insurance is really a risk assessment process. It is looking for the risk of that individual for premature death or an early claim for disability or LTC. That process involves the use of a variety of pieces of information, including whether an individual is at risk for certain diseases like cardiovascular diseases, or has already developed diseases that may have a mortality or morbidity impact. By law, insurers must classify similar risks similarly and that approach is balanced against what we might call a standard life-expectancy risk pool. The key benefit of that approach is that it enables insurers to make products available at the lowest price to as many people as possible. If you have everyone in one pool like in a group insurance product, the price for individuals who are really healthy is higher than what they might get on the open market and they are subsidizing others in the pool who are not as healthy.

Unlike health insurance, P&C insurance, and disability insurance, life insurance underwriting is a one-time event. When an individual knows something about themselves that the insurer doesn't there is a risk that the individual will be

inappropriately placed in a better-than-should-be risk classification pool. That is the concept of adverse selection. If you have too many unhealthy people in a healthy pool, that will skew the results over time and prices will go up resulting in healthy people leaving the pool altogether.

Starting in 1865 when Gregor Mendel discovered the laws of basic genetics, it took almost 100 years until the biochemistry of DNA was elucidated. Since then, there has been both baby steps and big steps, the most recent big step being the completion of the human genome sequence in 2003 at a cost of hundreds of millions of dollars in both the public and private sectors. Now the cost per genome to sequence is less than \$1,000. With that efficiency comes more research and it is almost every day there are new research findings related to genetics.

Additionally, a DTC genetic testing market now exists where consumers can go on the internet, obtain a kit, submit some of their saliva, and get an analysis of their DNA. A lot of that is recreational and done for ancestral purposes but there are some companies that will give you some genetic risk profile based on the sample given. That is a potential source for adverse selections for insurers as individuals may discover they have a predisposition for a certain disease and they then purchase a life, LTC or disability insurance policy.

Dr. Margolis stated that it is important to note that these are complex issues that have social, ethical, medical and business aspects to them. There are different types of genetics tests. A diagnostic genetic test can confirm a clinically suspected disease such as cystic fibrosis. A predictive genetic test determines risk for a particular disorder by determining “penetrants.” Screening genetic testing can be done with prenatal and newborn screening. A field of pharmacogenomics exists where geneticists look at an individual’s genetic makeup to determine whether a drug is suitable for the individual and what the safest and most effective dose is. Tumor analysis exists, and is one of the fastest growing genetic fields, whereby the genetic markers in a tumor, not the patient, are examined to guide treatment. Pharmaceutical companies have been able to create biologics that target that abnormal genetic profile and have achieved significant improvements in cancer survival.

Dr. Margolis stated that several different types of people are involved with these issues: insurers, physicians and researchers, consumers, and legislators and regulators. Insurers want to sell insurance but want to ensure that it is a fair product and a level playing field exists where they understand and appropriately risk-classify individuals. Issues that have come up surrounding genetics include privacy, confidentiality, disclosure, utilization, discrimination, and genetic exceptionalism – the concept that genetic information is different from other medical information. Dr. Margolis stated that from his medical perspective, genetic information is medical information, but others may see it from a different perspective.

In 1990, the Ethical, Legal and Social Implications (ELSI) Program was established by the National Human Genome Research Institute and was charged with researching the ethical, legal and social implications of genetic research for individuals, families and communities. The insurance industry is heavily regulated and is bound by a number of consumer privacy protections. Insurers also must notify individuals of the reason for an adverse underwriting decision and give them the chance to correct that if there is some misinformation involved.

Dr. Margolis stated that a number of states have genetic-based laws and while a lot of the laws are centered around privacy, authorization, and confidentiality issues, some relate directly to the topic being discussed today. In Vermont, VT 8 V.S.A. § 4724 prohibits insurers from using genetic testing information unless the insurer can show reasonable anticipated experience that the risk is related to that particular genetic issue. In Massachusetts, MA 175 § 120E restricts the industry's use of genetic information but allows an insurer to use the information if it is based on sound actuarial principles or reasonable expected experience.

Dr. Margolis stated that the economic success of voluntary insurance products hinges on a level playing field of information for appropriate and fair risk categorization. Insurers need to properly understand the risk to appropriately price the risk. The field of genomics is also growing at a very fast rate as the industry is starting to see more and more genetic information on insurance applications – some of which is not pertinent to the risk but the fact that it is there is clear. The clinical use of genetic information remains limited but is expanding at a rapid pace and will become commonplace over time. How long that will take is not clear as getting from research to clinical use is extensive, but we will get there and there will be a tipping point along the way where it will take place significantly. Dr. Margolis closed by stating that public discourse such as the conversation today needs to continue and consider all stakeholders in order to maintain wide access to competitively priced insurance products while protecting individual privacy rights and allaying concerns over proper information use.

Rep. Deborah Ferguson (AR) – Chair of the Committee – asked if all of the labs conducting the DNA and genetic tests are subject to FDA regulations. Dr. Margolis stated that there are two realms of control: the Clinical Laboratory Improvement Amendments (CLIA) controls the lab itself; individual tests can be FDA approved. As an example, with a company such as 23 & Me, their lab can seek CLIA approval and in 2013 the FDA told them to cease and desist because the tests they were using had not gone through FDA-certification. 23 & Me is now back with a very limited, FDA-approved genetic test. Prof. Prince stated that the regulations often look at the clinical and analytical validity of the tests and don't necessarily look at clinical utility which is really the question relating to risk. Accordingly, there is information that could be clinically useful on an aggregate level but depending on the individual and their gender, ethnicity and family history, the clinical utility changes.

Further, there is a debate in other countries (less so in the U.S.) about research findings. Should research findings be able to be used? In the U.S., if a research finding is returned to an individual for treatment purposes, it is supposed to be re-certified in a CLIA lab but there is some debate among researchers about what that means for treatment. There is theoretically a way that there could be information that falls outside of those regulatory schemes that could come into play. Dr. Margolis stated that there are tests that come to clinicians. For example, there is a test to determine how well an individual metabolizes or doesn't metabolize a certain type of anticoagulant. Dr. Margolis thought that clinicians were going to use the test because it has been validated but the clinical utility of the test has not been found. Similarly, insurers have to look at the risk utility of certain information: just because something is there does not mean it relates to morbidity and mortality. Rep. Ferguson stated that with the implementation of personalized medicine, policy should be avoided that would inhibit people getting the care they need.

Rep. Keiser stated that both Dr. Margolis and Prof. Prince have given the indication that

we are early in the stage of development of these procedures, but he does not agree with that. As a member of a fully integrated healthcare delivery system, 2 years ago they implemented a major project throughout the system for genome testing for cancer patients. There are very individualized treatment programs and the success rate is phenomenal. At the same time they did that, a program was enacted for the public that risk testing could be done and as a board member he got it for free. The program that he got was not primitive and very scientific. What intrigued him was the reaction of other board members when their tests came back with markers that were not favorable and their first comment was that they have to increase their life insurance. Accordingly, Rep. Keiser stated that the technology that Dr. Margolis and Prof. Prince describe is not as primitive as they suggest and that its use is more widespread than they think, particularly among those who can afford such tests to make very important decisions that can have a big impact on reserves and the industry.

Prof. Prince agreed that the technology and testing is indeed rapidly improving and increasing but what we are very early in understanding is the question of what exactly the risk is. As an example, when the BRCA gene was first discovered which relates to breast and ovarian cancer risk, early estimates were that the penetrants of that marker measured out to be a likelihood of 60% to 80% of getting that type of cancer. That is because we have an ascertainment bias because the families tested first were the ones with the most penetrants. That estimate has lowered over the years and now we're down to around 60%. Accordingly, we're not there yet to where we can truly pinpoint what the risk information means. We're starting to get more people tested, but as more tests occur, that complicates the factors. So what do you do if you get a positive BRCA test and you have a very large family and none have breast or ovarian cancer? What does that mean for an insurer? Those are questions that still need to be answered and that reinforces the point that more people should get tested so that we can better understand the risk. If we have it so that such information can be used by insurers and people are scared of getting tested, that is a problem.

Prof. Prince acknowledged the concern of people taking genetic tests and then quickly going to get a policy if the test showed unfavorable results. Now, the practice is that if you go to get a single predictive genetic test often times genetic counselors will suggest that the consumer secure their insurance first. The Canadian Institute of Actuaries made an assumption that 75% of people who test positive for 13 genetic conditions will go out and get as much life insurance as they possibly can. Based on that assumption, they found a high impact on premiums. Prof. Prince stated that she does not believe that is accurate because a lot of people cannot afford that much life insurance; and they want it to cover their house to make sure their family is ok, but they don't want to necessarily go out and scam the insurance system. Accordingly, more research is needed to determine changes in insurance purchasing behavior. People are also bad at understanding their risk so if you say you have a 60% increase in risk of breast cancer which means you have a 16% increase in risk over the percentage risk in the general population, you may have people going out and getting more insurance than they need based on odds ratios vs. overall risk.

Dr. Margolis agreed with Rep. Keiser in that the technology is already here and keeps getting better. In terms of utilization, Dr. Margolis looks at 40 to 50 sets of medical records every day and most of them have no genetic testing information, but the prevalence is increasing. What he sees today is very different from a couple of years ago. Healthcare systems are thinking about how to integrate this into the process of

what we are calling personalized medicine and precision medicine. Efforts are underway at the Federal level via the All of Us Research Program which is an effort to gather data from one million or more people living in the U.S. to accelerate research and improve health.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 7, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Friday, December 7, 2018 at 1:45 p.m.

Senator Dan “Blade” Morrish of Louisiana, NCOIL Vice President, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)
Rep. Martin Carbaugh (IN)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)

Rep. Michael Webber (MI)
Sen. Jerry Klein (ND)
Rep. Lewis Moore (OK)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Steve Riggs (KY)
Sen. Gary Dahms (MN)

Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)
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

After a motion was made by Sen. Jason Rapert (AR) – NCOIL President – and seconded by Rep. Lewis Moore (OK) to waive the quorum requirement, the Committee voted without objection by way of a voice vote to approve the minutes of its July 13, 2018 meeting in Salt Lake City, UT upon a separate motion made by Rep. Michael Webber (MI) and seconded by Sen. Rapert.

