TENTATIVE GENERAL SCHEDULE
NCOIL ANNUAL MEETING
DECEMBER 10 - 13, 2019

As of November 27, 2019, and Subject to Change

The JW Marriott Hotel
Austin, Texas

NCOIL ANNUAL MEETING
Austin, Texas
December 10 - 13, 2019
TENTATIVE SCHEDULE

TUESDAY, DECEMBER 10TH

Tour of Texas State Capitol	3:30 p.m.		
Budget Committee	6:00 p.m.	-	6:30 p.m.
Welcome Reception	6:30 p.m.	-	7:30 p.m.

WEDNESDAY, DECEMBER 11th

Registration *Exhibits Open: 8:00 a.m. – 6:45 p.m.*	7:00 a.m.	-	6:00 p.m.
Welcome Breakfast	8:00 a.m.	-	9:30 a.m.
Networking Break	9:30 a.m.	-	9:45 a.m.
Special Committee on Natural Disaster Recovery	9:45 a.m.	-	11:00 a.m.
NCOIL – NAIC Dialogue	11:00 a.m.	-	12:15 p.m.
The Institutes Griffith Foundation Legislator Luncheon Microinsurance: A Primer for Public Policymakers (Open to Public Policymakers Only)	12:15 p.m.	-	1:15 p.m.

Concurrent Sessions: 1:15 p.m. – 2:30 p.m.

Microinsurance Explosion: Lessons from Abroad and their Impact on the U.S. Market (Open to All Attendees)	1:15 p.m.	-	2:30 p.m.
Start Up CEO: The Role of Price in the Biopharmaceutical Business Model (Open to Public Policymakers and Staff Only)	1:15 p.m.	-	2:30 p.m.
Health Insurance & Long Term Care Issues Committee	2:30 p.m.	-	4:15 p.m.
NCOIL Innovation Series The Gig Gap: Does Insurance Come With That?	4:15 p.m.	-	5:30 p.m.
Financial Services & Multi-Lines Issues Committee	5:30 p.m.	-	6:45 p.m.
Adjournment	6:45 p.m.		
Nominating Committee (Members Only)	6:45 p.m.	-	7:05 p.m.
CIP Member & Sponsor Reception	6:45 p.m.	-	7:45 p.m.

THURSDAY, DECEMBER 12TH

Registration *Exhibits Open: 8:30 a.m. – 4:30 p.m.*	8:00 a.m.	-	4:00 p.m.
Joint State-Federal Relations and International Insurance Issues Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
General Session Insuring the Previously Unimaginable: A Discussion on the Active Shooter Insurance Coverage Landscape	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.
Legislative Micro Meetings	1:30 p.m.	-	2:00 p.m.
Workers' Compensation Insurance Committee	2:00 p.m.	-	3:15 p.m.

Networking Break	3:15 p.m.	-	3:30 p.m.
Life Insurance & Financial Planning Committee	3:30 p.m.	-	4:45 p.m.
Adjournment	4:45 p.m.		
IEC Board Meeting	4:45 p.m.	-	5:30 p.m.

FRIDAY, DECEMBER 13TH

Registration *Exhibits Open: 8:15 a.m. – 12:00 p.m.*	8:00 a.m.	-	10:30 a.m.
Health General Session The U.S. Healthcare System in Flux. Judicial Repeal of the ACA? Medicare for Whom?	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
Property & Casualty Insurance Committee	10:45 a.m.	-	12:30 p.m.
Business Planning Committee and Executive Committee	12:30 p.m.	-	1:30 p.m.
Adjournment	1:30 p.m.		

******Please note all speakers listed are scheduled to speak as of November 27, 2019. There may be modifications between now and the start of the Meeting.*****

TUESDAY, DECEMBER 10, 2019

Tour of Texas State Capitol
Tuesday, December 10, 2019
3:30 p.m.

Tours meet at the South entrance of the Capitol in the tourist office located in the old Treasury office.

Budget Committee
Tuesday, December 10, 2019
6:00 p.m. – 6:30 p.m.

Chair: Asm. Ken Cooley (CA) – NCOIL Treasurer
Vice Chair: Sen. Neil Breslin (NY)

1.) Call to Order/Roll Call/Approval of July 10, 2019 Committee Meeting Minutes
2.) Consideration and Adoption of 2020 Budget
3.) Any Other Business
4.) Adjournment

Welcome Reception
Tuesday, December 10, 2019
6:30 p.m. – 7:30 p.m.

WEDNESDAY, DECEMBER 11, 2019

Welcome Breakfast
Wednesday, December 11, 2019
8:00 a.m. – 9:30 a.m.

1.) ***Senator Dan "Blade" Morrish (LA) – NCOIL President***
    a.) President's Welcome
    b.) New Member Welcome and Introduction
2.) Texas Welcome
    The Hon. Kent Sullivan, Commissioner – Texas Department of Insurance
3.) Comments from NCOIL CEO
    The Hon. Tom Considine
4.) Interstate Insurance Product Regulation Commission (IIPRC) Update
    Karen Schutter, Executive Director – IIPRC
5.) Any Other Business
6.) Adjournment

Networking Break
Wednesday, December 11, 2019
9:30 a.m. – 9:45 a.m.

Special Committee on Natural Disaster Recovery
Wednesday, December 11, 2019
9:45 a.m. – 11:00 a.m.

Chair: Sen. Vickie Sawyer (NC)

1.) Call to Order/Roll Call/Approval of July 11, 2019 Committee Meeting Minutes
2.) Discussion of NCOIL Private Flood Insurance Model Act
    Rep. David Santiago (FL) – Sponsor
    NAMIC Representative
    Ron Jackson, VP, State Affairs Southeast Region - APCIA
    Wes Bissett, Senior Counsel, Gov't Affairs – IIABA
    Birny Birnbaum, Director - Center for Economic Justice (CEJ)
3.) Lessons in Natural Disaster Recovery
    Michael Hecht, President and CEO - Greater New Orleans, Inc.
4.) Any Other Business
5.) Adjournment

NCOIL – NAIC Dialogue
Wednesday, December 11, 2019
11:00 a.m. – 12:15 p.m.

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

1.) Call to Order/Roll Call/Approval of July 12, 2019 Committee Meeting Minutes
2.) Update on NAIC Annuity Suitability Working Group
3.) Update on NAIC Retirement Security Working Group
4.) Discussion on Regulatory Issues Surrounding Marijuana Legalization
5.) Update on State Adoption/Introduction of Amended NAIC Credit for Reinsurance Models
6.) Update on International Insurance Developments
7.) Any Other Business
8.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Wednesday, December 11, 2019
12:15 p.m. – 1:15 p.m.
A Primer on Microinsurance for Public Policymakers

Michael McCord
Managing Director
MicroInsurance Centre at Milliman

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

Concurrent Sessions (1:15 p.m. – 2:30 p.m.)

Microinsurance Explosion: Lessons from Abroad and their Impact on the U.S. Market
Wednesday, December 11, 2019
1:15 p.m. – 2:30 p.m.

*Michael McCord**
Managing Director
MicroInsurance Centre at Milliman

**Brought to you by The Institutes Griffith Foundation (Foundation). In keeping with the non-partisan, non-advocative mission of the Foundation, this presentation will be purely educational.*

*****Open to All Attendees*****

Start Up CEO: The Role of Price in the Biopharmaceutical Business Model
Wednesday, December 11, 2019
1:15 p.m. – 2:30 p.m.

Debbie Hart, MS, CAE, APR
President and CEO
BioNJ

Tom Kowalski
President and CEO
Texas Healthcare and Bioscience Institute

Walter E. Horton, Jr., Ph.D.
Associate Vice President for Research and Federal Relations & Chief Research Officer
Texas State University

Neil K. Warma
CEO/GM – I-Mab Biopharma US
Partner – Lonestar Bioventures

Paul Lammers, MD, MSc
President & CEO
Triumvira Immunologics

*****Open to Public Policymakers and Staff Only*****

Health Insurance & Long Term Care Issues Committee
Wednesday, December 11, 2019
2:30 p.m. – 4:15 p.m.

Chair: Asw. Pam Hunter (NY)
Vice Chair: Rep. Tom Oliverson, M.D. (TX)

1.) Call to Order/Roll Call/Approval of July 13, 2019 Committee Meeting Minutes
2.) Consideration of NCOIL Drug Pricing Transparency Model Act
- ***Rep. Tom Oliverson, M.D. (TX) – Sponsor***
- ***Sen. Dan "Blade" Morrish (LA) – Co-Sponsor***
- ***Brendan Peppard, Regional Director, State Affairs – America's Health Insurance Plans (AHIP)***
- ***Melodie Shrader, Senior Director, State Affairs – Pharmaceutical Care Management Association (PCMA)***
- ***Saiza Elayda, Senior Director, State Policy - PhRMA***

3.) Continued Discussion on NCOIL Short Term Limited Duration Insurance (STLDI) Model Act
- ***Rep. Martin Carbaugh (IN) – Sponsor***
- ***Brian Blase – Blase Policy Strategies***
- ***Steve Kline, Director, Gov't Relations – National Association of Insurance and Financial Advisors (NAIFA)***

4.) Discussion on NCOIL Health Care Sharing Ministry (HCSM) Model Act
- ***Rep. Martin Carbaugh (IN) – Sponsor***
- ***Joann Volk, Research Professor - Georgetown University Center on Health Insurance Reforms***
- ***Bradley Hahn, CEO – Solidarity HealthShare***
- ***Keith Hopkinson, Of Counsel – Winstead PC***

5.) Briefing on Upcoming Health Committee Topics
a.) Introduction of Patient Dental Care Bill of Rights Model Act
- ***Rep. George Keiser (ND) – Sponsor***
- ***Chad Olson, Director, State Gov't Affairs - American Dental Association (ADA)***
- ***National Association of Dental Plans (NADP) Representative***
- ***Karen Melchert, Regional VP, State Relations – American Council of Life Insurers (ACLI)***
- ***AHIP Representative***

b.) Prior Authorization Reforms

Mark Pratt, SVP, Public Affairs - CAQH

c.) Update on Biosimilar Landscape

Julie Reed, VP of Corporate Affairs - Pfizer Immunology, Inflammation & Biosimilars

d.) Introduction of Vision Care Services Model Law Concept

Sen. Bob Hackett (OH) – Sponsor
Robert Holden, State Gov't Affairs Dir. – National Association of Vision Care Plans (NAVCP)
Brendan Peppard, Regional Director, State Affairs – America's Health Insurance Plans (AHIP)

6.) Any Other Business
7.) Adjournment

NCOIL Innovation Series
The Gig Gap: Does Insurance Come With That?
Wednesday, December 11, 2019
4:15 p.m. – 5:30 p.m.

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

*Dr. David Russell**
Professor of Insurance and Finance
Director of the Center for Risk and Insurance
Cal. State University – Northridge

Ira Goldstein
Executive Director
NY Black Car Fund

Lamine Zarrad
CEO
Joust Bank

Curtis Scott
VP of Global Risk
Lyft

**Brought to you by The Institutes Griffith Foundation (Foundation). In keeping with the non-partisan, non-advocative mission of the Foundation, this presentation will be unbiased and purely educational.*

Financial Services & Multi-Lines Issues Committee
Wednesday, December 11, 2019
5:30 p.m. – 6:45 p.m.

Chair: Sen. Bob Hackett (OH)
Vice Chair: Rep. Bart Rowland (KY) – Presiding Chair

1.) Call to Order/Roll Call/Approval of July 12, 2019 Committee Meeting Minutes
2.) Continued Discussion on Development of NCOIL Insurance Modernization Model Legislation
    a.) Consideration of NCOIL Insurance E-Commerce Model Act
        Rep. Edmond Jordan (LA) (Sponsor)
        Birny Birnbaum, Director - Center for Economic Justice (CEJ)
        Ron Jackson, VP, State Affairs Southeast Region - American Property Casualty Insurance Association (APCIA)
    b.) Discussion on NCOIL Rebate Reform Model Act
        Rep. Matt Lehman (IN) – NCOIL Vice President (Sponsor)
        John Fielding, General Counsel – The Council of Insurance Agents & Brokers (CIAB)
        Frank O'Brien, VP, State Gov't Relations - APCIA
        Karen Melchert, Regional VP, State Relations – American Council of Life Insurers (ACLI)
        Erin Collins, Asst. VP, State Affairs – NAMIC
        Birny Birnbaum, Director - Center for Economic Justice (CEJ)
        Wes Bissett, Senior Counsel, Gov't Affairs - Independent Insurance Agents & Brokers of America (IIABA)
        The Hon. Dean Cameron, Director of the Idaho Department of Insurance & NAIC Secretary- Treasurer
    c.) Discussion on NCOIL E-Titling Model Act
        Del. Steve Westfall (WV) – Sponsor
        Frank O'Brien, VP, State Gov't Relations - APCIA
        Jim Taylor, VP - Auto Data Direct, Inc.
    d.) Other Insurance Modernization Initiatives
3.) Any Other Business
4.) Adjournment

Nominating Committee (Members Only)
Wednesday, December 11, 2019
6:45 p.m. – 7:05 p.m.

Co-Chairs: Sen. Travis Holdman (IN) – NCOIL Immediate Past President
Sen. Jason Rapert (AR) – NCOIL Immediate Past President

1.) Call to Order/Roll Call
2.) Consideration of Candidates
3.) Any Other Business
4.) Adjournment

CIP Member & Sponsor Reception
Wednesday, December 11, 2019
6:45 p.m. – 7:45 p.m.

THURSDAY, DECEMBER 12, 2019

Joint State – Federal Relations & International Insurance Issues Committee
Thursday, December 12, 2019
9:00 a.m. – 10:30 a.m.

Chair: Sen. Jerry Klein (ND)
Vice Chair: Sen. Roger Picard (RI)

1.) Call to Order/Roll Call/Approval of July 11, 2019 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Insurance Business Transfer (IBT) Model Law
Asm. Andrew Garbarino (NY) (Sponsor)
Rep. Lewis Moore (OK) (Sponsor)
Karen Melchert, Regional VP, State Relations – American Council of Life Insurers (ACLI)
National Conference of Insurance Guaranty Funds (NCIGF) Representative
Bob Ridgeway, Senior Gov't Relations Counsel America's Health Insurance Plans (AHIP)
3.) Continued Discussion of Proposed Amendments to NCOIL Market Conduct Surveillance Model Law
Sen. Travis Holdman (IN) (Sponsor) – NCOIL Immediate Past President
Birny Birnbaum, Director – Center for Economic Justice (CEJ)
The Hon. Dean Cameron, Director of the Idaho Department of Insurance & NAIC Secretary- Treasurer
4.) Discussion on the Reauthorization of the Terrorism Risk Insurance Act (TRIA)
Jim Lynch, FCAS MAAA, Chief Actuary and VP of Research and Education – Insurance Information Institute (III)
5.) Any Other Business
6.) Adjournment

Networking Break
Thursday, December 12, 2019
10:30 a.m. – 10:45 a.m.

General Session
Thursday, December 12, 2019
10:45 a.m. – 12:00 p.m.
Insuring the Previously Unimaginable: A Discussion on the Active Shooter Insurance Coverage Landscape

Moderator: Sen. Travis Holdman (IN) – NCOIL Immediate Past President

Paul Marshall
Director of Active Shooter Insurance Programs
McGowan Program Administrators

Stuart A. Miller, Esq.
Partner
Wilson Elser

Ryan Searless
Senior Consultant Protective Services
IMEG Corp.

Luncheon with Keynote Address
Thursday, December 12, 2019
12:00 p.m. - 1:30 p.m.

Legislative Micro Meetings
Thursday, December 12, 2019
1:30 p.m. – 2:00 p.m.

Facilitator: Hon. Tom Considine, NCOIL CEO

Workers' Compensation Insurance Committee
Thursday, December 12, 2019
2:00 p.m. – 3:15 p.m.

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

Acting Chair: Sen. Jerry Klein (ND)

1.) Call to Order/Roll Call/Approval of July 11, 2019 Committee Meeting Minutes
2.) Consideration of NCOIL Workers' Compensation Drug Formulary Model Act
    Rep. Matt Lehman (IN) – NCOIL Vice President (Sponsor)
3.) Discussion on Post Traumatic Stress Syndrome (PTSD) Coverage and other Expanding Benefit Changes in the Workers' Compensation Insurance Marketplace
    Professor Michael Duff, University of Wyoming College of Law
    Robert Stokes, Esq., Flahive, Ogden & Latson
    Glenn Deshields, Legislative Director – Texas State Ass'n of Fire Fighters (TSAFF)
4.) Any Other Business
5.) Adjournment

Networking Break
Thursday, December 12, 2019
3:15 p.m. – 3:30 p.m.

Life Insurance & Financial Planning Committee
Thursday, December 12, 2019
3:30 p.m. – 4:45 p.m.

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

1.) Call to Order/Roll Call/Approval of July 13, 2019 Committee Meeting Minutes
2.) Discussion on the use of Genetic Testing Information in Life Insurance Underwriting

Mark Rothstein, JD – Director of the University of Louisville's Institute for Bioethics, Health Policy and Law
Dr. David Rengachary, Sr. VP & Chief Medical Director for US Mortality Markets, RGA Reinsurance Co.

3.) Discussion on Life Insurance Underwriting Trends and Developments
Colin Devine, Principal – C. Devine and Associates
Dave Dorans, CEO – Clareto

4.) Any Other Business

5.) Adjournment

IEC Board Meeting
Thursday, December 12, 2019
4:45 p.m. – 5:30 p.m.

FRIDAY, DECEMBER 13, 2019

Health General Session
Friday, December 13, 2019
9:00 a.m. – 10:30 a.m.
The U.S. Healthcare System in Flux.
Judicial Repeal of the ACA? Medicare for Whom?

Moderator: Rep. Deborah Ferguson (AR)

Matthew J.B. Lawrence
Professor of Law
Penn State Dickinson Law School

Leanne Gassaway
Senior VP – State Affairs and Policy
AHIP

Robyn Crosson
Attorney
Chaiken Law LLC

Stacey Pogue
Senior Policy Analyst
Center for Public Policy Priorities

Networking Break
Friday, December 13, 2019
10:30 a.m. – 10:45 a.m.