DISCUSSION ON NAIC CANNABIS INSURANCE WORKING GROUP

Sen. Dan “Blade” Morrish – NCOIL Vice President - stated that as states continue to legalize both medicinal and recreational marijuana, the marijuana industry has become a multibillion-dollar business in the U.S. that’s drawing attention from some legislators eager for tax revenue and investors looking for profits. That is in despite of the fact that the Federal government has still not taken any action to remove marijuana from its Schedule 1 drug classification. Sen. Morrish asked the Commissioners for some background as to how the NAIC Cannabis Insurance Working Group (WG) was formed and what its goals are in light of those realities. Sen. Morrish also asked what the WG has identified so far as the main policy gaps for cannabis insurance coverage availability and gaps in coverage for cannabis businesses.

The Honorable Gordon Ito, Hawaii Insurance Commissioner and NAIC Vice President, stated that Hawaii was actually one of the states that adopted medical cannabis many years ago. Recently, Hawaii enacted a law relating to cannabis dispensaries. From an insurance aspect, last year, Hawaii's work comp carrier insurer of last resort decided that it would not be providing any work comp policies or coverages to any companies or entities involved with medicinal cannabis in Hawaii. That is an issue that the WG is examining. Cmsr. Ito stated that more than 45 states have passed laws legalizing cannabis or a derivative of it. Nine states (AK, CA, CO, ME, MA, NV, OR, WA, D.C.) have legalized cannabis for medicinal and recreational use. Michigan voted to legalize for recreational use on Nov. 6 of this year. Vermont made it legal to possess limited cannabis amounts on January 22, 2018. About 20 other states allow medical cannabis and 17 states allow cannabinoid products. FL, NJ, NY, and PA are currently looking into legalizing cannabis. Therefore, Cmsr. Ito stated that most states are involved with cannabis in one way or another.

With regard to the issues in Hawaii and other states relating to the difficulty for those involved in the cannabis industry in obtaining insurance, the insurance market for cannabis is very fragmented with about 27 carriers. There is a general lack of data for the market which makes underwriting requirements difficult. Coverage is primarily available in the surplus lines market. Cmsr. Ito stated that just a few months ago when Hawaii was experiencing the aforementioned issues in its work comp market, he and others had heard that some states were looking at using captives to provide coverage in addition to surplus lines.

With regard to the NAIC's involvement with these issues, the NAIC Property & Casualty Committee created the WG to consider the insurance regulatory issues surrounding the legalized cannabis business, including availability and scope of work comp coverage, and consumer information and protection. That includes the development of a white paper outlining the issues containing recommendations for development of regulatory guidance as appropriate. The WG is expected to sunset in 2020. At the 2018 NAIC Fall National Meeting, the WG heard presentations from various industry associations as well as insurance companies and law firms. Cmsr. Ito stated that the white paper is intended to identify insurance gaps such as coverage for such things as product contamination, landlord liability, distribution, and transportation, due in part to the regulatory uncertainty.

The white paper will include state-by-state comparisons of insurance availability by line and discuss state, local, and federal authority, the operation of the cannabis industry from seed to sale, how insurers determine rates, and the best practices and recommendations. Cmsr. Ito stated that in addition to meeting at the recent NAIC Fall National Meeting, the WG has had a number of conference calls. The current timeframe anticipates WG adoption of the white paper at the NAIC 2019 Spring National Meeting and adoption by the NAIC at the 2019 NAIC Fall National Meeting.

The Honorable Ken Selzer, Kansas Insurance Commissioner, stated that he believes that everyone needs to work to get the federal government to remove marijuana from schedule 1 classification. That is the biggest issue in the insurance industry. The issue should at least be bifurcated so that ag hemp and medical non-THC marijuana are taken off schedule 1 classification. Anything that comes from a cannabis plant even though it hardly has any THC in it still mandates a schedule 1 classification. Cmsr. Selzer stated that in Kansas, an ag hemp bill was recently passed and in the Summer of 2019,

applications will start being processed to grow ag hemp. The incredible regulations that have to be met are bizarre; you will burn your lungs out before you get high from ag hemp, which is something that not everyone understands. Cmsr. Selzer stated that legislators and regulators should take some time to understand the difference between something that has THC in it and something that does not such as CBD oils.

Cmsr. Selzer stated that he looked into growing 10 acres of ag hemp and it turned out that he needed to be willing to sit out by the fields armed during the last 3 weeks or so of growth because the Kansas Bureau of Investigation (KBI) was concerned about people coming along and cutting off some of the plants and altering them in such a way as to change their chemical makeup so as to get high from them. The point is that there are a lot of issues surrounding cannabis. The plants look different when comparing ag hemp and regular marijuana but ag hemp can be camouflaged and used for inappropriate purposes. One of the big issues with marijuana around the country is that it is sometimes getting sprayed with fentanyl. Cmsr. Selzer stated that there are many issues to be discussed but above all he believes that they should be bifurcated between the products that have THC and those that do not or have hardly any in them. Doing so will make a big difference in insurance availability. Cmsr. Selzer stated that when he asked his insurance carrier this morning about growing ag hemp, the carrier told him to think about it because although it is not specifically excluded by the policy they have no interest in continuing the policy if he grows ag hemp. Cmsr. Selzer stated that he is very thankful that the NAIC is taking the time to study these issues.

The Honorable Jessica Altman, Pennsylvania Insurance Commissioner, stated that PA legalized medical marijuana last year and is therefore beginning to grapple with the myriad of regulatory issues. The issue is twofold in terms of the issue of insuring the production line itself, the liability insurance, the work comp insurance, but also the potential for insurance covering it as the medicine it is intended to be. It is also important to keep in mind that the availability of medical marijuana is not the same as accessibility because it is quite expensive and potentially too expensive for many patients that need it on an ongoing basis. Cmsr. Altman also noted that banking regulators are also grappling with similar difficult issues and her team is making sure to be in close contact with them in order to understand the issues together.

Sen. Rapert asked if the NAIC has attempted to formally request that marijuana be removed from schedule 1 classification? Cmsr. Selzer stated that he was speaking with regard to his own personal beliefs and not on behalf of the NAIC. Sen. Rapert stated that the entire country needs to take a long look at these issues because to his knowledge there has never been a peer-reviewed scientific report from the medical community that has deemed any medicinal benefit from marijuana even though there has been ample time for such a report to be issued. Sen. Rapert acknowledged that CBD oil differs in certain ways but in Arkansas, it was found that it is never advisable to light something on fire and inhale it. The fact of the matter is that this whole issue has never been about medicine in the first place; it is about having access to smoke marijuana whenever people want to under the guise of medical benefits.

Sen. Rapert stated that he has yet to see a physician verify certain medical assertions from the proponents of legalized marijuana, and in Arkansas, physicians actually clamored to be removed from prescribing it because they feared they would lose their medical license. Sen. Rapert stated that he believes this whole issue to be a farce because marijuana is not medicine and he hopes that the issues continue to be studied.

Sen. Rapert further stated that he understands the differences with hemp and he is fine with that but noted that marijuana was already approved in the form of marinol but nobody wants to take a pill – they want to smoke it. Sen. Rapert stated that he had asked his colleague in Arkansas who sponsored medical marijuana legislation, what is the dosage level and he replied that if you don't feel pain alleviated at first, you smoke more until you do. Sen. Rapert stated that he understands the issues are being grappled with across the country but he is not sure that ignoring science, reality, and facts so that certain people can feel good is good policy.

Cmsr. Selzer stated that the FDA just approved its first cannabinoid medicine so clearly there was some research behind that and he suspects more approvals will be coming. Cmsr. Selzer again stressed his belief that the the issues need to be bifurcated as he does not believe he would ever support recreational marijuana but would support non-THC CBD oils and ag hemp. Sen. Rapert stated that it would be helpful to the whole country if the supporters would admit that this is all about opening the door to federal law that legalizes recreational marijuana. Sen. Rapert stated that there was a report recently issued from a University in Colorado that stated Colorado was spending \$4 for every \$1 in tax revenue Colorado was making off of legalized marijuana. Sen. Rapert stated that is not good policy.

Rep. Deborah Ferguson (AR) stated that with regard to the bifurcation issue, that concerns her because all over Arkansas you see billboards advertising CBD oils in vaping shops and many purchase CBD oil online. Rep. Ferguson stated that she does not disagree that CBD oil should be available but it is concerning. It is Rep. Ferguson's understanding that this is an un-litigated area and the Hemp Act is being used to sell CBD oil in vape shops but CBD oil may not be properly placed under the Act's jurisdiction. Accordingly, it is concerning as to how pure and validated for safety the CBD oil is. Cmsr. Selzer stated that some states have addressed the issue by requiring CBD oil to be distributed through a pharmacy which is something that he would support. The question becomes do you want to deal with part of the issue or just say no to all of it? Cmsr. Selzer stated he personally would like to do the former. Rep. Ferguson stated that she has spoken to pharmacists in Arkansas about having it only distributed through them.

Rep. Tom Oliverson, M.D. (TX) stated that if it is a schedule 2 classification, lets treat it like a pharmaceutical. Rep. Oliverson stated that he can obtain IV fentanyl as an anesthesiologist to use on his patients on a daily basis since it is a schedule 2 drug. But that does not mean that you can go to the local dispensary and get it and you cannot grow it in your backyard. Rep. Oliverson believes that these issues get muddled when there is a rush to allow people to, for example, have up to 6 plants in your backyard and harvest it and smoke it whenever you want so that you feel better in an effort to treat your pain, PTSD or seizure activity. However, there is no attention paid to purity, potency, dosage, or an actual chain of custody in terms of how a controlled substance is getting from the manufacturer to the user who is a patient who has a legitimate medical reason to have it. Rep. Oliverson stated that he believes the devil is in the details related to questions such as how you actually regulate the dispensing of marijuana and CBD oils. If you say you are going to treat it as a schedule II drug, should you treat it like every other schedule II drug out there? Should a licensed pharmacist always be dispensing it and does it have the appropriate safeguards in place through the Dep't of Pharmacy and FDA so that we know what drugs are being dealt with and we know how pure it is and how it is protected.

Cmsr. Altman stated that many of the questions put forth today are outside the realm of insurance departments and insurance regulators but that she believes many of those questions are dealt with in the PA legislation and regulations. For example, in PA, marijuana in its raw form is not available even for medical purposes. Cmsr. Altman also clarified that the NAIC is focused on ignoring the question of whether marijuana should be legalized because that is not for them to decide and instead ensure that the white paper outlines what the regulatory implications that are necessary to understand for states that do decide to legalize marijuana, either medicinally, recreationally, or both.

Cmsr. Selzer stated that the insurance regulator in almost every state is working between the insurance carrier and the consumer. The insurance regulator is not involved with the providers or the pharmaceutical companies, other than where PBM statutes have been passed. The insurance department is focused on protecting the consumer in that contract with the insurance company. It is not until a law gets passed in a state regarding marijuana and a specific assignment is made to the insurance department that a lot of the questions discussed today are relevant for insurance departments.