Property & Casualty Insurance Committee
Friday, December 13, 2019
10:45 a.m. – 12:30 p.m.

Chair: Rep. Edmond Jordan (LA)
Vice Chair: Rep. Richard Smith (GA)

1.) Call to Order/Roll Call/Approval of July 12, 2019 Committee Meeting Minutes
2.) Discussion on NCOIL Peer-to-Peer Car Sharing Program Model Act
    Rep. Bart Rowland (KY) – Sponsor
    Ethan Wilson, Gov't Relations Manager & Senior Legislative Counsel – Turo
    Tomi Gerber, VP – Gov't & Public Affairs – Enterprise Holdings
    Frank O'Brien, VP, State Gov't Relations, American Property Casualty Insurance Association (APCIA)
3.) Discussion on NCOIL Electric Scooter Insurance Model Act
    Sen. Jerry Klein (ND) - Sponsor
    NAMIC Representative
    Ben LaRocco, Senior Manager, State Policy – Lime
    Edward Fu, Senior Regulatory Counsel - Bird
4.) Insurance Rating Variables: What They Are and Why They Matter
    Kendall Williams, Staff Actuary – Casualty Actuarial Society (CAS)
5.) Re-Adoption of NCOIL Model Act Regarding the Use of Insurance Claims History Information in Homeowners and Personal Lines Residential Property Insurance
6.) Any Other Business
7.) Adjournment

Business Planning Committee & Executive Committee
Friday, December 13, 2019
12:30 p.m. – 1:30 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 July 13, 2019 Committee Meeting Minutes
2.) 2021 Annual Meeting Location
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials
4.) Resolution Honoring Former NCOIL President William Larkin (NY)
5.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
6.) Other Sessions
    a.) The Institutes Griffith Foundation Legislator Luncheon
    b.) Featured Speakers
7.) Nominating Committee Report/Election of Officers
8.) Any Other Business
    -Consideration of Auditor
9.) 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)

Resolution in Support of the Reauthorization of the Terrorism Risk Insurance Program

Sponsored by Sen. Dan "Blade" Morrish (LA)

Adopted by the NCOIL Officers on September 17, 2019. To be discussed and considered for ratification by the NCOIL Executive Committee on December 13, 2019.

WHEREAS, the United States continues to be engaged in an ongoing war against terrorism and the threats of future attacks inside the country remains; and

WHEREAS, future attacks could include the use of unconventional (nuclear, biological, chemical or radiological) weapons that could result in a large number of casualties or could involve attacks such as cyber-terrorism that would impact businesses and critical infrastructure across the nation; and

WHEREAS, the Terrorism Risk Insurance Program (TRIP), created through the enactment of the Terrorism Risk Insurance Act (TRIA) of 2002 and extended and modified through the Terrorism Risk Insurance Program Reauthorization Act (TRIPRA) in 2005, 2007, and 2015 has allowed for a viable and stable terrorism risk insurance market; and

WHEREAS, absent extension by Congress, TRIA will expire on December 31, 2020; and

WHEREAS, failure by Congress to extend TRIA would likely result in the inability of insurers to offer widespread coverage for future catastrophes resulting from terrorism or would likely create capacity concerns where terrorism coverage must be provided; and

WHEREAS, without adequate terrorism insurance coverage, banks may be unwilling or less likely to extend loans for commercial transactions, such as mortgages, construction projects and other capital-intensive initiatives; and

WHEREAS, the lack of private terrorism insurance to cover losses from future terrorist attacks may require the federal government to cover such losses; and

WHEREAS, without the shared public-private responsibility program established by TRIA, a limited availability of insurance against terrorism would have a severe adverse effect on our country's economy as financiers might be reluctant to lend, businesses might be reluctant to invest, and commercial consumers might be unable to afford insurance; and

WHEREAS, TRIA is an essential component of effective national economic recovery following a catastrophic terrorist attack in the United States; and

WHEREAS, NCOIL supported the enactment of TRIA and subsequent extensions in 2005, 2007 and 2015; and

NOW, THEREFORE, BE IT RESOLVED, that NCOIL supports a long-term extension of TRIA; and

NOW, THEREFORE, BE IT FURTHER RESOLVED, that NCOIL urges Congress and the Administration to take action as soon as possible to extend TRIA.

NOW, THEREFORE, BE IT FINALLY RESOLVED, that a copy of this Resolution shall be sent to the Chair of the U.S. Senate Committee on Banking, Housing, and Urban Affairs; the Chair of the U.S. Senate Committee on Banking, Housing, and Urban Affairs' Subcommittee on Securities, Insurance, and Investment; the Chair of the U.S. House Financial Services Committee; the Chair of the U.S. House Financial Services' Subcommittee on Housing, Community Development and Insurance; the Chair of all state committees that have jurisdiction over insurance matters; each State's Insurance Commissioner; and the Director of the Federal Insurance Office.

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Resolution in Honor of Past President William J. Larkin Jr., NY

To be discussed and considered by the NCOIL Executive Committee on December 13th, 2019
Sponsored by Senator Neil Breslin (NY), Past NCOIL President; Senator Dan "Blade" Morrish (LA), NCOIL President; Assemblyman Kevin Cahill (NY), NCOIL Secretary; Assemblywoman Pamela Hunter (NY); Assemblyman Andrew Garbarino (NY)

WHEREAS, William Larkin served for over 40 years in the New York State Legislature, having served in the Assembly from 1979-1990 and elected to the New York State Senate in November 1990; and

WHEREAS, Bill served NCOIL faithfully as President of the National Conference of Insurance Legislators in 2002 and passed many pieces of landmark legislation over the last four decades, earning the recognition of one the "100 Most Powerful People in the Insurance Industry-North America"; and

WHEREAS, Bill led the charge on legislation recognized as the greatest veteran's reform package since WWI and later became a founding member of the Genesis Group, which founded the National Purple Heart Hall of Fame and the campaign to create the Purple Heart Forever Stamp; and

WHEREAS, he sponsored legislation which required Pulse Oximetry testing on all newborns, for which he was named the American Heart Association's Legislator of the Year for his leadership in passing this bill; and

WHEREAS, as NCOIL President, Bill helped in the response to the September 11 terrorist attacks and held multiple sessions where legislators focused on state disaster management and recovery, the Congressional response, impacts on specific lines of insurance, and industry forecasts; and

WHEREAS, Bill was a veteran who volunteered for the draft and entered service at the age of 16 and eventually served more than 23 years in the United States Army; and

WHEREAS, he was appointed Army Project Officer for the visit of John F. Kennedy during his trip to Germany in 1963 and later guarded Dr. Martin Luther King Jr. during his march from Selma to Montgomery, Alabama; and

WHEREAS, among the many honors Bill received are the Decoration for Distinguished Civilian Service medal, the New York State Senate Veterans Leadership Award, an honorary degree of Doctor of Humane Letters, and the prestigious Ottaway Medal; and

NOW, THEREFORE, BE IT RESOLVED that NCOIL lawmakers Recognize and Honor Senator Larkin for his record of unmatched service and will remember him by his version of the motto "Duty, Honor, and Country" by adding the word Respect, and

BE IT FINALLY RESOLVED that NCOIL, with great appreciation, will send this resolution to Bill's family in honor of his special place in NCOIL history.

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

National Council of Insurance Legislators (NCOIL)

Model Workers' Compensation Drug Formulary Act

Sponsored by Rep. Matt Lehman (IN) – NCOIL Vice President

To be discussed and considered during the Workers' Compensation Insurance Committee on December 12th, 2019.

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Section 4. Operation of Formulary
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Section 7~~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 in order to facilitate the safe and appropriate use of prescription drugs in the treatment of work-related injury and occupational disease.

Section 3. Selection or Development of Drug Formulary

(A) It is the intent of the Legislature that the [insert appropriate state agency/department] select a nationally recognized, evidence-based drug formulary, for use in the workers' compensation system, or to develop such a formulary, by rule. Such formulary shall apply to prescription drugs that are prescribed and dispensed for outpatient use in

connection with workers' compensation claims with a date of injury on or after [insert date]. The drug formulary shall not apply to care provided in an emergency department or inpatient setting.

(B) In developing by rule or selecting a nationally recognized, evidence-based drug formulary for adoption, the [department] shall consider the following factors:

(1) Whether the formulary focuses on medical treatment specific to workers' compensation.

(2) Whether the basis for the formulary is readily apparent and publicly available.

(3) Whether the formulary includes measures to aid in management of opioid medications.

(4) The cost of implementation and post-implementation associated costs of the formulary.

(5) Evidence-based guidelines for the treatment of workplace injury and disease.

(C) Within [thirty (30)] days of the effective date of this Act, the [department] shall solicit public comments regarding the selection of a nationally recognized, evidence-based prescription drug formulary under this section. The public comment period shall be [ninety (90) days]. During the public comment period, the [department] shall conduct at least one public hearing on the selection of a drug formulary. The [department] shall publish notice of the public comment period and public hearings on its website. The public hearing shall include, but not be limited to, employers, insurers, private sector employee representatives, public sector employee representatives, treating physicians actively practicing medicine, pharmacists, pharmacy benefit managers, attorneys who represent applicants, and injured workers.

(D) Commencing [insert date], and concluding with the implementation of the formulary, the [administrative director] shall publish at least two interim reports on the internet web site of the [division of workers' compensation] describing the status of the selection of the formulary.

(E) The [department] shall [annually] review updates issued by the formulary publisher to the selected formulary.

(F) The [department] shall ensure that the current nationally recognized, evidence-based prescription drug formulary is available through its publicly accessible Internet website for reference by physicians and the general public.

Section 4. Operation of Formulary

(A) Beginning [insert date] reimbursement is not permitted for a claim for payment of a drug that:

(1) is prescribed for use by an employee who files a notice of injury under this Act; and

(2) is listed ~~included~~ but not approved ~~recommended~~ in the formulary, or omitted from the formulary, unless the employee begins use of such drug after [insert date], and the use continues after [insert date].

(3) if the employee begins use of the such drug before [insert date], and the use continues after [insert date], reimbursement is permitted for such drug until [insert date].

(B) If a prescribing physician submits to an employer a request to permit use of a drug that is listed ~~included~~ but not approved ~~recommended~~ in the formulary, or omitted from the formulary, including the prescribing physician's reason for requesting use of such drug and the employer approves the request, the prescribing physician may prescribe such 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 a drug that is listed ~~included~~ but not approved ~~recommended~~ in the formulary, or omitted from the formulary, the employer shall:

(1) send the request to a third party that is certified by the [Utilization Review Accreditation Commission (URAC) or another Accreditation Organization] to make a determination concerning the request. The use by the employer of an independent review organization selected by the [department] shall also satisfy this subsection; and

(2) notify the prescribing physician and the injured employee of the third party's determination not more than [three ~~five~~ (3~~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 drug that is listed ~~included~~ but not approved in the formulary, or omitted from the formulary, ~~recommended~~ and 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 the drug that is listed ~~included~~ but not approved ~~recommended~~ on the formulary, or omitted from ~~not included in~~ the formulary:

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

(2) the injured employee may apply to [workers' 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 a drug that is listed ~~included~~ but not approved ~~recommended~~ on the formulary, or omitted from the formulary.

Section 5. Third Party Conflict of Interest

(A) The URAC certified third party identified in Section 4(C)(1) shall be independent of any workers' compensation insurer or workers' compensation claims administrator doing business in this state.

(B) No URAC certified third party identified in Section 4(C)(1) shall have any material professional, material familial, or material financial affiliation with any of the following:

(1) The employer, insurer or claims administrator.

(2) Any officer, director, employee of the employer, or insurer or claims administrator.

(3) A physician, the physician's medical group, the physician's independent practice association, or other provider involved in the medical treatment in dispute.

(4) The facility or institution at which either the proposed health care service, or the alternative service, if any, recommended by the employer, would be provided.

(5) The development or manufacture of the drug proposed by the employee whose treatment is under review, or the alternative therapy, if any, recommended by the employer.

(6) The injured employee or the employee's immediate family, or the employee's attorney.

Section 6~~5~~. Rules

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

Section 7~~6~~. Effective Date

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

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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)

Peer-to-Peer Car Sharing Program Model Act

Sponsored by Rep. Bart Rowland (KY)

Discussion Draft as of November 1st, 2019. To be discussed during the Property & Casualty Insurance Committee on December 13th, 2019

Also to be discussed during the interim conference call meeting of the NCOIL Property & Casualty Insurance Committee on November 19th, 2019 during which changes may be made to this draft.

Changes made pursuant to the November 19th, 2019 conference call are sponsored by Rep. Rowland and indicated by underline and ~~strikethrough.~~

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Chapter 1. Short Title
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AN ACT concerning transportation.

Be it enacted by the Legislature of the State of X:

[(*New Act*) / or / (*The statutes of the jurisdiction are hereby amended as follows*)]:

Chapter 1. Short Title

This Act may be cited as the Peer-to-Peer Car Sharing Program Act.

Chapter 2. Definitions

Application of definitions

Sec. 1. Except as otherwise provided, the definitions in this chapter apply throughout this article.

"Peer-to-Peer Car Sharing"

Sec. 2. "Peer-to-Peer Car Sharing" means the authorized use of a vehicle by an individual other than the vehicle's owner through a peer-to-peer car sharing program. "Peer-to-Peer Car Sharing" does not mean rental car or rental activity as defined in _____.

"Peer-to-Peer Car Sharing Program"

Sec. 3. "Peer-to-Peer Car Sharing Program" means a business platform that connects vehicle owners with drivers to enable the sharing of vehicles for financial consideration. "Peer-to-Peer Car Sharing Program" does not mean rental car company as defined in _____.

"Car Sharing Program Agreement"

Sec. 4. "Car Sharing Program Agreement" means the terms and conditions applicable to a shared vehicle owner and a shared vehicle driver that govern the use of a shared vehicle through a peer-to-peer car sharing program. "Car Sharing Program Agreement" does not mean rental car agreement, or similar, as defined in _____.

"Shared Vehicle"

Sec. 5. "Shared vehicle" means a vehicle that is available for sharing through a peer-to-peer car sharing program. "Shared vehicle" does not mean rental car or rental vehicle as defined in [*insert citation to the State's statutory definition of "rental car" or the equivalent term in that State's laws*].

"Shared Vehicle Driver"

Sec. 6. "Shared Vehicle Driver" means an individual who has been authorized to drive the shared vehicle by the shared vehicle owner under a car sharing program agreement.

"Shared Vehicle Owner"

Sec. 7. "Shared Vehicle Owner" means the registered owner, or a person or entity designated by the registered owner, of a vehicle made available

for sharing to shared vehicle drivers through a peer-to-peer car sharing program.

“Car Sharing Delivery Period”

Sec. 8. “Car Sharing Delivery Period” means the period of time during which a shared vehicle is being delivered to the location of the car sharing start time, if applicable, as documented by the governing car sharing program agreement.

“Car Sharing Period”

Sec. 9. “Car Sharing Period” means the period of time that commences with the car sharing delivery period or, if there is no car sharing delivery period, that commences with the car sharing start time and in either case ends at the car sharing termination time.

“Car Sharing Start Time”

Sec. 10. “Car Sharing Start Time” means the time when the shared vehicle becomes subject to the control of the shared vehicle driver at or after the time the reservation of a shared vehicle is scheduled to begin as documented in the records of a peer–to–peer car sharing program.

“Car Sharing Termination Time”

Sec. 11. “Car Sharing Termination Time” means the earliest of the following events:

(1) The expiration of the agreed upon period of time established for the use of a shared vehicle according to the terms of the car sharing program agreement if the shared vehicle is delivered to the location agreed upon in the car sharing program agreement;

(2) When the shared vehicle is returned to a location as alternatively agreed upon by the shared vehicle owner and shared vehicle driver as communicated through a peer-to-peer car sharing program; or

(3) When the shared vehicle owner or the shared vehicle owner’s authorized designee, takes possession and control of the shared vehicle.

Chapter 3. Insurance

Insurance Coverage During Car Sharing Period

Sec. 1. (a) A peer-to-peer car sharing program shall assume liability, except as provided in subsection (b) of this chapter, of a shared vehicle owner for bodily injury or property damage to third parties or uninsured and underinsured motorist or personal injury protection losses during the car sharing period in an amount stated in the peer-to-peer car sharing program agreement which amount may not be less than those set forth in (State's financial responsibility law).

(b) Notwithstanding the definition of "car sharing termination time" as set forth in Chapter 2 or 3 of this Act, the assumption of liability under subsection (a) of this subsection does not apply to any shared vehicle owner when:

(1) A shared vehicle owner makes an intentional or fraudulent material misrepresentation or omission to the peer-to-peer car sharing program before the car sharing period in which the loss occurred, or

(2) Acting in concert with a shared vehicle driver who fails to return the shared vehicle pursuant to the terms of car sharing program agreement.

(c) Notwithstanding the definition of "car sharing termination time" as set forth in Chapter 2 or Chapter 3 of this Act, the assumption of liability under subsection (a) of this section would apply to bodily injury, property damage, uninsured and underinsured motorist or personal injury protection losses by damaged third parties required by [*insert citation to the applicable state financial responsibility law*]

(d) A peer-to-peer car sharing program shall ensure that, during each car sharing period, the shared vehicle owner and the shared vehicle driver are insured under a motor vehicle liability insurance policy that provides insurance coverage in amounts no less than the minimum amounts set forth in [i*nsert citation to applicable statute establishing state minimum coverage*], and:

(1) Recognizes that the shared vehicle insured under the policy is made available and used through a peer-to-peer car sharing program; or

(2) Does not exclude use of a shared vehicle by a shared vehicle driver.

(e) The insurance described under subsection (d) may be satisfied by motor vehicle liability insurance maintained by:

(1) A shared vehicle owner;
(2) A shared vehicle driver;
(3) A peer-to-peer car sharing program; or
(4) Both a shared vehicle owner, a shared vehicle driver, and a peer-to-peer car sharing program.

(f) The insurance described in subsection (e) that is satisfying the insurance requirement of subsection (d) shall be primary during each car sharing period.

(g) The peer-to-peer car sharing program shall assume primary liability for a claim when it is in whole or in part providing the insurance required under subsections (d) and (e) and:

(1) a dispute exists as to who was in control of the shared motor vehicle at the time of the loss; and

(2) the peer-to-peer car sharing program does not have available, did not retain, or fails to provide the information required by Section 5 of this Chapter 3.

The shared motor vehicle's insurer shall indemnify the car sharing program to the extent of its obligation under, if any, the applicable insurance policy, if it is determined that the shared motor vehicle's owner was in control of the shared motor vehicle at the time of the loss.

(h) If insurance maintained by a shared vehicle owner or shared vehicle driver in accordance with subsection (e) has lapsed or does not provide the required coverage, insurance maintained by a peer-to-peer car sharing program shall provide the coverage required by subsection (d) beginning with the first dollar of a claim and have the duty to defend such claim except under circumstances as set forth in Chapter 3 Section (1)(b).

(i) Coverage under an automobile insurance policy maintained by the peer-to-peer car sharing program shall not be dependent on another automobile insurer first denying a claim nor shall another automobile insurance policy be required to first deny a claim.

(j) Nothing in this Chapter:

(1) Limits the liability of the peer-to-peer car sharing program for any act or omission of the peer-to-peer car sharing program itself that results in injury to any person as a result of the use of a shared

vehicle through a peer-to-peer car sharing program; or

(2) Limits the ability of the peer-to-peer car sharing program to, by contract, seek indemnification from the shared vehicle owner or the shared vehicle driver for economic loss sustained by the peer-to-peer car sharing program resulting from a breach of the terms and conditions of the car sharing program agreement.

Notification of Implications of Lien

Sec. 2. At the time when a vehicle owner registers as a shared vehicle owner on a peer-to-peer car sharing program and prior to the time when the shared vehicle owner makes a shared vehicle available for car sharing on the peer-to-peer car sharing program, the peer-to-peer car sharing program shall notify the shared vehicle owner that, if the shared vehicle has a lien against it, the use of the shared vehicle through a peer-to-peer car sharing program, including use without physical damage coverage, may violate the terms of the contract with the lienholder.

Exclusions in Motor Vehicle Liability Insurance Policies

Sec. 3. (a) An authorized insurer that writes motor vehicle liability insurance in the State may exclude any and all coverage and the duty to defend or indemnify for any claim afforded under a shared vehicle owner's motor vehicle liability insurance policy, including but not limited to:

(1) liability coverage for bodily injury and property damage;

(2) personal injury protection coverage as defined in [CITE STATUTE];

(3) uninsured and underinsured motorist coverage;

(4) medical payments coverage;

(5) comprehensive physical damage coverage; and

(6) collision physical damage coverage

(b) Nothing in this Article invalidates or limits an exclusion contained in a motor vehicle liability insurance policy, including any insurance policy in use or approved for use that excludes coverage for motor vehicles made available for rent, sharing, or hire or for any business use.

Recordkeeping; Use of Vehicle in Car Sharing

Sec. 4. A peer-to-peer car sharing program shall collect and verify records pertaining to the use of a vehicle, including, but not limited to, times used, fees paid by the shared vehicle driver, and revenues received by the shared vehicle owner and provide that information upon request to the shared vehicle owner, the shared vehicle owner's insurer, or the shared vehicle driver's insurer to facilitate a claim coverage investigation. The peer-to-peer car sharing program shall retain the records for a time period not less than the applicable personal injury statute of limitations.

Exemption; Vicarious Liability

Sec. 5. A peer-to-peer car sharing program and a shared vehicle owner shall be exempt from vicarious liability in accordance with 49 U.S.C. § 30106 and under any state or local law that imposes liability solely based on vehicle ownership.

Contribution against Indemnification

Sec. 6. A motor vehicle insurer that defends or indemnifies a claim against a shared vehicle that is excluded under the terms of its policy shall have the right to seek contribution against the motor vehicle insurer of the peer-to-peer car sharing program if the claim is: (1) made against the shared vehicle owner or the shared vehicle driver for loss or injury that occurs during the car sharing period; and (2) excluded under the terms of its policy.

Insurable Interest

Sec. 7. (a) Notwithstanding any other law, statute, rule or regulation to the contrary, a peer-to-peer car sharing program shall have an insurable interest in a shared vehicle during the car sharing period.

(b) Nothing in this section creates liability on a Peer-to-Peer Car Sharing Program to maintain the coverage mandated by this Chapter 3, Sec. 1.

(c) A peer–to–peer car sharing program may own and maintain as the named insured one or more policies of motor vehicle liability insurance that provides coverage for:

(1) liabilities assumed by the peer–to–peer car sharing program under a peer–to–peer car sharing program agreement; or

(2) any liability of the shared vehicle owner; or

(3) damage or loss to the shared motor vehicle; or any liability of the shared vehicle driver.

Chapter 5. Consumer Protections Disclosures

Sec. 1. Each car sharing program agreement made in the State shall disclose to the shared vehicle owner and the shared vehicle driver:

(a) Any right of the peer-to-peer car sharing program to seek indemnification from the shared vehicle owner or the shared vehicle driver for economic loss sustained by the peer-to-peer car sharing program resulting from a breach of the terms and conditions of the car sharing program agreement;

(b) That a motor vehicle liability insurance policy issued to the shared vehicle owner for the shared vehicle or to the shared vehicle driver does not provide a defense or indemnification for any claim asserted by the peer-to-peer car sharing program;

(c) That the peer-to-peer car sharing program's insurance coverage on the shared vehicle owner and the shared vehicle driver is in effect only during each car sharing period and that, for any use of the shared vehicle by the shared vehicle driver after the car sharing termination time, the shared vehicle driver and the shared vehicle owner may not have insurance coverage;

(d) The daily rate, fees, and if applicable, any insurance or protection package costs that are charged to the shared vehicle owner or the shared vehicle driver.

(e) That the shared vehicle owner's motor vehicle liability insurance may not provide coverage for a shared vehicle.

(f) An emergency telephone number to personnel capable of fielding roadside assistance and other customer service inquiries.

(g) If there are conditions under which a shared vehicle driver must maintain a personal automobile insurance policy with certain applicable coverage limits on a primary basis in order to book a shared motor vehicle.

Driver's License Verification and Data Retention

Sec. 2. (a) A peer-to-peer car sharing program may not enter into a peer-to-peer car sharing program agreement with a driver unless the driver who will operate the shared vehicle:

(1) Holds a driver's license issued under _____ that authorizes the driver to operate vehicles of the class of the shared vehicle; or

(2) Is a nonresident who:

(i) Has a driver's license issued by the state or country of the driver's residence that authorizes the driver in that state or country to drive vehicles of the class of the shared vehicle; and

(ii) Is at least the same age as that required of a resident to drive; or

(3) Otherwise is specifically authorized by _____ to drive vehicles of the class of the shared vehicle.

(b) A peer-to-peer car sharing program shall keep a record of:

(1) The name and address of the shared vehicle driver;

(2) The number of the driver's license of the shared vehicle driver and each other person, if any, who will operate the shared vehicle; and

(3) The place of issuance of the driver's license.

Responsibility for Equipment

Sec. 3. A peer-to-peer car sharing program shall have sole responsibility for any equipment, such as a GPS system or other special equipment that is put in or on the vehicle to monitor or facilitate the car sharing transaction, and shall agree to indemnify and hold harmless the vehicle owner for any damage to or theft of such equipment during the sharing period not caused by the vehicle owner. The peer-to-peer car sharing program has the right to seek indemnity from the shared vehicle driver for any loss or damage to such equipment that occurs during the sharing period.

Automobile Safety Recalls

Sec. 4. (a) At the time when a vehicle owner registers as a shared vehicle owner on a peer-to-peer car sharing program and prior to the time when the shared vehicle owner makes a shared vehicle available for car sharing on the peer-to-peer car sharing program, the peer-to-peer car sharing program shall:

(1) Verify that the shared vehicle does not have any safety recalls on the vehicle for which the repairs have not been made; and

(2) Notify the shared vehicle owner of the requirements under subsection (b) of this section.

(b) (1) If the shared vehicle owner has received an actual notice of a safety recall on the vehicle, a shared vehicle owner may not make a vehicle available as a shared vehicle on a peer-to-peer car sharing program until the safety recall repair has been made.

(2) If a shared vehicle owner receives an actual notice of a safety recall on a shared vehicle while the shared vehicle is made available on the peer-to-peer car sharing program, the shared vehicle owner shall remove the shared vehicle as available on the peer-to-peer car sharing program, as soon as practicably possible after receiving the notice of the safety recall and until the safety recall repair has been made.

(3) If a shared vehicle owner receives an actual notice of a safety recall while the shared vehicle is being used in the possession of a shared vehicle driver, as soon as practicably possible after receiving the notice of the safety recall, the shared vehicle owner shall notify the peer-to-peer car sharing program about the safety recall so that the shared vehicle owner may address the safety recall repair.

Chapter 5. Effective Date.

Sec. 1. This Act shall take effect on the day that occurs [*the effective date should be **at least** nine (9) months after the Act becomes law—insert date **here***] after the date on which the Act becomes law.

Drafting Note *– The effective date should be a minimum of 9 months from the date the Governor signs the legislation.*

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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 and amended on May 8, 2019). Draft as of November 11th, 2019.***

****To be discussed during the Joint State-Federal Relations and International Insurance Issues Committee on December 12th ~~July 11th~~, 2019****

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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 options to address the significant limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that provides needed legal finality for such transfers in order to provide for improved operational and capital efficiency for insurance companies, stimulates the economy by attracting segments of the insurance industry to the state, make this state an attractive home jurisdiction for insurance companies, encourages economic growth and increased investment in the financial services sector and increases the availability of quality insurance industry jobs in this state. These purposes are accomplished by providing 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, annuity 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.

> *Drafting Note: States may wish to remove certain lines of insurance from the scope of 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. description of how the transferring and assuming insurers will be licensed for guaranty association coverage purposes,

Drafting Note: The regulatory authorization language of Section 6D. is meant to allow for the promulgation of regulations that address issues including, but not limited to:

(1) Guaranty association coverage;

(2) The financial implications of the transaction including solvency, capital adequacy, cash flow, reserves, asset quality and risk-based capital;

(3) An analysis of the assuming insurer’s corporate governance structure to ensure that there is proper board management oversight and expertise to manage the subject business;

(4) The competency, experience and integrity of the persons who would control the operation of an involved insurer; and

(5) Ensuring the transaction is not being made for improper purposes, including fraud.

n~~m~~. evidence of approval or nonobjection of the transfer from the chief insurance regulator of the state of the transferring insurer's domicile, and

o~~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) a listing and summaries of 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 o 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 3~~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 that are not inconsistent with ~~to effectuate the provisions of~~ the Insurance Business Transfer Act.

E. The portion of the application for an Insurance Business Transfer that would otherwise be confidential, including any documents, materials, communications or other information submitted to the Commissioner in contemplation of such application, shall not lose such confidentiality.

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. The transferring insurer and the assuming insurer shall jointly be obligated to pay any compensation, costs and expenses of the independent expert and any consultants retained by the independent expert and approved by the Department incurred in fulfilling the obligations of the independent expert under this act. Nothing in this act shall be construed to create any duty for the independent expert to any party other than the Department or the Court.

D~~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 _____.

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)

E-Titling Model Act

Sponsored by Del. Steve Westfall (WV)

Draft as of November 11th, 2019. To be discussed and considered by the Financial Services & Multi-Lines Issues Committee on December 11th, 2019

Section 1. Title

This Act shall be known as the [State] E-Titling Model Act.

Section 2. Purpose

The purpose of this Act is create efficiency, accuracy and accountability in the titling process.

Section 3. E-Titling Process

The Department of Motor Vehicles, or appropriate State Agency, shall develop or utilize an existing electronic vehicle titling system to process motor vehicle title transactions, including, without exception, salvage, junk and/or non-repairable titles. The system shall allow for the use of electronic signature and provide for the submission of all required and/or associated documents by electronic means.

(a) The use of an electronic signature in association with any title transaction satisfies any signature required under law, except that an electronic signature on an odometer disclosure by or on behalf of an insurance company must utilize a secure authentication system identifying a specific individual with a degree of certainty equivalent to Level 2 as described in NIST Special Publication 800-63-3, Revision 3, *Digital Identity Guidelines*, June 2017.

(b) Notarization is not required for any power-of-attorney form or any other form submitted in association with either a title application or odometer disclosure pursuant to subsection (a).

(c) The use of electronic signature pursuant to subsection (a) is not contingent upon the establishment or existence of an electronic vehicle titling system.

(d) The Department of Motor Vehicles, or appropriate State Agency, shall provide for third-party real-time, single inquiry access to the electronic vehicle titling system so as to facilitate access to title information.

Section 4. Rules

The [head of the appropriate state agency] shall have the authority to promulgate rules to implement the provisions of this Act.

Section 5. Effective Date

This Act shall take effect _____.

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

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 December 12th, 2019

Proposed Amendments Sponsored by Sen. Travis Holdman (IN) – NCOIL Immediate Past President

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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~~ issues and allegations that may 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 that rises to a level of material violations of state law or regulations and harms consumers; and

- Procedures to communicate and coordinate market conduct actions among states to foster the most efficient and effective use of resources.

- Notwithstanding any provisions in this code to the contrary, nothing in this act shall authorize a market conduct examination of the insurer's cybersecurity protection measures which is otherwise provided for in domiciliary state financial examinations consistent with the NAIC's coordinated approach to examinations.

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 materially from state law or ~~significantly from the norm or~~ regulations and that ~~may~~ pose a demonstrated material~~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 material 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 materially from state law or ~~significantly from the norm or~~ regulations and that ~~may~~ pose a ~~potential~~ material and demonstrated 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 material unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts].

(2) A number of material and confirmed complaints against the insurer or a confirmed 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 confirmed 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 material 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.

(5) Patterns of violations shall include such frequency as to connote a general business practice as opposed to non-material violations that do not rise to a business practice. Patterns of violations does not include *de minimus* violations or isolated occurrences or multiple *de minimus* non-material violations in single events or multiple non-confirmed complaints. Non-material violations regarding this section means technical violations of code that do not cause direct harm to consumers or other entities. Commissioners shall perform sufficient analysis and dedicate appropriate resources to ruling out allegations of misconduct before reaching the company contact level.

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. Additionally, a summary of all actions taken along the continuum of regulatory response shall be documented and provided to the targeted company. Upward deviations from estimated budgets shall be limited to 10%, should rarely occur and only with substantial documentation as to necessity for the same.

(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.; and

(F) Ascertain and resolve any apparent or known conflicts of interest by the outside vendors with insurers or insurance departments in accordance with Section 9;

(G) Maintain budgetary parameters and measures to require deviations from estimated costs be detailed and substantiated prior to incurrence. Commissioners should endeavor to keep costs in a reasonable range or hold outside vendors accountable for unjustifiable excesses; and

(H) Prohibit market conduct surveillance personnel from performing duplicative work or review of materials submitted in prior market conduct examinations in this state or in other states' examinations.

(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, unless those statements are made with reckless disregard for the truth or recklessly disclose confidential or proprietary information.

(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. <u>This same rational is intended to incent and reward insurers that engage in self-assessment, self reporting and remediation activity</u>.

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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National Council of Insurance Legislators (NCOIL)

Rebate Reform Model Act

***Sponsored by Rep. Matt Lehman (IN)**
***Discussion Draft as of November 11th, 2019. To be discussed during the NCOIL Financial Services & Multi-Lines Issues Committee on December 11, 2019**

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Section 1. Title

This Act shall be known as the [State] Rebate Reform Model Act.

Section 2. Purpose

The purpose of this Act is to modernize state anti-rebate statutes and regulations so that they recognize new products being offered by the insurance industry and maintain necessary consumer protections.

Section 3. Permissible Gifts and Prizes

Notwithstanding any other provision in the insurance code of [this state], an insurer, an employee of an insurer or a producer may:

(A) offer to give gifts in connection with marketing for the sale or retention of contracts of insurance, as long as the cost does not exceed [$250] per year per person; and

(B) conduct raffles or drawings, as long as there is no participation cost to entrants and as long as the prizes are not valued in excess of [$500].

Pursuant to this section, gifts and prizes given may not be in the form of cash.

Drafting Note: States may wish to alter the financial limitations set forth in this section depending upon each state's economic environment.

Section 4. Permissible Value-Added Service or Activity

An insurer, by or through its employees, affiliates, insurance producers or third-party representatives, may offer or provide products or services that relate to, or in conjunction with, a policy of insurance for free or at a discounted price that are exclusively intended to educate about, assess, monitor, control or prevent risk of loss to persons, their lives, health or property. The offer or provision of products or services in this subsection are exempt from the prohibitions set forth in [insert applicable citation].

Section 5. Services for Free or for Less than Market Value

This section does not prohibit a person from offering or providing services, as long as the services are at least tangentially related to an insurance contract or the administration thereof, for free or for less than fair market value as long as the receipt of the services is not contingent upon the purchase of insurance and the services are offered on the same terms to all potential insurance customers. A person that offers or provides services under this subsection for free or for less than fair market value shall disclose conspicuously in writing to the recipient before the purchase of insurance, receipt of a quote of insurance for insurance or designation of an agent of record that receipt of the services is not contingent on the purchase of insurance.

Section 6. Rules

The commissioner may adopt rules as necessary to make reasonable modifications to the standards in this Act. Additionally, the commissioner is expressly authorized to increase, by rule, the explicit financial limitations set forth in Section 3 so as to keep those limits relevant consistent with changing economic times.

Drafting Note: "Commissioner" may be replaced with the title of the state's chief insurance regulatory officer.

Section 7. Effective Date

This Act is effective immediately.