DISCUSSION ON PROPOSED AMENDMENTS TO NAIC CREDIT FOR REINSURANCE MODEL LAW AND REGULATION

Sen. Morrish stated that it is his understanding that at the recent NAIC Fall National Meeting last month, amendments to the NAIC's Credit for Reinsurance Model Law and Regulation (Reinsurance Models) were preliminarily approved due to the U.S. – EU Covered Agreement that was signed last year. Rather than draft a redundant Model, NCOIL simply endorsed the original NAIC reinsurance Models. Sen. Morrish asked for a summary of what the proposed amendments entail and what state legislators need to be aware of if they want to introduce such legislation in their respective states.

Cmsr. Ito stated that over the past year through the NAIC Reinsurance Task Force (Task Force) the NAIC has undertaken efforts to amend the NAIC Reinsurance Models to conform to the U.S.-EU covered agreement. The covered agreement was signed on Nov. 22, 2017 and will require states to eliminate reinsurance collateral requirements for EU reinsurers within 60 months or 5 years of the signing, or face potential federal preemption by the Federal Insurance Office (FIO). The U.S. Dep't of the Treasury (Treasury) also issued a policy statement on the covered agreement that specifically recognized the continued role of state insurance commissioners as the primary regulators of insurance in the U.S. Cmsr. Ito stated that what we all have to remember is that the clock is ticking on the above-mentioned preemption deadline.

Cmsr. Ito stated that the NAIC has been hard at work with efforts to conform its Reinsurance Models to the covered agreement. The NAIC heard comments at its Summer National Meeting and the Reinsurance Task Force received 13 comment letters from interested parties both in the U.S. and in the EU on the Task Force's initial draft proposal. The Task Force continued to work on amending the Reinsurance Models based upon the comments received. Both the Task Force and Financial Condition Committee met at the recent NAIC Fall National Meeting on Nov. 17 and approved the amendments to the Reinsurance Models. However, during the process there were certain comments made so the decision was made to send the Reinsurance Models back for technical amendments. In the interim, additional comments have been received so the Task Force is in the process of analyzing them and the NAIC is still deliberating

over when to bring the Reinsurance Models forward for adoption.

Cmsr. Selzer asked if it is likely that the amendments to the Reinsurance Models will be finished by the Spring. Cmsr. Ito stated that he is not certain but that the NAIC is aware of certain timeframes that exist and would like to have the Reinsurance Models ready for introduction in state legislatures in time for the next legislative session. That issue is under discussion internally at the NAIC. Cmsr. Ito noted that a related issue revolves around the discussions with respect to a U.S.-U.K. covered agreement. Treasury and the Office of the U.S. Trade Representative (USTR) have initiated negotiations with the U.K. regarding a covered agreement in light of Brexit. Cmsr. Ito stated that the NAIC believes that such a covered agreement will largely mirror the U.S.-EU covered agreement. The NAIC feels that the U.S.-UK covered agreement is an extension of the initial covered agreement and the NAIC is opposed to further covered agreements.

The Honorable Tom Considine, NCOIL CEO, asked Cmsr. Ito to clarify whether the NAIC is opposed to the U.S.-UK covered agreement, or only those beyond that covered agreement, as he had read a statement from the NAIC on the U.S.-UK covered agreement which stated that the NAIC was supportive of it but not additional agreements, which is similar to NCOIL's position. Cmsr. Ito clarified that the NAIC is supportive of the U.S.-UK covered agreement because the NAIC views it as an extension of the U.S.-EU covered agreement, but the NAIC is not supportive of any further covered agreements beyond those two.

UPDATE ON NAIC ANNUITY AND SUITABILITY WORKING GROUP

Sen. Morrish stated that it is his understanding that at the recent NAIC Fall National Meeting last month, amendments to the NAIC's Suitability in Annuity Transactions Model Regulation (Suitability Model) were preliminary approved, and asked for a summary of what the proposed amendments entail. Cmsr. Ito stated that the NAIC Annuity Suitability Working Group (WG) started drafting amendments to the Suitability Model late last year. The Suitability Model has been protecting consumers for 15 years since its adoption by the NAIC in 2003. Since then there have been two sets of significant revisions made, one made in 2006 and the other in 2010. Nearly every state has adopted one version of the Model; 39 states have adopted the 2010 version. The WG was appointed in 2017 to review and revise the Suitability Model to promote greater uniformity and access across NAIC-member jurisdictions.

Cmsr. Ito stated that renewed interest in the Model was prompted in part by the work of the U.S. Department of Labor (DOL). The DOL's final Fiduciary Rule (Rule) was published in 2016 but was then vacated in its entirety by the 5th Circuit. While the DOL declined to challenge the court's ruling it is considering other regulatory options and is expected to revisit the Rule by September 2019. Separately, the Securities and Exchange Commission (SEC) released a proposed rule package in April 2018 which included a proposed best-interest regulation (BI regulation). The NAIC submitted comments to the SEC to coordinate efforts so that each respective regulatory development could be as comparable, clear, and efficient as possible. The SEC has announced that it would like to finalize its rule package by September 2019.

Cmsr. Ito further stated that the NAIC believes first and foremost in the state's authority to regulate insurance products as state-based regulation better protects consumers. Furthermore, the NAIC believes that consumers are better protected when to the extent

possible there is harmonization of regulation enforced by the states, SEC, and DOL. Insurance carriers and agents need clear and understandable uniform requirements. Just as importantly, regulators need clarity. Broad principles have public relations appeal but the inconsistent interpretation of vague requirements will be ineffective and inefficient. Consumers are more likely to be protected when carriers and agents have a clear understanding of conduct rules.

Cmsr. Ito stated that the WG has held many meetings throughout the past year, including two separate in-person meetings – one in Kansas City in June, and the other in Chicago in October. All meetings were held in an open forum with full transparency and interested parties were given multiple opportunities to submit comments. Over the course of the last year, the WG has received nearly 400 pages of comments from interested parties. Cmsr. Ito stated that the WG's goal is to elevate the standard of care for annuity sales so consumers understand that the products they purchase and are made aware of any material conflicts of interest, and are assured that those making product recommendations are making recommendations in the consumer's interest and are not placing the producer's financial interests ahead of the consumer's.

Cmsr. Ito stated that, fundamentally, the Suitability Model is changed to make it clear that all recommendations by agents and carriers must be in the interest of the consumer and that interest must always be put ahead of any interest the agent may have in the transaction. The Suitability Model would also require that agents and carriers act with reasonable diligence, care, skill, and prudence. To assure the duty of putting the consumer first, the draft requires agents to disclose and answer questions about their role in the transaction, their compensation, and any material conflicts of interest. The draft codifies as a requirement the good business practice of carefully and clearly explaining to the consumer the basis for the recommendation. Such a requirement is designed to ensure consumers understand what particular products are consistent with their particular needs, situations and objectives.

Cmsr. Ito further stated that agents and carriers are required to document in writing any recommendation and justification for that recommendation. Each of the new requirements contemplated by the draft make a more robust regulatory framework that strengthens consumer protections already available under the existing Suitability Model. Cmsr. Ito stated that there are a number of things that the WG is still considering, one of which relates to whether amendments to the Suitability Model should apply to in-force policies. The New York Department of Financial Services (NY DFS) is seeking to introduce language related to that discussion. The WG would also like to have further discussions as to whether the amendments should apply to annuities that are not individually solicited under the IRS code if established or maintained by employers. Cmsr. Ito stated that at the recent NAIC Fall National Meeting the WG, in reporting to the Life Insurance and Annuities Committee, recommended that the preliminary draft of the amended version of the Suitability Model be exposed for comment at the Cmte level. Said Cmte adopted the WG's report and agreed to expose said version for comment up until Feb.15, 2019. The goal is to produce an NAIC draft of the Suitability Model containing placeholders for SEC issues. That would enable the SEC to benefit from the NAIC's work so that consistency can be provided to consumers, regulators and industry. Additional comments have already been received on the Suitability Model and it will be sent back to the WG for further drafting if necessary.

Sen. Morrish asked if the SEC rule, if adopted, would preempt state statutes that deal

with fiduciary and best interest standards. Cmsr. Ito stated that the NAIC's view is that the SEC rule would not preempt the NAIC's Suitability Model as the goal is for the NAIC to ultimately produce something that is consistent with the SEC's rule and vice versa.

Cmsr. Altman stated that there has been an uptick in annuity sales following the news of the Rule being vacated and that is not a bad thing as annuities can be an incredibly valuable part of financial and retirement planning and the majority are sold to the right people for the right purposes in the right way. However, when that is not the case the consequences for the consumer can be severe and PA has been active with enforcement, particularly as it relates to "twisting" whereby an existing annuity is changed over for a new one at a significant cost to the consumer. Those cases can be very challenging to prove because there is a lot of grey area about what was done and why and with whose permission, particularly when dealing with senior citizens. That is why having really good standards in place is very important in PA to make sure products are sold appropriately. Cmsr. Altman stated that she is very pleased to see the WG focus on what is in the consumer's interest because at the end of the day that is the goal of having the standards in the first place.

DISCUSSION ON PBM REGULATORY ISSUES SUBGROUP

Sen. Morrish stated that the proposed charge for the NAIC PBM Regulatory Issues Subgroup (subgroup) is: "Consider developing a new NAIC model to establish a licensing or registration process for PBMs. The Subgroup may consider including in the new NAIC model provisions on PBM prescription drug pricing and cost transparency." Sen. Morrish then asked if the NAIC has decided yet whether the Model will be a Model Law or Regulation because the NCOIL Health Committee is developing separate Model Laws on PBMs and drug pricing transparency and rather than have duplicative Model Laws from NCOIL and NAIC, this may be a good opportunity for the NAIC to draft more detailed Model Regulations on those topics to help address issues that may not be addressed in the NCOIL Model Laws.

Cmsr. Ito stated that the NAIC adopted revisions to the NAIC Health Carrier Prescription Drug Benefit Management Model Act (Model #22) at the 2018 NAIC Spring National Meeting. After adoption of those amendments, questions were raised as to the Model's approach and whether direct regulation of PBMs was desired. Cmsr. Ito stated that Model #22, like other NAIC Models, is structured to maintain a health carrier's ultimate responsibility of carrying out the Model's requirements if the carrier delegates those responsibilities to a third party such as a PBM. Insurance departments do not have direct authority with respect to provider contracts – contracts entered into between health insurance carriers and the providers that provide the services. Cmsr. Ito noted that Hawaii's involvement with PBMs started with the legislature wanting the Hawaii Insurance Department to be responsible for ensuring that local retail pharmacists are allowed into a PBM's network. Since then there has been an expansion of involvement to the point where the Insurance Department licenses PBMs. During the last legislative session, the legislature tried to shift the Maximum Allowable Cost (MAC) appeal process from the Department of Health to the Insurance Department but the bill did not move.

Cmsr. Selzer stated that the Kansas Insurance Dep't requires PBMs to register with them, but not to be licensed. It is the legislature's responsibility to create a statutory framework for departments and agencies to operate under in order to get involved with certain provider issues. In most states, including Kansas, there is very little authority to

interact or get involved with providers. Most regulation is centered on the carrier but that can change if legislation is enacted.

Cmsr. Ito stated that at the recent NAIC Summer National Meeting, the subgroup was created and then met for the first time in October via conference call to discuss issues certain states have encountered relating to PBMs. With regard to the subgroup's charge, Cmsr. Ito stated that the subgroup will look at what NCOIL ends up adopting, if anything, and that could be the starting point for the subgroup's discussions. Cmsr. Altman stated that insurance regulators today do hold the system accountable for PBM activities related to the consumer. Insurance regulator's historical authority has been tied to enforcement of the insurance contract between the insurance company and the consumer and in health insurance that is inclusive of the pharmaceutical benefit. Whether or not the health insurer chooses to leverage a TPA for the pharmaceutical administration for administration of behavioral and mental health services, which is very common in PA, it is ultimately the licensed health insurer's obligation to fulfill the terms of the policy that insurance regulators generally approve, if not otherwise oversee. Some of the recent conversations at NCOIL and NAIC venture into that second contract – the contract between the insurance company and the provider and that is somewhat of an un-crossed frontier for insurance regulators and that will be a robust dialogue within the subgroup when discussing whether to pursue a Model Law.

Cmsr. Selzer stated that he is very thankful that both NCOIL and the NAIC are looking at these issues. In Kansas, approximately 1/3 of all medical claims go into a database - that does not include large self-insured plans or Medicaid or Medicare – consisting of privately, commercially insured plan claims. When looking at that database, there are 4 components: a.) in-patient; b.) out-patient; c.) providers; and d.) pharmaceuticals. The only one of those costs going up like a rocket is pharmaceutical – the others are staying relatively flat. Sen. Morrish noted that the NCOIL PBM Model that is currently being developed is aiming to be a chassis which can provide state insurance departments with rulemaking authority and determining what that rulemaking authority will be is something that the NAIC and NCOIL can work together on.

Sen. Rapert thanked the NAIC for getting involved with these issues, and for including NCOIL in its deliberations. NCOIL believes that the state insurance departments are best positioned to deal with these complex issues. Sen. Rapert believes that the subgroup is a very positive development and the sense is that NCOIL will be able to deliver a chassis in the form of a PBM Model Law that will provide state insurance departments with appropriate regulatory authority. Sen. Rapert closed by reiterating that doctors are regulated by medical boards, pharmacists are regulated pharmacy boards, insurance companies are regulated by insurance departments but PBMs are regulated by no one. That cannot continue because costs are continuing to rise and consumers are bearing those costs. Sen. Rapert noted that he did not intend to deal with these issues during his time as NCOIL President but this was about responding to concerns that were present not only in Arkansas but across the country.

Rep. Oliverson echoed Sen. Rapert's comments and agreed that state insurance departments are best positioned to deal with these issues. Rep. Oliverson also stated that insurance regulators do step into the space between the provider and the insurer in numerous ways already with issues such as balance billing and network adequacy. Any time that the relationship between the provider and insurer can potentially result in disruption in services to the consumer then it is the insurance regulator's business to

step in and be an independent third party, especially when there are stakeholders involved that have little or no negotiating ability.

UPDATE ON NAIC LIFE INSURANCE ILLUSTRATION POLICY OVERVIEW DEVELOPMENTS

Sen. Morrish stated that it is his understanding that the NAIC Life Insurance Illustration Working Group (WG), created in 2016, has been diligently working to revise the NAIC's Life Insurance Disclosure Model Regulation (Model) – specifically, how the narrative and police summaries required by the Model can be enhanced to promote consumer readability and understandability, including how they are designed, formatted and accessed by consumers. Sen. Morrish asked for an update on the WG's efforts and what to expect for the remainder of this year and 2019.

Cmsr. Ito stated that there are two NAIC Models that address the information required to be given to consumers about their life insurance policies. The Life Insurance Disclosure Model Regulation #580 and The Life Insurance Illustration Model Regulation #582. The purpose of Model #582 is to provide rules for life insurance policy illustrations that protect consumers and foster consumer education. An illustration is a presentation or depiction that includes non-guaranteed elements of a policy of life insurance over a period of years. Model #582 provides illustration formats, prescribes standards to be followed, prescribes when illustrations are to be used, and specifies the disclosures that are required in connection with the illustration. One such illustration is a narrative summary that must accompany all illustrations. Model #582 outlines what information must be included in the narrative summary.

Cmsr. Ito stated that Model #580 requires that insurers deliver to purchasers of life insurance information that will improve the buyer's ability to select the most appropriate plan of life insurance for the buyer's needs, and improve the buyer's understanding of the basic features of the policy that has been purchased or is under consideration. Model #580 includes a requirement that for policies that are not going to be illustrated, the insurer is to provide a policy summary and describe what information is to be included in the summary. The WG has a charge to explore how the summaries required in the two NAIC Models can be enhanced to promote consumer readability and understandability including how they are designed, formatted and accessed. Cmsr. Ito stated that after much discussion, the WG decided to pursue the development of a simplified 1 to 2 page consumer-oriented policy overview document that would accompany the summary required in the two Models to achieve its charge. The WG also agreed to provide a policy overview template to be an example of a format that would meet the requirements of the two Models.

Cmsr. Ito stated that the WG on its last two conference calls discussed a proposal to simplify the approach to incorporate a policy overview document requirement. Rather than amending both Models to require a policy overview with the summaries, under the new approach only Model #580 would be amended to require that the policy overview document be distributed along with the buyer's guide for all life insurance policies. Such amendments have been circulated for a comment period which ends Dec. 10. The WG intends to meet by conference call early in 2019 to discuss any comments received and revise the draft accordingly. Once the WG finishes the Model it will start developing the template likely early next year.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 7, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Friday, December 7, 2018 at 9:00 a.m.

Representative Matt Lehman of Indiana, NCOIL Treasurer and Acting Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Dan "Blade" Morrish (LA)
Rep. Lois Landgraf (CO)	Rep. Michael Webber (MI)
Rep. Martin Carbaugh (IN)	Rep. George Keiser (ND)
Rep. Joseph Fischer (KY)	Sen. Jerry Klein (ND)
Rep. Steve Riggs (KY)	Asm. Kevin Cahill (NY)
Rep. Bart Rowland (KY)	Rep. Lewis Moore (OK)
Rep. Edmond Jordan (LA)	Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Sam Kito (AK)	Sen. Paul Wieland (MO)
Sen. Gary Dahms (MN)	Rep. Joe Schmick (WA)
Sen. Paul Utke (MN)	

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

A motion was first made by Rep. Joseph Fischer (KY) and seconded by Rep. Michael Webber (MI) to waive the quorum requirement which the Committee approved without objection by way of a voice vote. A motion was then made by Rep. Bart Rowland (KY) and seconded by Rep. Tom Oliverson, M.D. (TX) to approve the minutes of the Committee's July 12, 2018 meeting in Salt Lake City, UT, which the Committee approved without objection by way of a voice vote.

UPDATE ON NATIONAL FLOOD INSURANCE PROGRAM AND PRIVATE FLOOD INSURANCE MARKET

Dr. Daniel Kaniewski, Deputy Administrator - Resilience, of the Federal Emergency Management Association (FEMA), began by applauding NCOIL in its efforts to close the insurance gap, something FEMA is very passionate about. 2017 and 2018 were very busy years for FEMA due to hurricanes, wildfires, earthquakes, and flooding. Dr.

Kaniewski stated that his first day at FEMA was when Hurricane Maria made landfall. FEMA has three main priorities that make up its 5-year strategic plan: building a culture of preparedness; readying the nation for catastrophic disasters; and reducing the complexity of FEMA.

Dr. Kaniewski stated that FEMA has actually re-organized its agency in order to carry out the first priority: building a culture of preparedness. In June of 2018, FEMA launched the FEMA-Resilience organization, which Dr. Kaniewski leads, that for the first time brings together FEMA's preparedness, mitigation, insurance, grants, and continuity programs all under one organization which consists of about 2,500 civil servants, \$3 billion in preparedness grants and mitigation grants, and \$1.2 trillion in insurance coverage through the NFIP. Under the culture of preparedness there are 4 objectives, the first of which is mitigation. One of the country's biggest challenges has been investing upfront prior to a disaster. In many cases that is mitigation. For those that question the value of mitigation, a report from the National Institute of Building Sciences earlier this year updated the return on investment for mitigation. It was 1 to 4 - \$1 invested in federal mitigation grants will save \$4 in response costs; it is now 1 to 6. That makes a very strong case for the notion that mitigation can make a difference. FEMA is doing everything it can to make those investments. For example, after Hurricane Maria, FEMA began mitigation investments in Puerto Rico because the goal is not to just re-build, but to re-build better. FEMA has also put in place a \$10 million code adoption in place in order to bring Puerto Rico's building codes up to 2018 standards. FEMA has also invested \$79 million in a building code enforcement project so that Puerto Rico will be able to hire up to 273 personnel to oversee and enforce building codes. FEMA views those as very worthwhile investments.

Dr. Kaniewski stated that mitigation experts at FEMA and throughout the nation continue to be in close contact with local officials, especially floodplain managers, to provide detailed information and expert advice on repairing and rebuilding those homes in the floodplain. Bringing homes and businesses into compliance with local floodplain ordinances is not only required but may reduce individual flood insurance premiums. To be clear, mitigation does not just save money; it saves lives. Going back to 2001, Tropical Storm Allison hit the Texas Medical Center and caused a great deal of damage. As a result of the Presidential Declaration, it was not just rebuilt, but rebuilt better, and thanks to that mitigation investment, the Texas Medical Center was able to stay open and operating, serving the victims of Hurricane Harvey last year.