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National Council of Insurance Legislators (NCOIL)

Private Flood Insurance Model Act

Sponsored by Rep. David Santiago (FL)

Discussion Draft as of November 11th, 2019. To be discussed during the Special Committee on Natural Disaster Recovery on December 11th, 2019.

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Section 1. Title

This Act shall be known as the Private Flood Insurance Model Act.

Section 2. Purpose

In an effort to provide protection of lives and property from the peril of flood, this legislation is designed to encourage a robust private flood insurance market to provide consumer choices and alternatives to the existing National Flood Insurance Program (NFIP).

Section 3. Definitions

For purposes of this Act:

(a) "Authorized Insurer" means an insurer that is authorized by the [State entity for regulating insurance] to write insurance under a certificate of authority issued by the [State entity for regulating insurance] to transact insurance in this state.

(b) "National Flood Insurance Program" means the program of flood insurance coverage and floodplain management administered under the National Flood Insurance Act of 1968 (42 U.S.C. 4001 et. seq) and applicable federal regulations promulgated in Title 44 of the Code of Federal Regulations.

Section 4. Rates

(a) Rates for flood insurance coverage established pursuant to this paragraph are not subject to prior approval by the [state entity for regulation of insurance]. An insurer must attest that the rates are based on actuarial data, methodologies, standards and guidelines relating to flood that are not excessive, inadequate, or unfairly discriminatory. The [state entity for regulation of insurance] may audit an insurer's flood rates to ensure compliance with state laws and regulations.

(b) An insurer may file and/or 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.

Section 5. Forms

The [State entity for regulating insurance] may require, through the application of the State's existing regulatory system, that an insurer file the forms for this coverage and that an authorized insurer may issue an insurance policy, contract, or endorsement that at least meets the private flood insurance requirements as specified in 42 U.S.C. s. 4012a(b).

Section 6. Duties of Insurer

(a) Authorized insurers must notify the [State entity for regulating insurance] of plans to sell private flood insurance products in accordance with the state's rate filing laws 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.

Section 7. Duties of Producer

A producer must:

(a) notify the applicant of the existence of the NFIP and private market alternatives for flood insurance coverage;

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

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

A surplus lines broker may place a policy or endorsement providing flood insurance coverage to an eligible surplus lines insurer in accordance with [insert applicable state statute authorizing a surplus lines licensee to place coverage].

It shall be a best practice for producers to maintain in their records, written or electronic evidence, to be signed by the applicant, acknowledging (a) through (c) above. There is no specific, prescribed format for the producer documentation. This section is to ensure that the interaction between the insurance producer and customer occurred and that producer documentation of the consumer's flood insurance choice is documented.

Section 8. 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 of a private flood insurance policy by the [state entity for regulation of insurance] as a condition of qualifying for federal 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] certify that a policy, contract, or endorsement provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the NFIP.

(d) The authorized insurer or its producer may reference or include a certification under paragraph (c) in advertising or communications with an producer, 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 producer 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.

Section 9. Rules

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

Section 10. Effective Date

This Act shall take effect _____.

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National Council of Insurance Legislators (NCOIL)

Insurance E-Commerce Model Act

Sponsored by Rep. Edmond Jordan (LA)

Draft as of November~~June~~ 11th, 2019. To be discussed during the Financial Services & Multi-Lines Issues Committee on December~~July~~ 11~~2~~th, 2019

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Section 1. Title

This Act shall be known as the "[State] Insurance E-Commerce Model Act."

Section 2. Purpose

The purpose of this Act is to provide consumers more choice, convenience and flexibility in managing their insurance.

Section 3. Definitions

As used in this Chapter, the following definitions apply:

(1) "Delivered by electronic means" means either of the following:

(a) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(b) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party. The separate notice of the posting shall contain the internet address at which the documents are posted. <u>For purposes of this subsection, delivery shall be effective upon the latter of the posting or the actual delivery of the separate notice of the posting.</u>

(2) "Party" means any recipient of any notice or document required as part of an insurance transaction, including but not limited to an applicant, an insured, a policyholder, or an annuity contract holder.

Section 4. Electronic delivery of insurance documents and notices

A. Subject to the requirements of this Section, any notice to a party or any other document required by law in an insurance transaction or that is to serve as evidence of insurance coverage, except cancellation or nonrenewal of any insurance coverage, may be delivered, stored, and presented by electronic means if the electronic means meet the requirements of the [Uniform Electronic Transactions Act/state technology law].

B. Delivery of a notice or document in accordance with this Section shall be considered equivalent to and have the same effect as any delivery method required by law, including delivery by first class mail, first class mail with postage prepaid, certified mail, certificate of mail, or certificate of mailing.

C. A notice or document may be delivered by electronic means by an insurer to a party pursuant to this Section if all of the following apply:

(1) The party has affirmatively consented electronically, or confirmed consent electronically, in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means to which the party has given consent, and the party has not withdrawn the consent.

(2) The party, before giving consent, is provided with a clear and conspicuous statement informing the party of all of the following:

(a) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(b) The types of notices and documents to which the party's consent would apply.

(c) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn.

(d) The procedures a party must follow to withdraw consent, which can be no more burdensome than providing consent, to have a notice or document delivered by electronic means and to update the party's electronic mail address.

(e) The right of a party to have any notice or document delivered, upon request, in paper form.

D. An insurer shall take all measures reasonably calculated to ensure that delivery by electronic means pursuant to this Section results in receipt of the notice or document by the party.

Section 5. Change in hardware or software requirements

After the consent of a party is given, in the event a change in the hardware or software requirements needed to access or retain a notice or document to be delivered by electronic means creates a material risk that the party will not be able to access or retain ~~a subsequent~~the notice or document to which the consent applies, the insurer shall not deliver a notice or document to the party by electronic means unless the insurer complies with Section 4 of this Act and provides the party with a statement that describes all of the following:

(1) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(2) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

Section 6. Applicability

A. The provisions of this Section shall not be construed to affect requirements related to content or timing of any notice or document required by any other provision of law.

B. If a provision of this Title or other applicable law requiring a notice or document to be provided to a party expressly requires confirmation of receipt of the notice or document,

the notice or document may be delivered by electronic means only if the method used provides for active confirmation of receipt by the recipient.

C. This Chapter shall not apply to a notice or document delivered by an insurer in an electronic form before the effective date of this Chapter to a party who, before that date, has consented to receive the notice or document in an electronic form otherwise allowed by law.

Section 7. Contracts and policies not affected

The legal effectiveness, validity, or enforceability of any contract or policy of insurance executed by a party shall not be denied solely because of the failure of the insurer to obtain electronic consent or confirmation of consent of the party in accordance with the provisions of this Chapter if the notice or document is delivered in paper form.

Section 8. Withdrawal of consent

A. A withdrawal of consent by a party shall not affect the legal effectiveness, validity, or enforceability of a notice or document delivered by electronic means to the party before the withdrawal of consent is effective.

B. A withdrawal of consent by a party shall be effective within a reasonable period of time after receipt of the withdrawal by the insurer.

C. Failure by an insurer to comply with any provision of Section 4 or 5 of this Act may be treated, at the election of the party, as a withdrawal of consent for purposes of this Chapter.

Section 9. Prior consent to receive notices or documents in an electronic form

If the consent of a party to receive certain notices or documents in an electronic form is on file with an insurer before the effective date of this Chapter, and an insurer intends to deliver additional notices or documents to the party in an electronic form pursuant to this Chapter, then prior to delivering the additional notices or documents electronically, the insurer shall comply with the provisions of Section 4 of this Act and shall provide the party with a statement that describes both of the following:

(1) The notices or documents that shall be delivered by electronic means that were not previously delivered electronically.

(2) The party's right to withdraw consent to have notices or documents delivered by electronic means, without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

Section 10. Alternative method of delivery required

An insurer shall deliver a notice or document by any other delivery method permitted by law other than electronic means if either of the following occurs:

(1) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party.

(2) The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

Section 11. Limitation of liability

An insurance producer shall not be subject to civil liability for any harm or injury that occurs because of a party's election to receive any notice or document by electronic means or by an insurer's failure to deliver or a party's failure to receive a notice or document by electronic means.

Section 12. Posting Policy on Internet

A. An insurance policy and an endorsement that does not contain personally identifiable information may be mailed, delivered, or, if the insurer obtains separate, specific consent, posted on the insurer's website. If the insurer elects to post an insurance policy and an endorsement on the insurer's website in lieu of mailing or delivering the policy and endorsement to the insured, the insurer shall comply with the following conditions:

(1). The policy and an endorsement must be accessible to the insured and producer of record and remain that way while the policy is in force;

(2). After the expiration of the policy, the insurer shall either ~~archive the expired policy and endorsement for a period of five years or other period required by law, and make the policy and endorsement available upon request. After expiration of the policy, the insurer shall also keep active the insured's user ID used to access the insurer's website for a period of five years or other period required by law~~:

(a). Make the expired policy and endorsement available upon request, for a period of five years; or

(b). If the insurer continues to make the expired policy or endorsement available on its website, keep the insured's user ID active for a period of five years;

(3). The policy and endorsement must be posted in a manner that enables the insured and producer of record to print and save the policy and endorsement using a program or application that is widely available on the internet and free to use;

(4). The insurer shall provide the following information in, or simultaneous with, each declaration page provided at the time of issuance of the initial policy and any renewals of the policy:

(a). A description of the exact policy and endorsement form purchased by the insured;

(b) A description of the insured's right to receive, upon request and without charge, an electronic and/or a paper copy of the policy and endorsement; and

(c) The internet address at which the policy and endorsement are posted;

(5) The insurer, upon an insured's request and once without charge following receipt of the initial copy, shall mail a paper copy of the policy and endorsement to the insured; and

(6). The insurer shall provide notice, either electronically or in writing at the insured's option~~in the format preferred by the insured~~, of any change to the forms or endorsement; the insured's right to obtain, upon request and once without charge following receipt of the initial copy, a paper copy of the forms or endorsement; and the internet address at which the forms or endorsement are posted.

B. This section does not affect the timing or content of any disclosure or document required to be provided or made available to any insured under applicable law

Section 13. Receipt of Claim Payments by Electronic Transfer

All claims brought by insureds, workers' compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer or, if offered by the insurer and the claimant consents, electronic transfer of funds to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or her/his attorney, or upon direction of the claimant to one specified; however, the check or draft shall be made jointly to the claimant and the employer when the employer has advanced the claims payment to the claimant. The check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer.

Section 14. Rules

The Insurance Commissioner may adopt rules to implement the provisions of this Act.

Section 15. Effective Date

Section 14 of this Act shall take effect immediately. The remaining sections of the Act shall take effect 180 days following enactment.

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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)**

***~~Discussion~~ Draft as of ~~June~~November 11th, 2019. To be discussed during the Health Insurance and Long Term Care Issues Committee on ~~July~~December ~~13~~11th, 2019.**

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

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

"Commissioner" means the Insurance Commissioner.

"Department" means the Insurance Department.

“Director” means the Medicaid Director.

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

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

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

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

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

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

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

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

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

“Wholesale acquisition cost” means, with respect to a pharmaceutical drug or biological product, the manufacturer's list price for the pharmaceutical drug or biological product to wholesalers or direct purchasers in the United States for the most recent month for which the information is available, as reported in wholesale price guides or other publications of pharmaceutical drug or biological product pricing data, not including any rebates, prompt pay or other discounts, or other reductions in price.

Section 4. Disclosure of prescription drug pricing information.

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

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

(b)(1) Not more than thirty days after an increase in wholesale acquisition cost of ~~fifty~~sixty percent or greater over the preceding five calendar years or fifteen percent or greater in the preceding twelve months for a drug with a wholesale acquisition cost of ~~one hundred~~ seventy 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~~.~~; and

(G) A statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost.

(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~~.~~; and

(D) The aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were retained as revenue by the pharmacy benefit manager.

(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 (~~41~~) of this Act. For any pharmacy benefit manager with fewer than five (5) clients, the commissioner shall aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's internet website. The data from all of the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any pharmacy benefit manager.

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

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

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

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

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

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

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

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

(2) Within sixty days of receipt, the commissioner shall publish the report on the [INSURANE DEPARTMENT'S] prescription drug price information website developed pursuant to subsection (a)(2) of section (~~41~~) of this Act. For any health [CARRIER/INSURER] with an affiliated pharmacy benefit manager with fewer than five (5) clients, the commissioner shall aggregate all the collected data and publish the aggregated data from all reports for that year required by this section in an appropriate location on the department's internet website. The data from all of the reports must be published in a manner that does not disclose or tend to disclose proprietary or confidential information of any health [CARRIER/INSURER].

(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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National Council of Insurance Legislators (NCOIL)

Short Term Limited Duration Insurance Model Act

Sponsored by Rep. Martin Carbaugh (IN)

To be discussed during the NCOIL Health Insurance and Long Term Care Issues Committee on <u>December</u>~~July~~ <u>11</u>~~3~~th, 2019. ~~Initial~~ ~~d~~<u>Draft</u> as of <u>November</u>~~June~~ 11th, 2019 based on Indiana HB 1631 (signed into law on May 6, 2019)

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Section 10. Rules
Section 11. Effective Date

Section 1. Title

This Act shall be known as the "[State] Short Term Limited Duration Insurance Model Act."

Section 2. Purpose

The purpose of this Act is to establish standards for the regulation of short term limited duration insurance plans that may be sold in [State].

Section 3. Definitions

For purposes of this Act:

(a) "Covered Individual" means an individual entitled to coverage under a short term insurance plan

(b) "PPACA" means the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)

(c) "Preferred Provider Organization" means a type of health plan that contracts with healthcare providers to create a network of participating providers to provide healthcare services at a discounted cost to covered persons.

(d~~e~~) "Short Term Insurance Plan" means a policy of health insurance that:

(1) may be renewed for the greater of:

(i) thirty-six (36) months; or

(ii) the maximum period permitted under federal law;

(2) has a term of not more than three hundred sixty-four (364) days; and

(3) has an annual limit of at least two million dollars ($2,000,000).

Section 4. Renewal and Underwriting

(a) An insurer may require an applicant for coverage under a short term insurance plan to specify, before issuance of the short term insurance plan, the number of renewals the applicant elects.

(b) After issuance of a short term insurance plan, the insurer may not require underwriting of the short term insurance plan until:

(1) all renewal periods elected under subsection (a) have ended; and

(2) the covered individual enrolls in a new ~~renews the~~ short term insurance plan beyond the periods described in subdivision (1).

Section 5. Coverage Requirements

A short term insurance plan must include coverage for the following:

(1) Ambulatory patient services;

(2) Hospitalization;

(3) Emergency services; and

(4) Laboratory services

Section 6. ~~Preferred Provider~~ Network Based Plan Requirements

(a) This section applies to an insurer that issues a short term insurance plan and undertakes a preferred provider plan to render health care services to covered individuals under the short term insurance plan.

(b) An insurer described in subsection (a) shall ensure that the preferred provider plan meets the following requirements:

(1) The preferred provider plan includes essential community providers in accordance with PPACA.

(2) The preferred provider plan is sufficient in number and types of providers (other than mental health and substance abuse treatment providers) to assure covered individuals' access to all health care services without unreasonable delay.

(3) The preferred provider plan is consistent with the network adequacy requirements that:

(i) apply to qualified health plan issuers under 45 CFR 156.230(a) and 45 CFR 156.230(b); and

(ii) are consistent with subdivisions (1) and (2).

Section 7. Disclosure Requirements

(a) An insurer that issues a short term insurance plan shall disclose to an applicant, in bold, 12-point type, the following:

(1) That the short term insurance plan is not required to include coverage for all ten (10) of the essential health benefits required under the PPACA and specify the essential health benefits where no coverage is offered.

(2) That the short term insurance plan does not necessarily provide the full coverage that is required under PPACA.

(3) That the full coverage required by the PPACA may be secured during the next PPACA annual open enrollment, which typically commences on November 1 and can be found at https://www.healthcare.gov/quick-guide/dates-and-deadlines/

(b) An insurer shall obtain the signature of an applicant to whom the disclosures required by subsection (a) are made.

Section 8. Tiering/Rating

An insurer shall not, as a condition of enrollment or continued enrollment in a short term insurance plan, require an individual to pay a premium or contribution greater than the premium or contribution for a similarly situated individual enrolled in the short term insurance plan on the basis of a health status related factor in relation to the individual or a dependent of the individual.

Section 9. Discounts/Rebates/Out-of-Pocket Payment Modifications

This Act does not prevent an insurer from establishing a premium discount, a rebate, or out-of-pocket payment modifications in return for adherence to programs of health promotion and disease prevention.

Section 10. Rules

The Insurance Commissioner may adopt rules regulating short term limited duration plans that are consistent with this Act.

Section 11. Effective Date

This Act shall take effect [_____].

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National Council of Insurance Legislators (NCOIL)

Health Care Sharing Ministry Registration Model Act

Sponsored by Rep. Martin Carbaugh (IN)

Discussion Draft as November 11th, 2019. To be discussed during the Health Insurance & Long Term Care Issues Committee on December 11th, 2019

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Section 10. Effective Date

Section 1. Title

This Act shall be known as the "[State] Health Care Sharing Ministry Registration Act."

Section 2. Purpose

The purpose of this Act is to provide a registration and reporting mechanism for state insurance regulators to be informed of health care sharing ministries open to enrollment in each jurisdiction.

Section 3. Definitions

"Health care sharing ministry" is defined by 26. U.S.C. § 500A(d)(2)(B).

Section 4. Notice Requirements

A health care sharing ministry must provide a written disclaimer on or accompanying all applications, marketing materials and guidelines materials distributed by or on behalf of the health care sharing ministry that states, in substance:

NOTICE

> The organization facilitating the sharing of medical expenses is not an insurance company, and neither its guidelines nor plan of operation constitute an insurance policy. Without health care insurance, there is no guarantee that you, a fellow participant or any other person who was a party to the health care ministry agreement will be protected in the event of illness or emergency. Regardless of whether you receive any payment for medical expenses or whether this organization terminates, withdraws from the faith-based agreement or continues to operate, you are always personally responsible for the payment of your own medical bills. If your participation in such an organization ends, state law may subject you to a waiting period before providing coverage.
>
> *Drafting Note: This notice should be harmonized to reflect any existing notice requirement that may exist for health care sharing ministries in the given state.*

Section 5. Registration and Reporting Requirements

(A) A Certificate of Registration as a Health Care Sharing Ministry shall be obtained by submitting to the Department of Insurance:

> (1) An application for registration on a form promulgated by the Insurance Commissioner which much include:
>
> > (a) The responsible director or manager of the health care sharing ministry plans;
> >
> > (b) Contact address for the health care sharing ministry; and
> >
> > (c) Contact phone number for the responsible director or manager.
>
> (2) A copy of the certification letter issued to the Health Care Sharing Ministry by the Centers for Medicare & Medicaid Services;

(3) A copy of the current annual audit required pursuant to 26 U.S.C. § 500A(d)(2)(B);

(4) A list of any third-party vendors acting on behalf of the organization for purposes of enrolling members, or for the purpose of negotiating with medical providers, or the financial sharing of member's medical needs;

(5) A copy of any application forms and ministry guidelines used by the Health Care Sharing Ministry;

(6) A report of the Health Care Sharing Ministry's (state name) members as of the date of application and the report must include:

(a) Total number of enrolled members;

(b) Distribution of members by age; and

(c) Distribution of members by sex.

(7) The [$100] fee for issuance of the certificate of registration;

(8) An application for a Certificate of Registration may only be rejected if the application does not provide the information required by this subsection.

(B) The Certificate of Registration obtained pursuant to Section 5(A) may be renewed annually on or before January 1 by submitting to the Department of Insurance:

(1) An application for renewal on a form promulgated by the Commissioner;

(2) Any current application forms or ministry guidelines that are not presently on file with the Department;

(3) An updated list of any third-party vendors acting on behalf of the organization for purposes of enrolling members, or for the purpose of negotiating with medical providers, or the financial sharing of member's medical needs;

(4) A report of the Health Care Sharing Ministry's (state name) members as of the date of the application for renewal and the report must include:

(a) Total number of enrolled members;

(b) Distribution of members by age; and

(c) Distribution of members by sex.

(5) A copy of the current annual audit required pursuant to 26 U.S.C. § 500A(d)(2)(B);

(6) The [$100] fee for renewal of the certificate

(7) An application for renewal of a Certificate of Registration may only be rejected if the application does not provide the information required by this subsection.

(C) A Health Care Sharing Ministry shall not operate under any name other than the name for which the Certificate of Registration has been issued. The Certificate of Registration expires at midnight on the last day of December. The Commissioner shall send a notice of the impending expiration of a current Certificate of Registration no later than 30 days prior to expiration of the current Certificate of Registration.

(D) The Commissioner may renew a registration which has inadvertently been permitted to expire if a request is made within 3 months after expiration. Any failure to timely renew shall be subject to the following penalties:

(1) 1-30 days late – [$250]

(2) 31-60 days late – [$500]

(3) 61-90 days late – [$1,000]

(4) After 90 days – the Health Care Sharing Ministry is barred from reapplying for two years and will not be permitted to operate in the state until they are permitted to reregister.

Section 6. Posting Requirements

The commissioner shall post all non-proprietary/confidential information submitted pursuant to Section 5 on the insurance department's website. The information shall be prominently displayed on the insurance department's website in addition to an explanation of the differences between health care sharing ministries and insurance.

Section 7. Anti-Fraud Protections

Each health care sharing ministry registered in [state] shall be subject to the anti-fraud provisions of the insurance code of [state].

Section 8. Enforcement

Any purported Health Care Sharing Ministry that is operating in [state] without a current Certificate of Registration shall be subject to the full authority of the Department of Insurance pursuant to [cite the state's Insurance Code provisions for Unauthorized Insurance) and the State Attorney General's authority over non-profit corporations.

Section 9. Rules

The Insurance Commissioner may promulgate rules regarding health care sharing ministries to the extent that they are consistent with this Act.

Section 10. Effective Date

This Act shall take effect [_____].

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding the Use of Insurance Claims History Information in Homeowners and Personal Lines Residential Property Insurance

Adopted by the NCOIL Property-Casualty Insurance Committee on July 8, 2005. Amended and adopted by the NCOIL Executive Committee on July 8, 2005. Readopted by the NCOIL Property & Casualty Insurance Committee on November 18, 2011 and by the NCOIL Executive Committee on November 20, 2011.

To be considered for re-adoption during the NCOIL Property & Casualty Insurance Committee on December 13th, 2019

Sponsored by Sen. David Bates, RI; Rep. Dan Tripp, SC; and Rep. Rich Golick, GA

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Section 1. Short Title

This Act may be called the *Model Act Regarding the Use of Insurance Claims History Information* in Homeowners and Personal Lines Residential Property Insurance.

Section 2. Purpose

The purpose of this Act is to regulate the use of claims history information for homeowners and personal lines residential property insurance and provide certain consumer protections with respect to the use of such information.

> *[Drafting Note: In certain respects, this model does not address or restrict the manner in which an insurer may respond to the claims of existing policyholders. Many states already regulate the treatment of existing policyholders, and any jurisdictions that wish to address the issue will need to do so independently.]*

Section 3. Definitions

A. "Adverse Action" means a denial or cancellation of, an increase in any charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of any insurance, existing or applied for, in connection with the underwriting of homeowners and personal lines residential property insurance.

B. "Claim" means a request to an insurer for payment of a benefit by an insured or third-party. A mere report of loss or a question relating to coverage shall not constitute a claim.

C. "Claims history report" means information provided by a claims history report provider to an insurer, insurance producer, or other authorized party regarding the claims history or loss experience of natural persons or properties, including reports generated from or by the APLUS Property Database and the Comprehensive Loss Underwriting Exchange (CLUE).

D. "Claims history report provider" means any person that regularly engages in the practice of assembling, collecting, or disseminating information regarding the individual claims history of natural persons or properties for the primary purpose of providing such information to insurers, insurance producers, or other authorized parties for underwriting or rating. Government institutions, insurers, and insurance producers shall not be considered "claims history report providers."

E. "Consumer" means an insured or an applicant for insurance coverage.

F. "Inquiry" means a telephone call and other communication made to an insurer regarding the terms, conditions, or coverage afforded under an insurance contract that does not result in a claim, including questions concerning whether a policy will cover a loss or the process for filing a claim. An "inquiry" under this Act shall not be considered a "claim" for purposes of [*insert reference to State Unfair Trade Practices Act*].

G. "Insurer" means an insurance company authorized to do business in this state.

Section 4. Use of Claims History Information Generally

A. An insurer that uses insurance claims history or loss experience information to underwrite or rate risks shall not deny, cancel or non-renew homeowners or personal

lines residential property insurance coverage, or establish rates for such coverages, based solely on the claims history or loss experience of a previous owner of the property to be insured.

B. Failure of an insurer, within 30 days of binding coverage, to act upon the information contained in a claims history report shall preclude the insurer from declining homeowners or personal lines residential property insurance coverage or terminating a binder of such coverage based on that information. This subsection shall not apply if the insurer has commenced a further investigation, inspection, or other review of the property to be insured as a result of information contained in the report within the 30-day period and the investigation, inspection, or other review has not yet concluded. The requirements of this subsection shall also not apply to the renewal of an insurance policy.

C. When a consumer applies for homeowners or personal lines residential property insurance, an insurer may not consider or take an adverse action based upon information contained in a claims history report that is more than five (5) years old.

D. Notwithstanding subsections (A) and (B), an insurer may deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish rates for such coverages based on the known condition or use of the premises or due to fraudulent acts of the consumer

Section 5. Use of Inquiries and Other Information

A. An insurer shall not deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish insurance rates for such coverages, based in whole or in part on inquiries made by any consumer to an insurer.

B. An insurer shall not deny, cancel, or non-renew homeowners or personal lines residential property insurance coverage, or establish rates for such coverages, based in whole or in part on claims that have been closed without payment to or on behalf of an insured or third-party, unless 1) more than one such incident occurred within the previous three years or 2) the claim closed without payment affects the nature of the risk and is predictive of future loss.

C. Notwithstanding subsections (A) and (B), an insurer may deny, cancel or non-renew homeowners or personal lines residential property insurance coverage, or establish insurance rates for such coverages, based upon the known condition or use of the premises or due to fraudulent acts of the consumer.

Section 6. Dispute Resolution and Error Correction

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the claims history information of an insured or property was incorrect or incomplete and if a homeowners and personal lines residential property insurer receives notice of such determination from either the

consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within 30 days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

Section 7. Disclosure to Insurance Consumers

A. If an insurer writing homeowners or personal lines residential property insurance uses claims history or loss experience in underwriting or rating, the insurer shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain claims history or loss experience information in connection with such application. Such disclosure may be oral, written, or in electronic form. Such disclosure must explain the ways in which the insurer uses claims history or loss experience information, whether the claims history of the applicant and/or property to be insured will be reviewed, and whether future claims incurred by the applicant will be reported to a claims history report provider.

B. If a homeowners or personal lines residential property insurer takes an adverse action based upon the claims history report of a consumer or property, the insurer must meet the notice requirements of this subsection. Such insurer shall:

1. Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, if applicable.

2. Provide notification, upon request, to the consumer identifying the claim information that resulted in the adverse action. An insurer may comply with this paragraph by providing the requisite disclosure and claims information in any declination, nonrenewal, premium increase or surcharge, adverse action, or other notice required under other applicable law.

Section 8. Treatment of Certain Information

A. A homeowners or personal lines residential property insurer shall not disclose or submit to any claims history report provider or any other consumer reporting agency that an inquiry was made to the insurer by a consumer.

B. A claims history report provider shall not knowingly provide an insurer, insurance producer, or any other person with a claims history report that discloses that an inquiry was made to an insurer by a consumer.

Section 9. Disclosures by Claims History Report Providers

A claims history report provider must disclose the codes, classifications, and guidelines utilized in its claims history reports to the Department of Insurance, upon request.

Section 10. Severability

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

Section 11. Effective Date

This Act shall take effect on [*insert date*], applying to homeowners and personal lines residential property insurance policies either written to be effective or renewed on or after 9 months from the effective date of the bill.

© National Council of Insurance Legislators

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

National Council of Insurance Legislators (NCOIL)

Draft Model Act Regarding Vision Care Services

Sponsored by Sen. Bob Hackett (OH)

Discussion Draft as of November 11th, 2019. To be introduced during the Health Insurance & Long Term Care Issues Committee on December 11th, 2019

Note: This draft is meant solely for introduction purposes. This issue will be discussed throughout 2020.

(A) "Covered vision services" means vision care services or vision care materials for which a reimbursement is available under an enrollee's health care contract, or for which a reimbursement would be available but for the application of contractual limitations such as a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or any other limitation.

(B) "Vision care materials" includes lenses, devices containing lenses, prisms, lens treatments and coatings, contact lenses, orthopics, vision training, and any prosthetic device necessary to correct, relieve, or treat any defect or abnormal condition of the human eye or its adnexa.

(C) "Vision care provider" means either of the following:

(1) An optometrist licensed under Chapter XXX;

(2) A physician authorized under Chapter XXX.

(D) No contract or agreement between a vision care plan and a vision care provider shall do any of the following:

(1) Require that a vision care provider accept as payment an amount set by the vision care plan for vision care services or vision care materials provided to an enrollee unless the services or materials are covered vision services or as specified under (1)(a) and (b).

(a) Notwithstanding (D)(1), a vision care provider may, in a contract with a vision care plan, choose to accept as payment an amount set by the vision care plan for vision care services or vision care materials provided to an enrollee that are not covered vision services.

(b) No contract between a vision care provider and a vision care plan to provide covered vision services or vision care materials shall be contingent on whether the vision care provider has entered into an agreement addressing noncovered vision services pursuant to division (D)(1)(a).

(2) Include a provision that prohibits a vision care provider from describing out-of-network options to an enrollee.

(E) A vision care plan may communicate to its enrollees which vision care providers agree to accept as payment an amount set by the vision care plan for vision care services or vision care materials provided to an enrollee that are not covered vision services pursuant to (D)(1)(a). Any communication to this effect shall treat all vision care providers equally in provider directories, provider locators, and other marketing materials as participating, in-network providers, annotated only as to their agreements for pricing pursuant to (D)(1)(a).

(F) Vision care providers who choose not to enter agreements pursuant to (D)(1)(a) must post, in a conspicuous place, a notice stating the following:

"IMPORTANT: This vision care provider does not accept the fee schedule set by your insurer for vision care services and vision care materials that are not covered benefits under your plan and instead charges his or her normal fee for those services and materials. This vision care provider will provide you with an estimated cost for each non-covered service or material upon your request."

(G) This section shall be effective for contracts entered into, amended, or renewed on or after January 1, 20XX.

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National Council of Insurance Legislators (NCOIL)

Patient Dental Care Bill of Rights

Sponsored by Rep. George Keiser (ND)

Discussion Draft as of November 11th, 2019. To be introduced during the Health Insurance & Long Term Care Issues Committee on December 11th, 2019

Note: This draft is meant solely for introduction purposes. This issue will be discussed throughout 2020.

Contents:

A. Definitions
B. Network Leasing – Fair & Transparent Network Contracting
C. Prior Authorizations – Claim Payments Guarantee
D. Retroactive Denial – Fairness in Claim Payment Refund Requests
E. Virtual Credit Card – Claim Payment/Transaction Fees Options
F. Medical Loss Ratio – Transparency of Patient Premiums Invested in Dental Care

A. Definitions *

* (Dental coverage definitions and statutory language encompassing organizations that are engaged in financing dental care in return for a subscription fee can be complex. Multiple designs of dental coverage within health insurance or benefit plans make it nearly impossible to land on one definition that covers all designs. The intent of this model is to extend the benefits of the law to all situations where a patient is deemed covered by a commercial/private third party. The definitions below are taken from existing state laws; state bill drafting efforts should ensure as broad a reach as possible consistent with existing statutory construct.

The nature of definitions should be consistent with jurisdiction in a manner that is inclusive of all iterations of commercially available dental coverage designs and programs; definitions should be comprehensive and commensurate with state's statutory construct. Examples provided below for guidance)

"Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a third party administrator and a dental carrier.

"Covered person" means an individual who is covered under a dental benefits or health insurance plan that provides coverage for dental services.

"Credit card payment" means a type of electronic funds transfer in which a dental benefit plan or its contracted vendor issues a single-use series of numbers associated with the payment of dental services performed by a dentist and chargeable to a predetermined dollar amount, whereby the dentist is responsible for processing the payment by a credit card terminal or Internet portal. Such term shall include virtual or online credit card payments, whereby no physical credit card is presented to the dentist and the single-use credit card expires upon payment processing;

"Dental benefit plan" means a benefits plan which pays or provides dental expense benefits for covered dental services and is delivered or issued for delivery by or through a dental carrier on a stand-alone basis. (Note: some health insurers or health insurance plans integrate dental benefits and should be considered dental benefits plans for the purposes of this Act and in the provisions therein.)

"Dental carrier" means a dental insurance company, dental service corporation, dental plan organization authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

"Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. Dental services shall not include those services delivered by a provider that are billed as medical services.

“Dental Service Contractor” means any person who accepts a prepayment from or for the benefit of any other person or group of persons as consideration for providing to such person or group of persons the opportunity to receive dental services at such times in the future as such services may be appropriate or required, but shall not be construed to include a dentist or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom such services have been pre-diagnosed.

"Dentist" means any dentist licensed or otherwise authorized in this state to furnish dental services;

"Dentist agent" means a person or entity that contracts with a dentist establishing an agency relationship to process bills for services provided by the dentist under the terms and conditions of a contract between the agent and health care provider. Such contracts may permit the agent to submit bills, request reconsideration and receive reimbursement;

"Electronic funds transfer payment" means a payment by any method of electronic funds transfer other than through the Automated Clearing House Network (ACH), as codified in 45 CFR Sections 162.1601 and 162.1602;

"Health insurance plan" means any hospital or medical insurance policy or certificate; qualified higher deductible health plan; health maintenance organization subscriber contract; contract providing benefits for dental care whether such contract is pursuant to a medical insurance policy or certificate; stand-alone dental plan, health maintenance provider contract or managed health care plan; and

"Health insurer" means any entity or person that issues health insurance plans, as defined in this section.

"Prior authorization" means any communication indicating that a specific procedure is, or multiple procedures are, covered under the patient's dental plan and reimbursable at a specific amount, subject to applicable coinsurance and deductibles, and issued in response to a request submitted by a dentist using a format prescribed by the insurer.

"Provider" means an individual or entity which, acting within the scope of licensure or certification, provides dental services or supplies defined by the health benefits or dental benefit plan. "Provider" shall not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

"Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and providing for the delivery of and payment for dental services to covered persons.

"Third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. "Third party" shall not include any employer or other group for whom the contracting entity or dental carrier provides administrative services, including at least the payment of claims.

B. Fair and Transparent Network Contracting Act

An Act concerning practical dental provider network administration; enhancing contractual transparency and freedom of choice in network participation/contracting.

Section I. Responsible Leasing Requirements when Leasing Networks

A contracting entity shall not grant to a third party access to a provider network contract, or a provider's dental services or contractual discounts, or both, pursuant to a provider network contract, unless:

1. At the time the contract is entered into, sold, leased or renewed, or a when there are material modifications to a contract relevant to granting access to a provider network contract to a third party, the dental carrier allows any provider which is part of the carrier's provider network to choose to not participate in third party access to the contract or to enter into a contract directly with the health insurer that acquired the provider network. Opting out of lease arrangements shall not require dentists to cancel or otherwise end contractual relationship with the original carrier that leases its network.