Dr. Kaniewski stated that a major piece of legislation recently passed called the Disaster and Recovery Reform Act (DRRA) which is transformative to the field of emergency management. DRRA authorizes FEMA to have a major pre-disaster mitigation program. Many may not realize that currently, FEMA's mitigation funds follow a disaster. In other words, states and local governments are only eligible for mitigation funds after a disaster strikes. Accordingly, DRRA authorizes a major new pre-disaster mitigation program that allows FEMA to provide 6% of all disaster costs as a competitive program across the nation before a disaster strikes.

Dr. Kaniewski further stated that FEMA cares deeply about all types of insurance, not just flood insurance. The insurance gap is huge and the difference between what is insurable and what is currently insured is simply too large. On average, Swiss Re sets losses on natural disasters at \$55 billion each year which is a striking number but when you consider that \$30 billion of that is uninsured, it shows that we have our work cut out

for us. If more than half of disaster losses in this country are not covered by insurance, we have work to do. FEMA is focused on transferring those risks off the individual's back and off the disaster survivor's back and into the private insurance and reinsurance markets. FEMA cannot control a lot of this, only flood, but FEMA believes that through innovative programs and public education programs, FEMA can be a strong partner to NCOIL and other organizations and companies to make this happen.

Nationwide, only 1/3 of those in the highest risk flood areas have flood insurance. Additionally, only 4-5% of American's have flood insurance nationwide. Those numbers signify that we all have a lot of hard work to do. Dr. Kaniewski further stated that 2 out of 3 homes in America are underinsured. Also, only 40% of renters nationwide have insurance. Dr. Kaniewski noted that FEMA's individual assistance programs are offered to those disaster-survivors without insurance. However, using Hurricane Harvey as an example, FEMA put, on average, \$4,000 in the hands of uninsured disaster-survivors, which obviously is not enough money to rebuild a home. The only way to rebuild after a disaster is through insurance. Another FEMA program, the National Flood Insurance Program (NFIP), paid, on average, to Hurricane Harvey survivors with flood insurance \$110,000.

With regard to closing the insurance gap, Dr. Kaniewski stated that state governments have important roles to promote insurance coverage. Obviously, insurance is regulated at the state level but more broadly, state governments should be setting and enforcing building standards and promoting and funding mitigation to reduce these risk exposures. State legislators are in a strong position to partner with FEMA and close the insurance gap by: talking to colleagues and constituents about the value of being insured; working with state insurance leadership to provide effective regulatory environments to foster a private flood insurance market, enabling easier access to purchase affordable flood insurance; and advancing legislation. Legislators should facilitate the development of the private flood insurance market, something which Dr. Kaniewski noted that this Committee is considering.

Legislation passed in North Carolina following Hurricane Florence that places conditions on recovery; prohibits the use of state funds for construction of new residences in hazard areas; and conditions state-funded housing assistance in those areas on a homeowner obtaining flood insurance. Additionally, a constitutional amendment was passed in Virginia that set forth tax exemptions for real property that is subject to recurrent flooding if improvements have been made on the property to address the flooding. Numerous other states have laws that require disclosure of a property's flood-risk and flood-loss history before completing a sale; that is a key way to help homeowners and renters understand their true flood-risk.

There are also great ways to partner with Insurance Commissioners and state emergency managers. Dr. Kaniewski stated that one of the most worthwhile conversations he has had since his time in his current position has been with state emergency managers and explaining to them that they need to have a positive relationship with state insurance commissioners. Unfortunately, many of those state emergency managers had no idea who their insurance commissioner was. FEMA has been fostering dialogue and discussion through the 10 FEMA-regions, which can be more productive when state insurance commissioners and state emergency managers are present. In many of those regions, such discussions have been a huge success because FEMA has been able to convene those groups towards a common interest:

reducing disaster losses and increasing the resilience of the American public, largely through insurance.

Dr. Kaniewski stated that the private flood insurance market is key to closing the nation's insurance gap. The private flood insurance market does exist but is much less robust than the NFIP, especially in areas with the highest flood-risk. According to recent analysis, 14% of residential and commercial flood insurance policies are placed through the private market, 4% of which are residential. There is tremendous growth in the private flood insurance market as some of the estimates range from 50% and up to a 130% increase in activity between 2016 and 2017. FEMA's goal is to double the number of its insurance policies by 2022. Meeting that goal will be very difficult. Meeting the goal of doubling the number of policies nationwide through all types of avenues, including the private market, is eminently achievable.

Dr. Kaniewski stated that FEMA agrees that growth in the private flood insurance market and improving the NFIP are both important to expanding coverage. While FEMA does not have a regulatory role with respect to the private flood insurance market, FEMA does want to facilitate said market's growth, and FEMA has taken actions to do so. First, FEMA has recently included a change that allows write-your-own (WYO) companies to also sell competing private flood insurance policies. Second, FEMA is working with the insurance industry to share more data, including access to NFIP policy and historical claims data while of course being cognizant of federal regulations that touch upon privacy concerns. Third, FEMA is funding research to determine the best ways to move forward to close the insurance gap, including consideration of the private market. For example, in September, the Wharton Risk Management Center, using FEMA funding, published a report on the state of Florida's private residential flood market. The report addresses Florida's unique regulatory environment that reflects statutory changes adopted by the Florida legislature.

Dr. Kaniewski stated that FEMA believes private insurers can play a vital role in closing the nation's insurance gap. Helping customers understand the risks they face for all disasters and taking action to protect the lives they have built by means of insurance is very important. Providing customers with options and resources to mitigate their homes to bring down the cost of insurance should also be a priority. FEMA has also taken efforts to share the importance of flood insurance through existing networks and marketing channels by way of social media and distributing materials. FEMA would appreciate state legislators helping those efforts go viral.

Private insurers can bring the expertise and innovation to longstanding challenges around the product such as distribution and accumulation risk which the industry must solve to help the nation better manage risk. Dr. Kaniewski also stated that FEMA is very focused on individual preparedness, notably financial preparedness for disasters. For example, the Federal Reserve recently conducted a study that found that only 44% of Americans can put their hands on \$400 in the case of an emergency. Those that fall within that 44% will, in the case of a disaster, be completely reliant on state and local governments and FEMA. FEMA recently put out an emergency financial first-aid kit which can be found at [ready.gov](https://www.ready.gov). To improve its overall financial preparedness department, FEMA partnered with a non-governmental organization called Operation Hope to focus on financial literacy and financial education. FEMA believes that financial preparedness is a key part of financial education and financial literacy. To that end, FEMA is partnering with non-governmental organizations including the private sector,

financial services organizations, and the insurance industry, to implement pilot programs and test behavioral economics models such as nudging, and other ways to show Americans not only why they need to be financially prepared, which includes having insurance, but how they can do that.

Rep. George Keiser (ND) asked what the current financial status of the NFIP is, and what is Congress' attitude going forward regarding continuation of funding for the NFIP. Dr. Kaniewski stated that FEMA continues to confront many challenges with the NFIP, the biggest being the program's debt. The program is not going to get out of debt anytime soon and certainly not without major action by Congress. Even if tomorrow there were to be risk-adjusted rates, an affordability program, or increase in NFIP accessibility and availability, the program would not be out of debt. FEMA is looking for Congress to give them the necessary reforms FEMA has been asking for which would enable the NFIP to operate much more like a private sector insurer, and help meet the goal of having a robust private flood insurance market.

The NFIP is currently operating under a short-term re-authorization, but a long-term re-authorization is needed, something which Dr. Kaniewski urged the Committee members to advocate for because a long-term re-authorization would provide everyone some time to figure out the best strategy going forward. FEMA has been unsuccessful in the past several decades in trying to reform the NFIP and FEMA's actions and efforts to work with Congress have failed. Accordingly, support is needed to re-authorize the NFIP on a long-term basis and some thinking and analysis is necessary to propose a "gamechanger" similar to how the DRRRA was a "gamechanger" for mitigation.

Rep. Matt Lehman (IN), Acting Chair of the Committee and NCOIL Treasurer, stated that in meetings with members of Congress during NCOIL's D.C. fly-in this past June, the issue consistently brought up was that there has never been a true long-term plan with the NFIP and now that it has gone deeper into debt the extensions continue to get shorter and sometimes even bargains occur with the extension. One of the main issues discussed was that a 5-year extension and a plan to get the NFIP back on track is needed and that is something that NCOIL needs to continue to be engaged with. Rep. Lehman stated that the NFIP is broken and short-term extensions are not the answer. The program needs to be re-evaluated and perhaps the private market needs to be more involved because an affordability problem has been created. Rep. Lehman stated that one of his clients is refinancing his home and must obtain a flood insurance policy and his homeowners' policy is \$700 per year. The client is in a floodplain and his flood premium is \$2,700 per year and for him to try and understand why the disparity in cost between perils exists is very difficult.

Rep. Lehman then asked Dr. Kaniewski if there has ever been a discussion on where we build homes. If you look at certain beachfront areas, the expansion of multimillion-dollar homes and condominiums has increased dramatically over the years. Accordingly, one cannot be surprised to have billions of dollars in losses when you build where hurricanes are problematic. Dr. Kaniewski stated that FEMA welcomes the longest NFIP-extension that it can get and FEMA is ambitious in asking for 1 year, but FEMA believes that at least a 1 year extension is needed to come up with an appropriate strategy to fix the program. With regard to re-building in problematic areas, Dr. Kaniewski stated that is certainly a topic of discussion within FEMA and he is hopeful that local communities across the country are having that discussion. Unfortunately, FEMA has no ability to force those conversations, much less the ability to force homeowners to move out of

certain homes. Zoning is handled at the local level in addition building code standards. FEMA does have some tools available to incentivize homeowners from a flood insurance severe repetitive loss perspective. In those instances, FEMA has the ability to draw on additional funding from different programs through buyouts, re-locations, elevations, but the amount of funding in those programs is very small and there is no way FEMA by itself can solve the problem.

Rep. Keiser stated that Biggert-Waters was a clear demonstration that actuarially sound underwriting is not going to work for the NFIP. Rep. Keiser further stated that he hopes Dr. Kaniewski and FEMA understand that states and local communities have made tremendous programs in zoning and mitigation. Is there any discussion with Congress that would create a tax credit for personal property owner's mitigation actions similar to the green tax credit which had an amazing impact? Dr. Kaniewski stated that there are many discussions with Congress about how it can incentivize mitigation and right now, FEMA is focused on implementing the program just authorized, DRRRA, which is a gamechanger for mitigation.

DISCUSSION ON THE DEVELOPMENT OF MODEL LEGISLATION IN RESPONSE TO THE AMERICAN LAW INSTITUTE'S RESTATEMENT OF THE LAW OF LIABILITY INSURANCE

Rep. Lehman provided some background on NCOIL's involvement with the American Law Institute's (ALI) Liability Insurance Restatement (Restatement) and stated that NCOIL is at a time now where NCOIL must narrow its focus and decide how best to proceed.