2. The contract specifically states that the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and when the contracting entity is a dental carrier, the provider chose to participate in third party access at the time the provider network contract was entered into or renewed. The third party access provision of any provider contract shall be clearly identified in the provider contract as follows:

> "This contract grants third-party access to the provider network. The provider network contracting entity has entered into an agreement with other dental plans or third parties that allows the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity. The list of all third parties with access to this provider network can be found at (insert internet website as identified section 5). You have the right to choose not to participate in third-party access. Choosing to not participate in third party access to the contract shall not require termination of the original/contracting entity contract. To exercise your right to not participate in the third-party access, submit your written or electronic request to the health care service plan."

3. The third party accessing the contract agrees to comply with all of the contract's terms, including third party's obligation concerning patient steerage;

4. The contracting entity identifies, in writing or electronic form to the provider, all third parties in existence as of the date the contract is entered into, sold, leased or renewed;

5. The contracting entity includes on its website a listing, updated no less frequently than every 90 days, identifying all third parties;

6. The contracting entity requires each third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken, except this requirement shall not apply to electronic transactions mandated under the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191;

7. The contracting entity notifies the third party of the termination of a provider network contract no later than 30 days from the termination date with the contracting entity;

8. A third party ceases its right to a provider's discounted rate as of the date of termination of the provider's contract with the contracting entity;

9. The contracting entity delivers to participating providers a copy of the provider network contract relied on in the adjudication of a claim within 30 days after the date of a request from the provider.

No provider shall be bound by or required to perform dental treatment or services under a provider network contract that has been granted to a third party in violation of this act.

This act shall not apply to:

1. A provider network contract for dental services provided to beneficiaries of the state sponsored health programs such as Medicaid and CHIP;

2. Situations in which access to a provider network contract is granted to a contracting entity or dental carrier operating under the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A listing of all affiliates of the contracting entity shall be made available to the provider, in writing or electronic form, prior to access being granted; or,

3. Electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

Section II. Penalties

(Establish appropriate penalties for any violation of this Act.)

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

C. Prior Authorizations/Claim Payments Act

An Act prohibiting dental carriers from denying, revoking, limiting, conditioning, or otherwise restricting preapproved dental care claims or claims approved in prior authorizations; exceptions.

Section I.
Authorized Service(s) Claim Denial Prohibited/Exceptions

Dental benefit plans shall not deny any claim subsequently submitted by a dentist for procedures specifically included in a prior authorization unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;

2. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

3. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;

4. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used; or

5. The denial of the dental service contractor was due to one of the following:

a. another payor is responsible for payment,

b. the dentist has already been paid for the procedures identified on the claim,

c. the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier, or

d. the person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

Section II. Penalties
(Establish appropriate penalties for any violation of this Act.)

Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

D. Fairness in Collection of Overpayments by Health Insurers and Health Plans Covering Dental Services Act

An Act establishing time limits for dental benefit carriers to collect certain overpayments made to dentists; requiring notice; establishing policies and procedures allowing for challenges; exceptions.

Section I
Post-Payment of Claim/Payment Recovery Limitations

1. Other than recovery for duplicate payments, dental benefit plans or dental services contractors, whenever engaging in overpayment recovery efforts, shall provide written notice to the dentist that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

2. Dental benefit plans or dental services contractors shall provide dentists with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for dentists to follow to challenge an overpayment recovery.

3. Dental benefit plans or dental services contractors shall not initiate overpayment recovery efforts more than [Insert desired limit; suggest 12-18 months or emulate prevailing insurer limit on filing claims] after the original payment for the claim was made. No such time limit shall apply to overpayment recovery efforts which are:

a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

b. required by, or initiated at the request of, a self-insured plan; or

c. required by a state or federal government plan.

4. Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

E. Virtual Credit Card – Claim Payment/Transaction Fees Options Act

An Act concerning insurance; prohibiting certain restrictions on method of payment to health care providers; requiring certain notifications; prohibiting certain additional charges; prohibiting certain contracts, clauses or waivers; providing for enforcement by the Insurance Commissioner.

Section I.
Method of Payment Option

No dental benefit plan shall contain restrictions on methods of payment from the dental benefit plans or its vendor or the health maintenance organization to the dentist in which the only acceptable payment method is a credit card payment.

If initiating or changing payments to a dentist using electronic funds transfer payments, including virtual credit card payments, a dental benefit plan or its contracted vendor or health maintenance organization shall:

1. Notify the dentist if any fees are associated with a particular payment method; and

2. Advise the dentist of the available methods of payment and provide clear instructions to the dentist as to how to select an alternative payment method.

3. Notify the dentist if the dental benefit plan is sharing a part of the profit of the fee charged by the credit card company to pay the claim.

A dental benefit plan or its contracted vendor or health maintenance organization that initiates or changes payments to a dentist through the Automated Clearing House Network, as codified in 45 CFR Sections 162.1601 and 162.1602, shall not charge a fee solely to transmit the payment to a dentist unless the dentist has consented to the fee. A dentist's agent may charge reasonable fees when transmitting an Automated Clearing House Network payment related to transaction management, data management, portal services and other value-added services in addition to the bank transmittal.

The provisions of this section shall not be waived by contract, and any contractual clause in conflict with the provisions of this section or that purport to waive any requirements of this section are void.

Violations of this section shall be subject to enforcement by the Insurance Commissioner.

F. Transparency of Patient Premiums Invested in Dental Care Act

An Act concerning requirements for certain health care service plans to file a Medical Loss Ratio (MLR) report; uniform reporting and terminology; verification of MLR annual report; public access; exemptions

1. A health care service plan that issues, sells, renews, or offers a specialized health care service plan contract covering dental services shall file a Medical Loss Ratio (MLR) with the [state insurance authority] that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418).

2. The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.

3. If data verification of the health care service plan's representations in the MLR annual report is deemed necessary, the [state authority] shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

4. The health care service plan shall have 30 days from the date of notification to submit to the [state authority] all requested data. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.

5. The [state authority] shall make available to the public all of the data provided to the department pursuant to this section.

6. Exempts Health care service plans for health care services under Medicaid CHIP or other state sponsored health programs

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National Council of Insurance Legislators (NCOIL)

Electric Scooter Insurance Model Act

Sponsored by Sen. Jerry Klein (ND)

Discussion Draft as of November 11th, 2019. To be discussed during the Property & Casualty Insurance Committee on December 13, 2019.

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Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Insurance Requirements
Section 5. Rules
Section 6. Effective Date

Section 1. Title

This Act shall be known and cited as the "[State] Electric Scooter Insurance Act."

Section 2. Purpose

The purpose of this Act is to set forth insurance requirements for those involved in the distribution and operation of electric scooters.

Section 3. Definitions

"Electric Scooter" means a device with two or three wheels, handlebars and a floorboard that can be stood upon while riding, which is solely powered by an electric motor and/or human power.

"User" means any person operating or attempting to operate an electric scooter pursuant to an electronic rental usage agreement or fee.

"Pre-charging activity" or "Post-charging activity" means activities undertaken on behalf of an electric scooter company including the operation of a personal automobile for searching, transportation of scooters in a personal automobile and the loading or unloading of electric scooters using a personal automobile, prior to or after charging activity.

"Charging activity" means any related activity when engaged in the act of charging of the electric scooters in a public or private space"

Section 4. Insurance Requirements

(A) For all periods, that an electric scooter company-owned electric scooter is under a rental usage agreement by a user until the time that the rental agreement ceases, the electric scooter company shall ensure that liability insurance coverage is in place in an amount not less than_____.

(DRAFTING NOTE: SPECIFIC AMOUNTS OF COVERAGE TO BE DETERMINED STATE TO STATE)

(B) During the time period that an independent contractor is engaged in pre-charging or post-charging activity, insurance coverage shall be in place in an amount not less than

(DRAFTING NOTE: SPECIFIC AMOUNTS OF COVERAGE TO BE DETERMINED STATE BY STATE)

(C) The coverage requirements of Section 4(B) may be satisfied by any of the following

a. insurance maintained by the independent contractor; or

b. insurance maintained by the electric scooter company; or

c. Any combination of paragraphs (a) and (b) of this Section; or

d. Other applicable insurance.

(D) During the time period that an independent contractor is engaged in charging activity, insurance coverage shall be in place in an amount not less than:

(DRAFTING NOTE: SPECIFIC AMOUNTS OF COVERAGE TO BE DETERMINED STATE BY STATE).

(E) The coverage requirements of section 4(D) may be satisfied by any of the following:

a. Insurance maintained by the independent contractor; or

b. Insurance maintained by the electric scooter company; or

c. Any combination of paragraphs (a) and (b) of this Section; or

d. Other applicable insurance

(F) The provisions of this act shall not be interpreted to create any obligations under an existing contract for insurance, nor shall it be interpreted to create coverage under future policies that are issued that do not provide coverage for electric scooter use, pre-charging activity, post-charging activity or charging activity. This act shall not be interpreted to defeat any exclusions contained in a contract for insurance.

Section 5. Rules

The Insurance Commissioner shall have authority to promulgate regulations necessary for the implementation of this Act.

Section 6. Effective Date

This Act shall be effective _____.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 12, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Marriott Newport Beach Hotel on Friday, July 12, 2019 at 9:00 a.m.
Senator Bob Hackett of Ohio, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Austin McCollum (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Edmond Jordan (LA)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Jack Tate (CO)
Rep. Richard Smith (GA)
Rep. Tammy Nichols (ID)
Rep. Deanna Frazier (KY)
Sen. Dan "Blade" Morrish (LA)
Sen. Paul Utke (MN)
Rep. Kevin Ford (MS)
Sen. Vickie Sawyer (NC)
Asw. Ellen Spiegel (NV)
Asm. Kevin Cahill (NY)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Sen. Jerry Klein (ND) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 15, 2019 meeting in Nashville, TN upon a Motion made by Rep. Joe Fischer (KY), and seconded by Rep. Martin Carbaugh (IN).

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL INSURANCE MODERNIZATION MODEL LEGISLATION

Before the Committee's discussions began, Sen. Bob Hackett (OH), Chair of the Committee, provided a few words as a reminder for those not aware of the direction the Committee would like to take this topic of "Insurance Modernization." This discussion is aimed toward developing model legislation aimed at helping the insurance industry move past some outdated ways of doing business. At the NCOIL Spring Meeting in Nashville a few months ago, the Committee started the discussion having identified three main issues as ripe for development of model "modernization" model legislation: a.) rebate

reform initiatives; b.) optional electronic delivery and posting of insurance information; and c.) the electronic issuance of salvage titles. Sen. Hackett stated that today, the Committee will be continuing the discussion on rebate reform initiatives and the electronic delivery issues and will aim to have the salvage title issue back on the agenda at our next meeting in December. As a reminder, these are just three issues that the Committee have targeted as ripe for inclusion in the insurance modernization topic and NCOIL of course welcomes suggestions for other issues. Legislators and interested parties are encouraged to reach out to the NCOIL national office with any issues they think would be appropriately addressed under this topic of "insurance modernization."

a.) Rebate Reform Initiatives

The Honorable Eric Cioppa, Superintendent of the Maine Bureau of Insurance (Bureau) and NAIC President, stated that rebating is something that the NAIC is beginning to look at and is something that Maine enacted significant reforms on several years ago. Rebating is essentially giving some consideration as an inducement for someone to buy a policy. Supt. Cioppa stated that he has been at the Bureau for a long time and one of his first meetings as Deputy Supt. consisted of five Bureau insurance attorneys debating whether a frozen turkey was a rebate. Supt. Cioppa stated that following that meeting he said to himself if he ever got the opportunity he would change the rebating laws as it seemed like a waste of valuable resources to talk about frozen turkey being rebates. Maine had a series of stakeholder meetings over the course of two years to look at rebating and Supt. Cioppa that during his 30 years at the Bureau he has not had one complaint from a consumer expressing anger that his or her company gave them a rebate. If you look back at the history rebating, there was a valid reason why rebating laws were put in place – there were solvency and prudential implications for companies at the turn of the last century. But now we are talking about Fitbits and devices for homes and COBRA services that entities can offer to employers. Supt. Cioppa stated that he struggled in Maine when thinking why those products were a bad thing – why shouldn't companies be allowed to compete on services at some level as long as it is related to the policy. Accordingly, after the stakeholder meetings, Supt. Cioppa met with the Committee of jurisdiction and got a unanimous vote out of the Committee changing the rebating laws to accomplish meaningful reforms.

There were two main elements to the reforms. The dollar amounts for raffles and gifts you can give were increased, but the other part of the reform was more important – allowing entities and carriers to provide services related to the policy for loss control services such as Fitbits and water monitors. The Maine rebating statute was modernized to allow that. The NAIC through its Innovation and Technology Task Force under North Dakota Insurance Commissioner Jon Godfread's leadership is starting to look at these issues. Supt. Cioppa stated that he believes that carriers and entities should be able to allow and compete on services and rebating laws need to be modernized to allow for that but there also still needs to be some line. In Maine, the dollar amounts originally proposed were $250 for gifts and $2,500 for raffles and the legislature cut that back. It is incumbent upon NCOIL and NAIC to look at rebating in the context of what is going on today with the technology and services that carriers can offer to consumers as a good thing for consumers. Supt. Cioppa stated that the Maine rebate reforms took some time to get enacted because there was some trepidation among the producer community about competition issues, but at the end of the day they agreed that rebate modernization was needed.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that he participated in some of the stakeholder meetings referenced by Supt. Cioppa and vividly recalls the frozen turkey story. Mr. O'Brien stated that his home state of Massachusetts had a very strict rebating law where it was perfectly appropriate for an independent agent to put stress balls and pens on the table for a customer to take but the insurance division considered it a violation of rebate laws for the agent to actually hand them to the consumer. Mr. O'Brien stated that rebating statutes are anachronistic and may continue to serve a purpose in some ways but they cry out badly for reform, particularly with regards to the fact that the expectations of consumers are changing. With the availability of smart phones and wireless technology, customers are growing more and more accustomed to getting a wide variety of services and customers are saying "why can't you help us with this?" and "why can't you provide us with loss control services and other services that would assist us in managing our risk?" Customers essentially want more for the premium dollar.

Mr. O'Brien stated that APCIA has provided draft model language to be added to existing rebating statutes. To use a football analogy, the draft is a kickoff and something for people to react to. Based upon the Maine rebate statute and bulletin, and other state's rebate bulletins, APCIA focuses on the particular area of loss-control because that is the main item that APCIA's customers are asking for assistance with. More flexibility on marketing would be beneficial as well but that is not the focus – it is reacting to what the customer's needs and wants are.

In response to whether or not such language needs to be in a statute as opposed to a bulletin, as has been frequently stated during NCOIL innovation session the past several years, insurtech and fintech representatives state that they want to be able to look at the statute or regulations and tell from the get-go whether or not the particular service they want to provide is going to be something that is ok. Right now in many states that is not really possible. The response to some in the regulatory community has been "this is not a problem – just come in and talk to us." However, the problems with that are: a.) the aforementioned representatives don't want to come in and talk to regulators – they want to know form the beginning and avoid going down a path of developing a product or service and then going in and discussing whether or not is ok; and b.) it is important to have something that is predictable and hopefully encourage some sort of relative uniformity. Part of the problem with going in and speaking with the regulator is that it is a one-off process and could very well change when the regulator changes. One of the fundamental things that APCIA's members always ask for is to be told what the rules of the road are.

Accordingly, Mr. O'Brien stated that APCIA is looking to put some rules of the road in so that there is some predictability so that companies can begin to provide the type of products that their companies are asking for.

John Fielding, General Counsel for The Council of Insurance Agents & Brokers (the Council), stated that this is a huge issue for brokers and comes down to turf protection in many cases. There is uneven enforcement across the country and people do not know where the lines are drawn. The Council believes that for commercial insurance, the antirebating statutes should be repealed as rebating should not be a concept in the commercial insurance space. Sophisticated consumers should be able to negotiate like they do with any other transaction for the insurance and services they get.
Asm. Kevin Cahill (NY), NCOIL Secretary, stated that the confusion over rebating and

marketing materials continues to persist and there has been the risk of scandalizing companies because they have chosen to use some methodology of attracting customers that some regulators may not have understood. The idea of repealing rebating laws altogether, however, flies in the face of what is going on particularly in the health insurance field with pharmacy benefit managers (PBMs) hiding rebates that they are giving to insurance companies or rebates that somehow make there way back to the consumer. It appears that maybe the appropriate thing to do is not necessarily completely repeal rebating laws but at least allow continued restrictions or guidelines for sunshine so that we can be aware of what they are. Asm. Cahill asked for the panel's thoughts on that.

Mr. Fielding stated that one of the Council's policies that has been in place for about 20 years is for transparency in for example, compensation disclosure and things like that. Mr. Fielding stated that while he would have to discuss Asm. Cahill's proposal with the Council's Board before opining on it, the Council believes that transparency is really important in these areas and in terms of a negotiated deal, some things are going to be confidential but there is probably portions of it that would be subject to regulatory review and disclosure.

Mr. O'Brien stated that APCIA agrees with Asm. Cahill and they debated long and hard about whether or not it should support wholesale repeal of rebating laws. Some of APCIA's membership would support that, but at the end of the day it may be a step too far. There are certain practices that require some additional oversight and that is why APCIA's initial draft model law proposal has opted for simplification. Some rebating statutes are simple on their face but not simple as to how they have been enforced and interpreted. APCIA has tried to take an approach of trying to carve out some practices that there is consensus on, at least at NCOIL, being beneficial to consumers and making it clear that there are some practices are going to be ok. There are other things which the legislature in its wisdom could decide to prohibit or restrict. APCIA's proposal is a relatively modest start to this conversation and meets the needs of the general consensus that has been reached here at NCOIL and which is also beginning to develop at the NAIC.

Supt. Cioppa stated that when they went through the process in Maine they ended up in the same place – the dollar amounts mentioned earlier were increased to $100 for gifts and $500 for raffles but certain guardrails were kept in place such as marketing restrictions.

Sen. Hackett asked Mr. O'Brien if he supports the Maine reforms. Mr. O'Brien replied yes but with one caveat – one of the other issues that was debated was the merit of specific dollar amounts. From a simplicity point of view there is nothing simpler than having a bright-line dollar amount, but it is almost too simplistic as something may be introduced that saves the insurance industry and consumers a lot of money that costs $101. Accordingly, with inflation and other consideration, that is why APCIA in its draft proposal opted to focus on loss control and loss mitigation services and not on specific dollar amounts. Mr. O'Brien noted that that is not necessarily an opposition to the Maine reforms but rather an evolution in that area.