Erin Collins, Asst. Vice President – State Affairs of the National Association of Mutual Insurance Companies (NAMIC) stated that the Restatement has been a topic of discussion within the industry for years as it pertains to the business of insurance. The ALI is an organization that has a long and storied history and part of their role is to issue Restatements of Law which is an academic undertaking of looking at the law in a particular area and then creating a Restatement of it for use by the courts. Restatements are supposed to a re-statement of what the law and public policy is on a particular issue. In the last few years, some of the ALI's Restatements have morphed to be somewhat of an aspirational document, moving more towards what the ALI believes the law should be. That transformation is reflected in this Restatement.

Ms. Collins stated that this Restatement has been a 5-year project for the ALI and interested parties, including NCOIL, have raised multiple concerns throughout the entire process, citing instances where the Restatement is not only aspirational, but in some instances completely inaccurate in certain areas and therefore constituted a usurpation of state legislative authority. As of May, the ALI adopted the Restatement with some changes but not all concerns have been addressed. The ALI is now in its "technical review period" whereby the Restatement has been adopted but certain editorial changes can occur, which the industry believes can be positive.

Ms. Collins stated that from NAMIC's perspective, after the Restatement is published there will still be areas of concern that will need to be addressed for years to come in different ways in different states. NAMIC does not believe that there is a "silver bullet" fix to the Restatement or a one-size-fits-all approach. If NCOIL has an appetite for a Model-law response to the Restatement after the Restatement is final, NAMIC believes

that such a response should be multi-faceted so that states can determine which approach is more appropriate for their state, whether it be a Resolution or a bill that disavows the Restatement in its entirety. NAMIC does not believe that there is a singular approach that would be appropriate in all 50 states.

Ron Jackson, Vice President – State Affairs Southeast Region of the American Insurance Association (AIA) echoed Ms. Collins' statements and thanked NCOIL for its involvement with the Restatement. Mr. Jackson also noted that the process surrounding the Restatement is odd in that the ALI has adopted it but still can make certain changes to it during the "technical review period." It would certainly be odd if a state legislature operated in that manner whereby it passed a law and then made changes to it after it was sent to the Governor's desk. Mr. Jackson noted that in 2018, two states enacted legislation in response to the Restatement that took different approaches. Tennessee passed a law that only dealt with stating what the "plain meaning" rule is under Tennessee law; Ohio passed a law that stated that the Restatement was not the public policy of Ohio.

Mr. Jackson stated that AIA looks forward to working with NCOIL on this issue in 2019 and that careful deliberations will be needed to decide the form and substance of what NCOIL's response will be, in addition to determining which states to take action in. As stated in prior meetings when responding to the ALI's assertion that the Restatement was necessary to respond to states that do not have settled law on a certain issue, a state legislature's decision to not pass a law on a certain topic is equally an exercise of the legislative prerogative as is passing a law. For that reason, Mr. Jackson stated that a legislative response may not be seen in all 50 states and it will be difficult to try and craft a response suited to all states.

Frank O'Brien, Vice President – State Gov't Relations of the Property & Casualty Insurance Ass'n of America (PCI), thanked NCOIL for its steady involvement with these issues and noted that NCOIL has had a direct and tangible impact on both the course of consideration of the Restatement as well as an impact on some of its provisions. That is an extraordinary accomplishment. The window for public comment on the Restatement is closing rapidly as the "technical review period" is almost finished and therefore the Restatement will soon be final and "out there." Mr. O'Brien requested that NCOIL continue to be engaged with the Restatement and continue to move forward with thoughtful debate and consideration.

Over the course of the next year, PCI is hopeful that the Restatement will continue to be an agenda topic for this Committee and that the Committee will consider a range of options as to what form its work will take to represent the state insurance legislator perspective. NCOIL has typically responded to issues like the Restatement with either a Model Law, Resolution, or series of Best Practices. In this particular instance, since this issue is national in scope and its impact on the legal community and insurance marketplace can only be surmised, PCI urges NCOIL to carefully consider a range of options as to how it should respond because its response will be more magnified due to the level of impact it already has had on the Restatement.

Rep. Lehman stated that part of the difficulty with a response from NCOIL in the form of a Model Law is that there is such a wide range of ways in which states might want to proceed with their response, as evidenced by the differences between the Tennessee and Ohio approach. Accordingly, a Resolution may be the better way to proceed and

Rep. Lehman asked if there are specific provisions of the Restatement that should be addressed in it. Ms. Collins replied yes and stated that there are multiple areas in which industry believes that the Restatement deviates from certain statutory law. It is hard to say at this point which provisions should be specifically addressed because the ALI's "technical review period" is still ongoing, but a couple of possibilities would be the plain meaning rule and language permitting someone who is unhappy with their counsel to sue the insurance company for its selection of counsel. Another provision relates to interpretations of an insurance policy that involves principles of contract law. Ms. Collins stated that she believes at last count there were 8 remaining issues within the Restatement that were problematic, some of which may be difficult to address in a targeted fashion like Tennessee did with the plain-meaning rule.

Mr. Jackson noted that a document is in the midst of being prepared that pinpoints all of the remaining problematic provisions of the Restatement, one of which relates to rescission of an insurance policy in instances where the policyholder made a "substantial" misrepresentation; the use of the word "substantial" has been very controversial.

Rep. Lehman asked if there is a known date by which the ALI will be finished with its "technical review period." Mr. O'Brien stated no and that the entire process is very opaque. Mr. Jackson stated that industry has heard possible dates of "late 2018/early 2019" but no one is certain. Mr. O'Brien again noted that NCOIL should continue discussing the Restatement in 2019 due to the impact NCOIL has had on the Restatement and the credibility NCOIL has gained with the ALI.

Rep. Keiser stated that the Restatement represents a process that must be stopped and noted that just as the window is closing in on the ALI's "technical review period", the window is therefore closing on state legislatures and NCOIL to respond appropriately. Rep. Keiser stated that there should be some sort of language that can be introduced which states that the ALI cannot go beyond the intent or statement of law that the legislature has created. North Dakota already has a system in place to address that. Rep. Joseph Fischer (KY) agreed with Rep. Keiser and stated that even if all of the remaining problematic provisions within the Restatement have not yet been finalized, a list of issues should be presented to Committee members so that when they start session in 2019 they can examine them further in their respective states. Rep. Fischer stated that he has discussed this with several Appellate judges who have stated that the ALI does not have as much credibility as it used to have. Rep. Fischer stated that in the age of Westlaw and other research tools, the Restatement is therefore not as important as it once was and seems to be more aspirational in nature.

Prof. Daniel Schwarcz of the University of Minnesota Law School, and an advisor on the Restatement, stated that some of the statements made to the committee are not accurate regarding the nature of a Restatement and some of the provisions of this Restatement. The first thing to recognize is that most of the rules in the Restatement do not deal with anything that is statutory; rather, they deal with issues from judge-made law that are not clear. In those contexts, courts find it sometimes useful to utilize a Restatement and sometimes don't. It is not accurate to say that Restatements have been summations of majority law. Historically, Restatements have looked at what trends are in certain areas. Also, no one has suggested that judges and courts are somehow bound by Restatements. The only place where a Restatement is likely to influence the law is where no statute or binding court opinion exists on a certain issue. In those

contexts, it can be difficult to only utilize Westlaw because courts often rule in ways that are opaque and distinguishable and therefore the Restatement can be a useful summation. Prof. Schwarcz stated that there is risk that NCOIL is actually impeding on judicial authority as it is not always appropriate to tell courts how to rule on common-law issues. Statutes don't exist on certain issues because they can be extremely complex and it is the appropriate prerogative of courts to decide them.

Rep. Lehman stated that some of the concern relates to the plain-meaning rule. As an example: birds poked holes in someone's house and birds are excluded under the policy but the adjuster said if rocks were thrown at the house, that would be covered. In the policyholder's world he thinks the bird damage should be covered because the bird damage envisioned by the policy exclusion related to long-term bird damage such as nesting. Can the court then rule in favor of the policyholder due to the vagueness of the Restatement's plain-meaning provisions? Prof. Schwarcz stated that it would be reversible error to follow a rule in the Restatement if there was already binding authority in a state on that rule that was different. The reason for the Restatement is to inform people of different approaches and trends. There are areas in which the Restatement can affect how the law on a certain issue may evolve but that is only going to happen if there is not binding precedent on an issue in a state. A court cannot adopt a Restatement-view if there is binding precedence to the contrary.

Rep. Fischer disagreed with Prof. Schwarcz in that any state Supreme Court can change the binding precedent that exists on an issue and the Restatement does have some aspirational impact on the Supreme Court of certain states with respect to interpretation of certain issues. In that respect, inaccurate Restatements can be dangerous and it is therefore important for NCOIL to stay involved with this issue. Additionally, the legislature is always free to challenge common-law rules through legislation however longstanding the rules may be. Rep. Lehman noted that in 49 states pollution-exclusion language was ok, but Indiana's language was ruled unconstitutional as vague, and agreed with Rep. Fischer's point that a state Supreme Court is powerful and can always change certain things.

Rep. Keiser also noted that rather than set policy, the ALI could have visited certain states and presented legislatures with certain issues that have not been addressed through statutes and recommended that they should be. Rep. Lehman closed by stating that he agreed with Rep. Keiser's earlier statement that the window is closing for state legislatures and NCOIL to act on the Restatement. It appears that one NCOIL Model Law may not be able to meet the needs of each state and NCOIL therefore must consider the best way to proceed as to how to offer states with an effective work product. This issue needs to be a priority and hopefully by the NCOIL Spring Meeting in March, a clear draft of a Resolution or other work product can be presented. Until then, if other states start to act and a certain approach begins to develop, a Model Law may then be a good approach.

DISCUSSION ON THE RISKS ASSOCIATED WITH AND INSURANCE ISSUES RELATED TO "LAST MILE" SCOOTERS

Ashley Scott, Policy Counsel for Lime, stated that Lime is approximately 1.5 years old, is supportive of free-movement, and focused on last and first-mile transportation solutions. That means if you are a commuter and get off a bus stop or train stop – how do you get to your next location? Lime aims to fill that gap and provide additional technology to

provide additional first and last-mile transportation solutions to cities. Ms. Scott stated that as urban centers grow more dense and there is more congestion, getting more cars off the road is important. Some statistics that drive Lime include: there is 333 million tons of carbon dioxide emitted from cars annually; 45% of Americans have no access to public transportation; and the average U.S. driver spends about 41 hours per year in their car in congestion.