Mr. Fielding stated that with respect to the Maine and APCIA language, while the Council would prefer repeal of rebate laws, it is a good start. Mr. Fielding stated that he does have concerns with specific dollar amounts because they are different across the

country. The Council has conducted a state survey of rebating laws and there are significant differences, from $5 for a life application in Michigan to $10 for a P&C application in Michigan, to $500 in Maine. It is very difficult to figure out how to thread that needle so to have a logical approach to it, such as a product based or risk based approach, would be very helpful.

b.) Discussion on NCOIL Insurance E-Commerce Model Act

Rep. Edmond Jordan (LA), sponsor of the NCOIL Insurance E-Commerce Model Act (Model), stated that the Model is intended to be the first part of NCOIL's "insurance modernization" effort. The Model is essentially divided into three sections: a.) permitting insurers to deliver any document required by law in an insurance transaction or that will serve as evidence of insurance coverage – except cancellation or nonrenewal of any insurance coverage – to be delivered, stored, and presented by electronic means, if the party has affirmatively consented to such; b.) permitting an insurance policy and an endorsement that does not contain personally identifiable information to be posted on the insurer's website, if the insurer obtains affirmative consent from the policyholder to do so; and c.) permitting insurers, if the claimant requests, to pay claims via electronic transfer of funds.

Rep. Jordan stated that this type of legislation has been adopted in many states, including his home state of Louisiana, and he does not believe there has been any issues with it. Rep. Jordan stated that the Model protects consumers while modernizing insurance contracts and while a few tweaks may need to be made to it, he looks forward to adopting it in December at the NCOIL Annual Meeting.

Ron Jackson, VP of State Affairs – Southeast Region at APCIA, stated that APCIA supports modernization efforts and appreciates NCOIL this matter forward. With regard to the Model, APCIA does have some issues that it looks forward to discussing with the Committee between now and December. Louisiana is one of the 38 states that have taken action allowing for electronic commerce in insurance transactions with the express consent of the consumer which is a good thing as we all operate electronically more and more in our everyday life, and insurance should be no different. Mr. Jackson stated that the Model excludes cancellation and non-renewal notices and that has not been the case in Louisiana's enactment of the law, and while there has been variation in such language in a couple of states where it made it harder to execute, that has been allowed because it is only allowed with the express consent of the consumer. APCIA would like to address that portion of the Model.

With regard to e-posting, 24 states have enacted laws allowing for the posting of documents that don't contain personally identifiable information. The current Model includes language requiring express consent of the consumer for e-posting which is redundant to the consent they have given for e-delivery. In the other states that have passed this type of legislation, it has been in the opt-out nature whereby the insurer will post the standard documents online unless the consumer expressly says otherwise and wants the insurer to mail them. APCIA would like to address that portion of the Model. Along the same lines, that section of the Model address storage of those documents for a period of years and APCIA would like to address that as well. The maintenance of that standard form for a period of years after the policy has expired could be burdensome and there may be other ways to address altering consumers as to how they can keep those documents after the policy expires.

Sen. Hackett noted that NCOIL staff did reach out to consumer advocacy groups to attend and participate in this discussion in-person but they declined to do so.

MEASURING THE IMMEASURABLE? – A DISCUSSION ON A.M. BEST'S PROPOSAL TO SCORE AND ASSESS INSURER INNOVATION

Steve Irwin, Senior Director at A.M. Best, stated that the draft criteria titled "Scoring and Assessing Innovation" is currently out of the comment period and then walked through what the process is at A.M. Best when working on a new rating criteria. After internal reviews and approval of new or materially changed criteria, a draft copy of the criteria is released for comments for a period of no less than 30 days. The draft is accompanied by a press release which goes out to the public and indicates the reason for the new or revised criteria procedure. Once the comment period closes, all comments are reviewed to determine if changes are warranted based on the feedback received. Normally comments center around areas in the criteria that need further clarification. Once that process is completed, the criteria may be released for use following regulator notification or a second comment period may occur. If the latter option is chosen the process repeats itself and a FAQ may be released as well which highlights what changes are made and what the next steps may be. Mr. Irwin stated that for this criteria, A.M. Best is currently digesting the first set of comments received and can offer thoughts on some of the comments received at the end of his remarks.

A.M. Best believes innovation is important because the history of insurance and risk management is one of innovation. A.M. Best believes that innovation has always been important for the success of an insurance company to increase pace of changes in society, climate-related trends, and technology. Innovation is becoming increasingly critical for the long term success of insurers. By incorporating innovative principles, companies can develop sustainable competitive advantages and better respond to external challenges such as evolving consumer preferences, growing business complexity, shifting market dynamics and ever-expanding technological developments. A.M. Best believes that insurance companies need to innovate to outpace competitors, fend off potential external disruptors, and promote organizational longevity.

Mr. Irwin stated that given the accelerating pace of innovation and magnitude of change, insurance companies that fail to innovate may find it difficult to sustain long term success and profitability and may ultimately be subject to anti-selection and loss of relevant. Those insurers that successfully incorporate innovation will likely strengthen their organization, increase customer base, and improve efficiency which will support their financial strength. The release of this draft criteria outlines the procedures A.M. Best will use to evaluate a company's level of innovation. Mr. Irwin noted that there was a recent insurance company survey which asked if insurance will be more different in the next five years and 96% of those surveyed stated that the strongly agreed with that statement so innovation is certainly something that is on the industry's mind.

Mr. Irwin stated that A.M. Best conducted some research before it got started regarding how the industry feels about innovation. A.M. Best surveyed its rated universe to get a better read on the state of innovation in the insurance industry. More than 450 insurers in 48 markets representing every segment of the industry worldwide responded to the survey. The survey reported in A.M. Best's November 2018 report titled "Insurers Agree Innovation is Critical for Future Success." More than 80% of the insurers surveyed viewed innovation as either moderately to extremely to the success of their organization.

Accordingly, it is A.M. Best's view that as technology continues to evolve, insurance companies that do not successfully incorporate principles of innovation may be significantly disadvantaged. Over time, failing to innovate may inevitably lead to an erosion in their competitive advantage and ultimately their financial strength.
Mr. Irwin stated that at the same time, A.M. Best's survey also demonstrated that only a small segment of the industry believes that it has adopted and implemented innovation well and nearly a quarter of the respondents indicated that their assessment of the insurance industry's adoption and implementation as not well. Finally, the survey identified that nearly 90% of insurers are hopeful that innovation can help them address system inefficiencies while nearly 2/3 believe that ongoing investment in innovation can help them navigate business disruption and remain relevant, and more than half believe that innovation can minimize underwriting risk.

Mr. Irwin stated that historically, A.M. Best has captured innovation indirectly through the various building blocks of its rating process. A.M. Best is releasing this criteria now because A.M. Best now believes that the pace of innovation in the insurance industry is accelerating and that insurers' ability to innovate is becoming an increasingly important indicator of its long term financial strength. With this particular draft criteria, A.M. Best is forming a starting point for the formal assessment of a company's innovation level.
From a ratings perspective, A.M. Best's innovation initiative is two-pronged: a.) rated companies will be scored and then assigned an innovation assessment; and b.) within its business profile building block, A.M. Best will explicitly consider whether a company's innovation efforts have had a demonstrable effect on its long term financial strength.
Mr. Irwin stated that the first step is defining what innovation is, recognizing that there many different definitions of innovation. A.M. Best has chosen to define innovation as a "multi-stage process whereby an organization transforms new ideas into new or significantly improved products, processes, services, or business models that have measurable positive impact over time and enable an organization to stay relevant and successful and can be organically grown or adopted from external sources."

There are a few aspects to that definition. First, innovation can take many forms and is not limited to a specific type of innovation or technological development. The definition also allows for flexibility regarding the source of the innovation. For some organizations, innovation can be adopted to the most appropriate path as there may be inherent barriers to innovation within the organization. Second, A.M. Best expects the output of the innovation process of those new or significantly improved products, processes, services or business models to have a measurable impact. Some level of failure is an expected part of any innovation program but companies receiving higher innovation scores will have demonstrable success in innovating. Without productive results, the resources consumed by innovation processes may be a financial drain rather than a gain. Third, innovation is a dynamic and ongoing process as well as a long term commitment. Companies that receive higher scores will be those that treat innovation as part of a continuing cycle of organizational growth and development, and that successfully integrate their new-stream innovations with their main-stream legacy operations. Finally, while important, innovation is not just about technology.

Regarding the process of how A.M. Best will score insurer's innovation that is outlined in the draft criteria, A.M. Best's evaluation of a company's innovation level takes into account an input and output approach and is based on two elements. The first is the innovation inputs, or the components of a company's innovation process, and the second is innovation outputs, or the impact of the company's innovation efforts. The

resulting innovation score is the sum of those two evaluations. The innovation input score consists of four sub-components: leadership, culture, resources, and processes and structure. The sub-components capture a company's innovation capacity and its potential innovation ability or whether the structural elements of the innovation process are positioned in such a way that the company can leverage its available resources to create value. Each of the sub-components is scored from 1 to 4, with 1 corresponding to the most negative assessment and 4 the most positive.

Leadership can be a driver of innovation success or a cause of innovation failure and thus has a direct influence on the other sub-components in the innovation assessment. AM Best expects that industry leaders of innovation will have the sponsorship of top management and support throughout the organization—including board participation. Companies that successfully innovate typically benefit from buy-in at the senior management level, evidence of which can be found when the concept of innovation dovetails with the corporate mission statement. Encouraging new ideas, fostering productive organizational evolution, and backing innovation with strategic actions are among the hallmarks of management at an innovative organization. Good leadership should have a strategy communicated to employees that says: what are we doing and why are we doing it. Good leadership is supportive of a mindset that supports cross-functional collaboration to identify, develop, and implement new innovative ideas. The clear enumeration of goals by leadership is essential, so that all parts of the organization understand what the result should be. By embracing and fostering a culture of innovation, leadership can generate a high level of interest/buy-in, so that all employees are empowered to be change agents.

Like leadership, culture can either stimulate or suppress innovation. Organizational cultures that inspire innovation allow for risk-taking as well as the possibility of failure. Companies receiving the most positive assessment approach the innovation process purposefully and systematically, and can demonstrate that their innovation initiatives are integrated throughout the organization. The culture of these companies fosters ownership and transparency, while also encouraging cross-functional knowledge-sharing, recognizing that innovation flourishes in a diverse environment. For these companies, innovation is part of the enterprise mission statement and is embraced as a key element for long-term success. Mr. Irwin stated that this is an example of where A.M. Best took into consideration some of the comments received as there was some interpretation that this should be incorporated in the corporate mission-statement but that was not the intention so that clarification was helpful and will be mentioned in the next draft. Tolerance for risk-taking is well defined, with failure an acceptable option but with a process in place to kill ineffective innovation ideas after an appropriate and timely review. There is openness to both internal and external innovative solutions as part of a regular assessment of customer needs, market conditions, and internal/external threats to the business model.

The resources critical to a company's innovation strategy can generally be divided into one of three categories: technical, creative, and financial. It is important for a company to take stock of the resources it has internally and then decide whether to focus internally or partner with third parties – the decision could be a mix of both strategies. Technical resources include systems and data allocation, with an eye towards the potential for harnessing new technological breakthroughs. Creative oversight encompasses not just the generation of ideas to develop new, practicable solutions, but also ensuring that the right people are assigned to the project. Thus, hiring practices that

focus on a diversity of experience and backgrounds, as well as the ability to attract and retain high-level talent, are key. Finally, financial resources should focus on the appropriate allocation of budgetary resources: Is the process properly funded? Can the idea be monetized or implemented so that it results in improvement or growth in the top/bottom lines? Additionally, the financial process should include rewarding the organization's innovators. As a result, expenses may be temporarily elevated owing to innovation investments. AM Best expects that these expenses will be explained to the analytical team as part of the normal rating process. AM Best also expects that companies will be able to provide detailed analyses of the return on investment for their innovation initiatives. Partnering with, or purchasing solutions from, external providers is also incorporated into the Resources sub-component. Mr. Irwin stated that some questions typically asked by the company are: are we organized for speed and innovation?; do we need more people?; do we need more skills?; is agile development using small teams part of the overall resource allocation?

The organizations that optimize processes and structure promote organizational intelligence while avoiding innovation silos. Without a proper process and structure in place, implementing innovation process and initiatives will be difficult. Elements of an innovation program that may be evaluated include the company's data management, innovation strategy, and governance processes. Proper data management is a building block for a successful innovation strategy, as good data is fundamental for innovation to succeed. Proper data management includes data governance that is well defined and clearly delineates (1) the parameters for the organization's investment for data initiatives; (2) the prioritization of these investments; (3) data standardization policies/procedures; and (4) the responsibility for data quality, data stewardship, and data ownership. Access to data and transparency are embraced as corporate-wide objectives. Effective data management processes and structure will ultimately lead to better innovation outputs. Mr. Irwin stated that some typical questions that might be asked are: do we have the right processes in place to drive speed, agility and innovation?; are we managing our data well?; will governance help us?

The Innovation Output Score is based on two components: (1) results and (2) level of transformation. The formula for the output score is 2X the sum of the results + the transformation score. Ultimately, innovation needs to lead to measurable results to make the investment of resources worthwhile. Companies that invest significantly in innovation infrastructure (systems, talent, and processes) but derive no tangible benefit will score poorly on this sub-assessment – so companies may score well with input but measurable output is where the rubber hits the road. The innovation output can include results such as a lower expense ratio; higher revenue growth; more robust, customer-centric, data-driven product design; better customer retention; greater brand recognition; or stronger data analytics. Companies can sustain the competitive edge they gain from innovation only by continual evolution of their innovation strategies and initiatives. Therefore, companies receiving the highest scores in this sub-assessment will demonstrate: a well-balanced mix of operational and growth-oriented innovation; the ability to respond quickly to both internal and external pressures; and an implementation strategy that appropriately balances short and long-term initiatives—for example, by encompassing a mixture of incremental and disruptive innovations with various time horizons

Regarding the level of transformation, a company's innovation initiatives may be fruitful but may not be transformative or even allow the company to remain relevant or

competitive. For example, a company may switch from manual policy filings to digitized storage. Although this process would result in lower expense ratios and would therefore have a positive impact on the results sub-assessment, the level of transformation involved is rather low relative to the industry and leaders outside the insurance industry. The transformation score would therefore be low. Only those companies with best-in-class output will be eligible for a higher transformation sub-assessment. Transformation does not encompass splashy initiatives that do not create value; rather, it encompasses initiatives that create value, improve customer engagement and experience, lead to a superior business model, or significantly enhance growth opportunities. AM Best translates its innovation scores into five assessment categories: Non-innovator; Reactor; Adopter; Innovator; and Innovation Leader.

Mr. Irwin stated that the building blocks outline the process drive for credit rating. The starting point is the evaluation of balance sheet strength to develop a baseline and the rating analyst will then review the other building blocks, either increasing or decreasing from the baseline assessment, and as currently considered the innovation assessment will be captured within the business profile building block. Mr. Irwin stated that the official comment period for this criteria ended on May 13 and AM Best is still going through the comments submitted. The comments have been generally supportive of the initiative while some have asked for clarification of certain aspects of it. AM Best takes into consideration all comments received.

Mr. Irwin stated that AM Best will explicitly consider whether company's innovation efforts or lack thereof have had a demonstrable positive or negative impact on its long term financial strength within its business profile building block. To be clear, AM Best is not endorsing investment in InsurTech for all companies – the goal is really to provide a framework for understanding the role of innovation in the organization and providing a roadmap for discussion with companies. While a formal assessment is being created, it does not change the weight innovation is given in the rating process. It is important to note that the innovation score is not necessarily correlated with an insurer's credit rating. There may instances where lower rated companies may actually have a high innovation score and higher rated companies have a low innovation score. This means that there is an absolute assessment of the innovation score itself but the relative impact on the rating is different. The innovation score does not automatically translate into a rating positive or negative as AM Best must also asses whether innovativeness provides any enhancement or reduction in the company's long term financial strength.

Mr. Irwin closed by stating that no rating changes are expected at the time the criteria is finalized and in use. AM Best is evaluating the timeline of disclosure of innovation assessments and at this time is leaning towards publishing the assessments over time in a measured approach.

Erin Collins, Asst. VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC shares AM Best's interests of innovation and adaptability. The good news is that the insurance industry is pretty good at that already. NAMIC has 1,400 member companies and of those, 80% have been in operation over 100 years. 10% of NAMIC's members been in operation for over 150 years. To have that longevity, it is imperative to be adaptable and adaptability and innovation are in a way synonyms. The insurance industry is natural incentivized to adapt to changes not only in the world but to expectations of policyholders and future policyholders. NAMIC does have significant concerns with AM Best's proposal.

Innovation can mean a lot of things such as new products, or innovations to back office systems, platforms, or anti-fraud measures. Innovation is a moving target and is a balance to weigh in everything that insurers do, something they have done very well for a long time and will continue to do. The easiest way to try and capture that success of adaptability and change is to try and look at the outputs. In the rating methodology there already is methodology to measure those outputs – the things that are clear and not nebulous such as the enterprise risk management (ERM) or the operational success. Ms. Collins stated that NAMIC believes that having a separate factor like this as opposed to the clear-cut factors of ERM or other building blocks, may upset ERM and may create inappropriate market pressure towards innovation for just the sake of innovation as opposed to the concerted approach that companies take now to how best serve its policyholders and that is the mission insurance companies. Moving forward, NAMIC believes that the best way to foster innovation is to ensure that companies have the free market space to naturally innovate and that success can be measured in the easier, more finite methodologies mentioned.