In an effort to create new transportation frontiers and create more first and last-mile transportation options, Ms. Scott stated that Lime offers a fleet of multiple devices such as pedal bicycles, electrical assisted bicycles, as well as electric scooters. Most recently, Lime launched a free-floating car-sharing program, Lime Pod. Lime is the world's largest multi-model last-mile and micro-mobility transportation provider. Some sticking points for state legislators and municipal officials to consider are that unlike other industries such as docked bike-share providers, or traditional commuter transportation methods such as rail lines or bus stops, Lime does not require any initial public funding. Lime provides all of the product and places the product. There is some financial investment when it comes to administration of permits and enforcement of rules and regulatory frameworks but there is no initial investment for cities so it provides cities with a great opportunity to partner with operators in order to create and provide a new form of transportation for its citizens. Lime is an American-based company and was founded and funded in the Bay area and has a multi-model fleet. Lime also put a large emphasis on equity in terms of providing mobility options for low and moderate income people.

Ms. Scott stated that it can be recognized that in many municipalities and cities that are pockets and areas where there are transportation deserts in that hardly any train or bus stops exist. Lime has noticed from its data that people within those areas utilize Lime's transportation options the most to get into economic hubs and get into city centers. Lime also contributes to solving other issues that cities face such as low housing stock or access to jobs – transportation is key to financial freedom. Lime is proud to say that it contributes to free movement and moving the needle on those issues. Ms. Scott also noted that Lime is disbursed throughout the country.

Ms. Scott stated that what sets Lime apart from other operators is that Lime is fully committed to sustainability and Lime's entire foundation is based on providing options to create a more sustainable environment in all cities. Every ride is carbon-neutral and Lime has a goal to be completely carbon-free within its operations. Ms. Scott further stated that safety is a very important issue for Lime and is not an elephant in the room that it tries to divert its eyes from. Lime is tackling safety issues head-on and has launched a "Respect the Ride" PSA campaign that focuses on creating and educating rider behavior, and also educating car drivers to share the road with new technologies. Issues related to last-mile transportation are not going to go away so Lime is focused on efforts to change the culture of cities to allow all forms of transportation and movement.

Ms. Scott stated that Lime is dedicated to enhancing lives and communities and looks forward to partnering with state legislators and municipal officials to ensure that Lime is part of city and town sustainability plans moving forward. Lime is also focused on increasing transit access, reducing traffic congestion, and hiring locally to create localized economic opportunities for cities and towns and gain knowledge of the specific needs of certain cities and towns.

Ms. Scott stated that in San Francisco, Lime has had 300,000 total rides on their electronic scooters. 53% of riders said they might have used a car if they had not taken a Lime scooter. 39% of riders said that they used Lime to connect to or from public transit during their most recent trip. In Washington, D.C., Lime had 100,000 “unique” riders which means that they were not repeat-users. Lime is at a point now where it would like to start a dialogue with state legislators and municipal officials that centers on insurance issues. Transportation ridesharing is a relatively new industry and as such there is very limited actuarial data available for benchmarking. Scooter sharing is even more limited as there are very few companies that focus specifically on that type of shared economy so it becomes important to ask what is the “close cousin” of escooters? That speaks to many issues on the state level directly related to vehicle classification.

Accordingly, Ms. Scott discussed some important questions to ask when framing the discussion to create policy relating to Lime and other similar companies. What are comparable industries? Ms. Scott noted that Lime’s position is that its scooters are not on the same level playing field as cars as they travel at a speed comparable to the top speed a bicycle can reach so the goal is to start the conversation of how best to create the standards that make sense for the industry. Ms. Scott stated that she has seen the full spectrum of ordinances and permit structures within municipal cities. In many instances, they have regulated Lime in terms of insurance more in-depth than they have with car-sharing services.

What are cities concerns? Lime understands that cities are concerned about the safety of its citizens and ensuring that companies can meet those safety concerns and have coverage to cover loss and damage that is a direct result of company business operations. How do we create a reasonable standard? Ms. Scott noted that the questions she laid out are all open-ended questions but the most important thing is to start the dialogue and engage organizations like NCOIL to answer the questions appropriately. In order to bring all the pertinent voices to the table, Lime is willing to engage with cities and states and attend conferences such as this one to answer the questions that are at the forefront of the minds of legislators and regulators. Ms. Scott noted that Lime is currently primarily regulated at the municipal level so that means Lime is getting insurance requirements that run the gamut. One city only requires commercial general liability coverage. Another city asked for individual motor vehicle policies for each of the scooters. Cyber insurance, workers’ compensation insurance, errors and omissions insurance, and personal advertising insurance have also been raised by other cities. Ms. Scott stated that all of those issues being brought forth creates a friction between cities that may even be bordering each other in terms of what Lime must do to meet certain policy requirements.

Ms. Scott stated that most of the regulatory structures that Lime encounters that pertain to insurance are housed in municipal permits or MOUs that Lime enters into with cities. Each municipality or municipal official has been outlining coverage requirements and they have not been able to point to anything at the state level that provides them with guidance in creating the requirements. Lime’s biggest concern is a lack of uniformity and Lime would like to create some type of best practices that takes into account all of the pertinent opinions. Lime’s goal is to provide insurance coverage that comprehensively covers its business operations and riders; create indemnification provisions to protect municipal partners; serve as a partner to provide a global view of the insurance landscape for the industry; and starting a dialogue with state insurance

legislators and regulators in order to communicate the nature of the industry to create smart, common sense policy. Lime will travel to wherever is needed to start those conversations.

Paul Martin, Regional Vice President – Southwestern Region, of NAMIC stated that NAMIC agrees with Lime’s goal of starting a dialogue on these issues because, oftentimes when new transportation technology such as last-mile scooters are introduced, the perception is that industry is opposed to it, but that is not the case. However, NAMIC believes that there are some issues that state insurance legislators and regulators need to be aware of going forward as they start making policy. Mr. Martin stated that he recently contacted his insurance agent to ask if, when on a last-mile scooter, he was covered by a homeowner’s policy, auto policy or umbrella policy; the agent replied “no” to all of those policies. Regardless of that unresolved issue, Mr. Martin stated that he believes the technology has several benefits and he enjoys it.

Mr. Martin noted that the initial tendency thus far has been to compare the last-mile scooters to transportation network companies (TNCs) such as Uber and Lyft but besides the scooters being app-based and related to transportation, there are not too many similarities. Unlike a TNC vehicle where a personal auto policy is in effect for most of the time it is on the road except when engaged in TNC operations, there is no equivalent for last-mile scooters.

Mr. Martin then noted that there are some claim scenarios for the Committee to consider as the dialogue progresses: a.) liability issues when a scooter operator hits someone/something and does damage to them/the property; b.) how state comparative fault statutes come into play when a scooter operator is negligent and they cause an automobile driver to swerve and cause an accident; c.) damage to the scooter itself from riding into a pot-hole; d.) premises liability issues that can arise from recharging a scooter in a home/apartment. If a fire were to start and cause damage, would that be covered under a homeowner’s/renters policy if the re-charging process is deemed to be a commercial activity?; e.) someone tripping over a scooter parked on a sidewalk; and f.) premises liability issues arising from when businesses allow scooters to be left there and someone trips over one outside the premises. The same issue arises for businesses who do not allow scooters to be left outside its premises.

Mr. Martin stated that those insurance issues don’t seem insurmountable, and legislation dealing with last-mile scooters is expected to be introduced in state legislatures in 2019, thereby creating preemption issues relating to states and municipalities.

Rep. Lehman closed by stating that the last-mile scooters are just the tip of the iceberg in the sense that the larger issue is the sharing economy. The beauty of America is that people can use things in ways that the insurance industry never thought of and therefore the industry is going to have to respond accordingly. Rep. Lehman stated that he is not sure if a legislative or insurance policy solution is needed. Using the TNC issue as an example, the TNC and taxi industries did not want to meet in the middle and he hopes that the issues surrounding last-mile scooters can be dealt with better. Rep. Lehman stated that he hopes NCOIL will continue to stay involved with these issues in 2019 and beyond.

RE-ADOPTION OF STATE FLOOD DISASTER MITIGATION AND RELIEF MODEL ACT

Rep. Lehman noted that at the recent NCOIL Summer Meeting in Salt Lake City, the Committee had re-adopted the NCOIL State Flood Disaster Mitigation and Relief Model Act (Model) until this meeting in anticipation that Rep. David Santiago (FL), Vice Chair of the Committee, would be finished with proposed amendments to the Model. However, since he was not able to attend this meeting, the proposed amendments are not ready for consideration and the Model therefore needs to be re-adopted until the Spring Meeting in March so that Rep. Santiago and others can continue work on the amendments. Upon a Motion made by Rep. Keiser and seconded by Rep. Fischer, the Committee voted without objection by way of a voice vote to re-adopt the Model until the Spring Meeting

INTRODUCTION OF PROPOSED INSURANCE MODERNIZATION CONCEPTS

Rep. Lehman stated that some members of the Committee and NCOIL staff had received some interest earlier in the year as to how the market is ripe for some “clean up” legislation in terms of getting the industry to move past some outdated ways of doing business. For instance, some states still don’t have legislation on the books that allow the option of getting electronic notices from insurers; they require paper.

Therefore, Rep. Lehman stated that for 2019 a good topic for this Committee, and NCOIL in general, is to discuss some type of an “Insurance Modernization” Model Law that could address issues similar to the “electronic notice option” issue in terms of cleaning up certain sections of state insurance codes that may have been left behind and forgotten as the insurance industry continues to rapidly innovate. Rep. Lehman encouraged Committee members and representatives from all lines of insurance to contact the NCOIL national office with ideas and recommendations as to what could be put in such a Model.

Similarly, Rep. Lehman noted that another issue that he hopes the Committee can consider going forward is rebating laws and how there are different standards in different states. Rep. Lehman stated that it is his understanding that the NAIC is open to having a dialogue on that issue and therefore challenged the Committee to start the process of a possible NCOIL Model Law to promote rebate law uniformity.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
OKLAHOMA CITY, OKLAHOMA
DECEMBER 8, 2018
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Renaissance Oklahoma City Convention Center Hotel in Oklahoma City, Oklahoma on Saturday, December 8, 2018 at 10:15 a.m.

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

Other members of the Committees present were:

Sen. Jason Rapert (AR)	Asw. Pamela Hunter (NY)
Asm. Ken Cooley (CA)	Rep. Lewis Moore (OK)
Rep. Matt Lehman (IN)	Rep. Tom Oliverson, M.D. (TX)
Rep. Steve Riggs (KY)	

Other legislators present were:

Rep. Sam Kito (AK)	Sen. Gary Dahms (MN)
Rep. Deborah Ferguson (AR)	Sen. Paul Utke (MN)
Sen. Travis Holdman (IN)	Asm. Kevin Cahill (NY)
Sen. Dan "Blade" Morrish (LA)	Sen. Paul Wieland (MO)

Also in attendance were:

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

DISCUSSION/CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL MODEL ACT ON WORKERS' COMPENSATION REPACKAGED PHARMACEUTICAL REIMBURSEMENT RATES

Karl Aumann, Chair of the Maryland Workers' Compensation Commission (MWCC), stated that he is in his 14th year as Chair of the MWCC and an interesting aspect of workers' compensation systems across the country is that it is very difficult to come up with a single way to approach a problem. It is nevertheless critical that problems be identified, as well as solutions for them. He continued that NCOIL is one such organization that aims to find such solutions and others include the International Association of Industrial Accident Boards and Commissions (IAIBC), the Southern Association of Workers' Compensation Administrators (SAWCA), and the National Association of Workers' Compensation Judiciary (NAWCJ) that do their best to try and fix these common problems as they arise.

Mr. Aumann stated further that in an effort to analyze prescriptions and the costs and issues associated with physician dispensing and compounds, one organization undertook to conduct a study. In Maryland in 2010, the MWCC was presented with the results of that study, which indicated that close to 40% of all of the prescriptions that

were being used in workers comp were being dispensed by the doctors directly, not by pharmacies or pharmacy benefit managers (PBMs). Mr. Aumann stated that he sat at that meeting and was astonished because he thought with that kind of a percentage, why had the MWCC not been apprised of this before; why had the insurers not come in and said this is a terrible situation that needs to be fixed?

The MWCC then endeavored to take some steps to fix the problem by introducing regulations that would cap prices, but that was met with serious resistance by the state medical society and by many in the legislature. Therefore, the MWCC's proposed legislation was defeated, which was very unusual in the context of that process. That caused the MWCC to turn around and determine how to figure out solving this problem in another way.

Mr. Aumann stated that the MWCC then came to an interesting understanding that the problem was not as big as they were first led to believe. After digging down deeper into the facts of the initial report, which had stated that 40% of all of the prescriptions that were being used in workers comp were being dispensed by the doctors directly, not by pharmacies or PBMs, MWCC started talking with insurers and with people in the community who were incredulous in saying that they were not having that experience and they were not seeing that high of a number.

The MWCC therefore endeavored to conduct its own study, in part because the original study presented to the MWCC only included a certain subset of the data available. The MWCC determined that it needed to get all of the data from the self-insureds, from the people who had workers' compensation insurance policies available from the market, and from the captive state agency which at that point in time issued about 30 to 35% of the workers' compensation policies in Maryland.

Mr. Aumann stated that after gleaning through all of that data through the course of a year, MWCC determined that the real percentage of prescriptions being dispensed by doctors directly was about 18%. MWCC has followed that percentage subsequently and it is now down to about 15%, which is a small increment of reduction, but nonetheless, a reduction in the percentage of prescriptions that are being dispensed by the doctors. With regard to the lessons that the MWCC took from the process, Mr. Aumann stated that it is first and foremost important to identify the problem and then identify the problem as it pertains to a particular state. The comparisons to neighboring states or similarly situated states with respect to this problem don't have the same weight. MWCC also learned that getting all of the relevant data about physician dispensing and the costs associated with it in your own jurisdiction is extremely important.

Mr. Aumann reiterated that every state has its own rules with respect to workers' compensation and that makes each situation unique. It is important to make sure that those particular facts are taken into account when trying to solve a problem. For example, North Dakota and Ohio are two of about a handful of states at most that are monopolistic states because they require employers to purchase workers' compensation coverage from a government-operated insurance fund. Every state has its own approach to solving certain problems and you have to tailor the solution to a problem to the facts that you have in your own particular state.

Mr. Aumann stated that Maryland is what is referred to as claimant-choice state. The claimants get to pick their own doctors and there is no review board on selection of who

it is that can treat, and it is a very different system than many other states that have boards or provide for employers getting to select who the treating physicians are. That has a big impact on how you can go about implementing some controls on costs and on physician dispensing generally.

Mr. Aumann continued by noting that one thing that Maryland has experienced that he believes has been enormously helpful is that the state legislature instituted a prescription drug monitoring program (PDMP) about 3 years ago and the implementation of that process has really helped across the board because it was not limited to just workers' compensation prescriptions; it was across the board that everybody who was prescribing and dispensing needed to report to a database. That has been really helpful.

Additionally, one of the biggest components that was learned in Maryland throughout the process of examining these issues was that physicians were dispensing opioids at an alarming rate, in large measure because the marketing that went into the descriptions of those opioids was that they were a fail-safe problem and that they were not going to be addictive. Therefore, there needed to be a re-education process and an awareness on the part of all physicians and the healthcare providers in Maryland that these issues need to be paid attention to.

Mr. Aumann stated that another component that has been very helpful in Maryland when dealing with these issues is to get the buy-in from the carriers and from the folks who are handling the claims, the adjusters. They see what is happening on the front-end and what is being prescribed. The MWCC made it clear to them that if there was a problem in that they viewed an abuse of some type prescription practice, they should bring news of the problem to the MWCC. The MWCC can then listen to the problem, have all of the facts laid out, and determine if it is or is not an appropriate use of that particular prescription.

Mr. Aumann stated that the situation as a whole is still not fixed, obviously, as there are still people dying from opioids after being prescribed them for totally legitimate reasons. However, the community and stakeholders have come together to try and fix the problem and everyone is hopeful that strides that can continue to be made not only in reducing the financial cost, but the human cost that results from when prescriptions are overprescribed.

Mr. Aumann stated that he is very active with SAWCA and the IAIBC and noted that workers' compensation administrators are dealing with this across the country. One solution Mr. Aumann stated that he had heard about was finding the average wholesale price (AWP) of a drug and then applying it so that you could not charge more than a certain amount which is something that is referenced in the proposed amendments to the existing NCOIL Model before the Committee today. Mr. Aumann stated that one of the things that struck a chord with him at a hearing he attended was that some drug manufacturers were being purchased and therefore the AWP became fictitious because the new owners of the drug manufacturers could create their own AWP because they were the manufacturer of the drug. Accordingly, methods are always being crafted to try and maneuver around legitimate ways to fix the problem and Mr. Aumann stated that the issue must be looked at carefully to make sure that the states have the ability to make what works in their own jurisdictions available to them. Mr. Aumann stated that there is not a single piece of legislation that will work in all of the states. A solution has to be finely tuned to what's happening in particular jurisdictions.

Rep. Tom Oliverson, M.D. (TX) asked Mr. Aumann to comment on his experience in Maryland with drug compounding in workers' compensation as Rep. Oliverson has been hearing some things in Texas relating to how a pharmacist, physician or facility is basically combining any drugs they want to and sometimes it can result in a lethal dose of something that is put into something harmless such as Bengay.

Mr. Aumann stated that drug compounding is a problem in Maryland and is an offshoot of a way to get around certain rules because sometimes if you use prescriptions that are compounded then they fall outside of a classical AWP prescription and then they can charge whatever price they want to. Mr. Aumann stated that in Maryland, they found that coordinating with the adjusters and insurers closely to make them aware of the situation really helps. In Maryland there was a situation when conducting an annual study where a very large county was noticed to have what MWCC viewed as a big jump in the payment of prescriptions that were compounded. Mr. Aumann stated that he called the County Executive and asked him if he was aware of the big jump in the county's costs and notified him that it was a big problem.

Mr. Aumann further stated that the MWCC does not hesitate to contact insurers when monitoring these issues to discuss a big jump in drug compounding or opioid prescriptions. Mr. Aumann noted that he believes that physician dispensing of opioids is not as big of a problem as it used to be because there are so many rules associated with keeping it safe and many physicians don't want the hassle of keeping it in their offices because of all of the rules associated with securing those drugs. However, the compounding issue is something that Mr. Aumann believes is growing and it is important to go after the source, the adjusters, who are on the front lines, and notify them of what may be an inappropriate drug used in certain instances and contest its use in whatever form that the states have available.

Mr. Aumann noted that he has a special docket that is set up just on prescriptions and medical treatment so if the carriers and adjusters know that if they have a problem, that within 30 days they can get on the docket and have that problem fixed or at least addressed.

Sen. Klein asked Mr. Aumann if Maryland has adopted anything similar to what is in the proposed NCOIL amendments to address physician dispensing and drug compounding. Mr. Aumann replied no and stated that the original regulations that the MWCC sought to institute in 2010 would have expanded the existing medical fee guide to include prescriptions. That proposal was rejected but what is in the current Maryland statute is a requirement that the cost for prescriptions has to be in the usual and customary range and that becomes the lynchpin for reviewing whether the costs are appropriate or not and then testimony is taken if necessary that states what pharmacies and PBMs charge, and if the cost is beyond that then there will be an order issued saying that only a certain amount of money will be paid to the prescriber regardless of whether the prescriptions have already been dispensed or not.

Sen. Klein then noted that the proposed amendments to the Model have been on the agenda for several meetings but that the sponsor of the amendments - Rep. Marguerite Quinn (PA) - was not able to attend this meeting. Accordingly, Sen. Klein, as Acting Chair of the Committee, asked the Committee for guidance as to whether the Committee should move forward with a Motion to adopt the amendments. If the Committee declined to vote on the amendments, the proposed amendments would be kept on the agenda

again until the Spring Meeting in Nashville. Sen. Klein again asked for guidance from the Committee as to how it would like to proceed.

Rep. Oliverson then made a Motion to adopt the proposed amendments which was seconded by Asm. Ken Cooley (CA) – NCOIL Secretary. Sen. Klein noted that, pursuant to NCOIL's bylaws, the quorum needed to be waived in order to vote on matters before the committee. A motion was made by Rep. Oliverson to waive the quorum requirement which was seconded by Rep. Sam Kito (AK). The Motion carried without objection by way of a voice vote. Sen. Klein then returned to Rep. Oliverson's Motion to adopt the proposed amendments which also carried without objection by way of a voice vote.

MINUTES

Upon a Motion made by Asm. Cooley and seconded by Asw. Pam Hunter (NY), the committee approved the minutes from its July 13, 2018 meeting in Salt Lake City.

ADJOURNMENT

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