Sen. Hackett stated that many here have been in the industry for a long time and it seems that rating companies are moving towards the speculative side of things. In the past, numbers were the numbers. Sen. Hackett asked Mr. Irwin if he agreed with his comment. Mr. Irwin stated that he would not characterize the draft innovation rating criteria as speculative. The process of innovation is part of the ongoing dialogue that AM Best has with companies and innovation is one component of the business profile assessment. There are a number of other components in the business profile assessment. AM Best recognizes that there are changes going on in the industry. The framework set forth in the draft criteria provides companies some transparency in how AM Best likes to conduct the dialogue.

In response to Ms. Collins' comments, Mr. Irwin stated that AM Best supports the longevity and thought leadership of the insurance industry and part of the process of the draft criteria is to highlight the importance of innovation going forward. AM Best is certainly not saying that the insurance industry is not innovating, but it is seeing that the pace of change is accelerating and felt that it was appropriate to highlight it as part of its thought leadership to the industry, similar to the process that went on with ERM a number of years ago and that is incorporated into the building blocks.

Rep. Matt Lehman (IN), NCOIL Vice President, followed up on Sen. Hackett's question and asked if the rating criteria is speculative and if it will impact a company's credit rating. Rep. Lehman noted that the general public essentially cares only whether the company will pay claims appropriately and, as an agent, part of placing clients with companies is looking at its financial strength rating. Accordingly, will that rating now be clouded with things that are speculative? Mr. Irwin first stated that AM Best does not anticipate any rating changes at this point in time. Also, the criteria is absolute but its impact on the rating is relative as a company's level of focus on innovation may vary but need and geography, for example a company in Asia that is very technology driven and focused on customer engagement vs. a small company focused on funeral distribution that might not need to focus on innovation. The focus is really on whether the focus, or lack thereof, on innovation is going to erode the company's competitive position over time.

Rep. George Keiser (ND) stated that during the presentation he was wondering what the value is of a third party rating innovation when that is really the function of the

marketplace. A rating may be developed that has no correlation to what the market does in terms of innovative value. Accordingly, Rep. Keiser asked why this rating criteria is needed. Rep. Keiser also stated that he has a fear that if companies wish to score high on the rating criteria, even the innovative companies will start to "teach to the test" or will in effect look at the criteria and leave the potential to be innovative just so they can get a high score which is the opposite of what we want to happen in the industry.

Mr. Irwin noted that there is no specific innovation rating but rather it is part of the building block business profile. Rep. Keiser asked why that is necessary and why not let that market determine it. Mr. Irwin reiterated that the criteria is absolute but its impact on the rating is relative as a company's level of focus on innovation may vary by need – the criteria is really just a framework for companies to use. Regarding Rep. Keiser's "teach to the test" comment, Mr. Irwin noted that relates to this comments earlier regarding publishing the innovation assessments and AM Best's thought at this time is to take a measured position by initially discussing it with companies rather than publicly disclosing it. Rep. Keiser asked Mr. Irwin if he understood that if there is an innovation that he should be using and is not, he will lose market share so he does not need someone to score it. Mr. Irwin stated that is why this is in the business profile building block because the company would be losing market share and distribution breadth.

Sen. Hackett asked if this criteria is being introduced in part because of AM Best looking back at certain ratings it gave and wishing it had done things differently. Mr. Irwin stated that AM Best sees things moving more quickly as they were previously and noted the survey results he discussed earlier - AM Best is reacting to that.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that this is an interesting topic and when you look at the health side of things, long term care insurance was trying to be innovative but is now dealing with rating problems. In southern California there was Twentieth Century Auto which in the 1980s went into the homeowners market and started writing earthquake coverage as a part of that and following a big earthquake, all of their premium collected in nine years was gone with 15 seconds of shaking. Accordingly, aspects of change can seem to be of value until "life" happens. Asm. Cooley stated that he believes that if there was a productive area for AM Best to focus on it would be how to rate the internal culture of a company - not so much on innovation which is a buzz word that can push people in different directions - as to how they vet ideas. A start up can try to innovate by breaking the law. Also, Asm. Cooley noted that by providing certain insurers with poor innovation ratings, that could result in problems for the industry in attracting younger talent.

Mr. Irwin stated that AM Best is looking at the internal culture of companies in terms of what the process is when vetting new ideas and what is learned during that process. AM Best is certainly not trying to get companies to take more risk without having the proper safeguards in place.

Rep. Bart Rowland (KY), Vice Chair of the Committee, asked if any thought was given to creating a separate rating just for innovation and continue with the financial rating that everyone currently understands. Mr. Irwin stated that there were a number of iterations that the criteria went through but it was ultimately determined that it should be part of the overall rating structure. However, it is still in draft form so the final result could change.

DISCUSSION ON KENTUCKY'S FIRST-IN-THE-NATION INSURTECH REGULATORY SANDBOX

Rep. Rowland stated that the idea of Kentucky being the first state to pass an insurtech regulatory sandbox started last summer at the NCOIL Summer Meeting in Salt Lake City, UT with conversations between him and Greg Mitchell, Esq. of Frost Brown Todd, LLC. Conversations continued afterwards as it was an educational process for Rep. Rowland to learn more and more as to what the legislation would look like and kinds of innovators might be attracted to Kentucky. After several version of the legislation was discussed and debated, it was passed during "short session" overwhelmingly by both chambers and went into effect in late June. Rep. Rowland stated that he believes the bill allows innovates to test their new ideas in Kentucky while not creating unregulated competition between insurance agents and brokers. The bill is transparent and has consumer protections built into it.

Mr. Mitchell stated that he is Chair of the insurance industry group at Frost Brown Todd, LLC and has been involved in the insurance industry for almost 30 years. Mr. Mitchell states that among other things, he defends insurers in market conduct actions and deals with regulators across the country as well as internationally. He has had the fortunate opportunity as well as the angst of trying to innovate over that period of time of things that you would think today are common sense and are known in the market but when you understand the history you understand the difficult that exists in arcane insurance codes. The codes have only been updated in a piecemeal way and they don't contemplate things like cell phone coverage that we all take for granted now. Accordingly, a great deal of time is spent trying to help insurers comply with these arcane codes. Frost Brown Todd is an advocate for compliance but also understands the difficult and in some examples the complete frustration of the lack of common sense of some of the code's provisions that there is not an ability to conform regulations to whatever the subject is that is trying to be regulated.

Whether you want to call it insurance innovation or smart regulation in that you are trying to apply regulation around the innovation or the product so that you are tailoring it specifically to what you are trying to rather than opening up the code and trying to fit a square peg into a round whole which can put insurance executives into a bad situation. Or, as Supt. Cioppa indicated earlier, certain concepts may have been proper 100 years ago and it still in existence but no one really remembers why it is still in the code. Accordingly, the labor of putting the legislation together started with experience of defending companies and developing products.

Mr. Mitchell stated that the legislation was also a way to think about regulation from a different perspective – to allow a company or startup that wants to innovate, to come forward with the concept very clearly and point out the sections of the insurance code that they think will make the concept not work. If exceptions to those sections of the code were granted and the company can still protect the consumer than that is common sense. In working with Rep. Rowland, the insurance department and the administration, the legislation was developed to provide a framework for companies to beta-test a concept and if it worked properly than a no-action letter will be provided so the company is not worried about the regulator second guessing things or a different administration coming in with a different attitude, or worse – class action lawyers getting involved. Regulatory protection can be provided if there is upfront investment and thoughtful consideration to going about things the proper way and making sure consumers are

protected. The legislation is not perfect but it is a starting point and was done with the best intentions of trying to think about insurance regulation from a different perspective.

Patrick O'Connor, Deputy Commissioner of Policy at the Kentucky Department of Insurance, stated that Kentucky has a population of about 4.5 million people and is very geographically diverse. Kentucky's economy is generally known for coal, thoroughbred horse racing, and bourbon. However, the economy is expanding and evolving and since 2016 nearly 40,000 new manufacturing, service and technology jobs have located in Kentucky, and there has been over $15 billion dollars in new business investments. That is based on the pro-growth policies that Rep. Rowland and the administration have put forth. Kentucky is expanding and evolving and its economy is ripe for new sector innovation and investment. Accordingly, it was thought that insurance was underserved in Kentucky and new investment could be attracted by making Kentucky a hotbed for insurance innovation by allowing beta-tests that could being in new economic dollars and also new options for policyholders that would benefit all of Kentucky.

Mr. O'Connor stated that there were several goals in mind when developing the legislation. One was flexibility – to provide the insurance department with some flexibility to review meritorious innovation and permit its limited use in the marketplace. However, it was important to not sacrifice consumer protection. Accordingly, consumer protection essentially governs the legislation – the application process; the review of the application; the limited no-action letter process; and the beta-process. It was also important to create a dialogue, or at least an opportunity for a dialogue, between the regulators and the industry. Along those same lines it was important to foster a spirit of collaboration among interest parties.

Mr. O'Connor stated that the bill has certainly increased the dialogue and collaboration as he has fielded a number of calls from interested parties looking to take advantage of the legislation and some of the opportunities that may be out there. A lot of good discussions have taken place with some entities which has resulted in the department learning more about the entities and their products with the end result telling them that they actually don't need to utilize the legislation and put fears to bed.

Mr. O'Connor stated that the legislation sets forth a framework by providing the Insurance Commissioner with the statutory authority to waive specific regulatory and/or statutory barriers to permit the use, sale, or licensure of an approved insurance innovation. There is a detailed application process that is reviewed by the Director of Insurance Innovation as designated by the commissioner. The commissioner has broad discretion throughout the entire process and this is part of the bill that did undergo substantial changes. Consumer protection is the main priority, including a terms and conditions letter that sets forth the requirements for a beta test to adhere to and if it does not it gets terminated. Some statutes also specifically cannot be waived such as those related to taxes, investments, licensure, and guaranty funds. There is also an early termination and civil penalty provision so if somebody goes outside the guardrails set forth in the terms and conditions letter the Commissioner has the authority to shut it down and issue a penalty. Additionally, the bill requires legislative oversight as there are specific reporting requirements for the department of insurance to update the legislature an any applications received and granted and how the process worked and overall statistics to see what has been successful and what has not. The legislation also provides the opportunity to make recommendations as to possible statutory changes as it was important to use the process as not only to allow for innovation and to allow

Kentuckians to benefit from new products but also as a vehicle for change. So if the department sees an innovative product that is subject to a statutory or regulatory barrier, the department can report to the legislature that certain changes to the code should be made for the specific reasons.

Mr. O'Connor then noted the application process section of the legislation which basically reads like a checklist. At this point there is no formal application on the department's website but that may be done in the future. Some important requirements of the application include: a detailed explanation of the innovation and how it adds value and doesn't pose an unreasonable risk of consumer harm; applicable licensed that or held or will be held before the innovation goes live; specific citation to the regulatory/statutory barriers; and disclosure of financial security – the calls for a minimum of $25,000 but the Commissioner has the discretion to increase or decrease that amount and it can be satisfied in a number of different ways such as cash, bonds or a contractual liability insurance policy. The application can be submitted hard copy, hand delivery, and electronically - which is in progress of being developed on the department's website.

With regard to the application review process, Mr. O'Connor stated that the department has the authority to request more information and it is anticipated that the entire application process will be interactive in nature. The legislation calls for a 60 day initial timeframe plus a 30 day extension with a deemed approved stipulation at the end of 90 days if there is no decision made. The Commissioner them may issue a notice of acceptance or rejection to the applicant. Some other important noteworthy provisions of the legislation include the terms and conditions letter which is going to be the safeguard for the beta test – it will have all of the consumer protections in it and govern the whole process. At that point, a limited no-action letter (LNAL) could be issued which provides the initial safe-harbor and is good for a one year period. At the end of the one year period, an applicant may apply for another year. The LNAL and beta test can be terminated if complaints arise. An extended no-action letter (ENAL) comes at the end of an LNAL – if the reporting shows that it was successful and worthy for consumers then it can be issued and is posted on the website for other companies to use who are looking to engage in a similar process. The ENAL has a three year maximum period.

Mr. O'Connor noted that the system has been set up so that at the end of the ENAL it is essentially a five year process for the safe harbor to apply. If the legislature does not act at the end of that five year period to amend the statutory barriers that have been cited in the applications, then the safe harbor would cease to exist and everyone would have to comply with the code as it exists. Mr. O'Connor stated that the bill strikes a good balance of maintaining legislative oversight so that the legislature can review and make any necessary changes to any statutes, while still allowing the safe harbors to apply for as much as five years. Mr. O'Connor stated that the department is currently accepting applications and there has been a lot of interest thus far. Mr. O'Connor noted that any questions can be directed to him or his colleague, John Melvin, as they are splitting the duties of the Director of Insurance Innovation for the time being.

Wes Bissett, Senior Counsel of Gov't Affairs at the Independent Insurance Agents & Brokers of America (IIABA) stated that he appreciates the opportunity to talk about this Kentucky legislation as well as similar legislation that was recently enacted in Vermont. This is a fairly unique and novel approach to policymaking. The core element of the proposal is legislators giving their Commissioner the unique ability to waive requirements

that legislators enacted into law for certain competitors in the marketplace. It is an approach to policymaking that requires a balancing act and the Kentucky legislation enacted, thanks to Rep. Rowland, is a much better product than its original version.

Mr. Bissett stated that this is challenging as the things that the Commissioner is not going to be able to do are typically the kind of policymaking that legislators do – determining what statutory requirements apply to particular competitors. There are obviously marketplace fairness issues. If you are a competitor and you have an exemption from a statutory requirement that is great but if your competitors are still subject to it they may feel differently. Mr. Bissett noted that IIABA and some insurers were troubled by some of the provisions in earlier versions of the legislation but significant improvements were made. There was a provision that would have given a company that submitted an application essentially a monopoly on that service as others would not have been able to come into the marketplace and offer it – that provision was taken out. There was also a provision that would have required the use of a Kentucky-based regulatory compliance law firm which was taken. There is some irony about hiring a regulatory attorney to help you submit an application to get exempt from a regulatory requirement.

Mr. Bissett noted that one thing that Vermont address that Kentucky did not was the ability of outside interested parties to comment on an application. The only voices that the Kentucky insurance department will hear from when an application for a waiver is submitted is from the party submitting the application. Mr. Bissett stated that IIABA hopes that provision will be added in to the Kentucky process as you can imagine there are facts and situations that will not be brought to the department's attention that others can bring to the table. Mr. Bissett stated that IIABA looks forward to seeing how this process rolls out in Kentucky and thanked Rep. Rowland again for his leadership in making several improvements to the legislation.

Rep. Rowland thanked Mr. Bissett and everyone involved for working hard to improve the legislation and get it passed in such a short timeframe during "short session."

RE-ADOPTION OF INSURANCE FRAUD MODEL ACT

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that insurance fraud is a very serious problem that everyone faces in their respective states. Sen. Rapert stated that he greatly respects the work that the Coalition Against Insurance Fraud (Coalition) does to help states combat insurance fraud. In fact, Sen. Rapert noted that he spoke at a recent Coalition meeting on one of his favorite issues – the business practice of Pharmacy Benefit Managers – and it was a very productive discussion. Sen. Rapert stated that a few years ago, he also sponsored the NCOIL Storm Chaser Model Law which protects consumers from contractors who would travel around following the night of the storm, offer to fix a home or structure, receive a down payment, and never return to finish the job. Sen. Rapert stated that he continues to make efforts to fight insurance fraud in his home state of Arkansas, and urged everyone to do the same in order to make sure consumers are properly protected. Accordingly, Sen. Rapert stated that he supports the changes to this Model and then turned it over to Matthew Smith, Director of Gov't Affairs & General Counsel at the Coalition.

Mr. Smith stated that the Coalition was formed in 1993 and one of its initial charges was to develop what was then the first-in-the-nation model act on anti-insurance fraud efforts.

That model initially rolled out in 1995 and in 1998 it was amended by the Coalition and that is when NCOIL adopted it. From 1998 to today, the model has been adopted either in whole or in part in 28 different states. Proving the test of time, for 20 years the model went un-updated. A few things happened during that time like the internet and the movement towards international fraud and multi-ring fraud. Accordingly, in 2018 - the Coalition's 25th anniversary – the Coalition established a select committee to update the model which included NCOIL General Counsel, Will Melofchik. The model that is before the Committee today was adopted by the Coalition during its mid-year meeting last month.

Mr. Smith then noted some of the highlights and improvements to the updated model. The model provides increased authority for prosecutors; streamlines the proof of intent to defraud and how the intent to defraud is identified; and eliminates multiple-proof requirements in many areas so it allows for greater prosecution. Mr. Smith further noted that as the move towards international and multi-ring fraud accelerates the model allows for evidence of multi-state operations or fraud committed in another state to be used in the prosecution of insurance fraud in another state. The model also calls for – depending on individual state laws and federal bankruptcy laws – orders of restitution against people who commit fraud to be non-dischargeable in bankruptcy so that they cannot escape the restitution order.

Further, the model allows in civil actions the recovery of attorney's fees, and on the insurance carrier side, the model allows for the rise of the independent contractor's outsourcing third party's that insurance companies are using to both protect those individuals under provisions of the model and if they are the ones committing fraud, the model allows them to be held liable. The model now includes fraud in-the-part vs. fraud in-the-whole meaning that under the prior version of the model the entire claim or act had to be fraudulent before the model applied. Now, if only a portion of the claim or act such as medical billing is fraudulent, the model applies. Also, there have been a lot of changes in the past 20 years with regard to medical services, so now terms such as healing arts and pharmacology are included in the model.

Mr. Smith stated that the Coalition feels that the model is a very strong, pro-consumer advocacy model law and urged the Committee members to adopt it in their states.

Upon a Motion made by Rep. Keiser and seconded by Rep. Carbaugh, the Committee voted without objection to adopt the amendments by way of a voice vote. Upon another Motion by Rep. Keiser and seconded by Rep. Carbaugh, the Committee voted without objection to re-adopt the model as amended by way of a voice vote.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 13, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Marriott Newport Beach Hotel on Saturday, July 13, 2019 at 10:15 a.m.

Assemblywoman Pam Hunter of New York, Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asw. Maggie Carlton (NV)
Asm. Kevin Cahill (NY)
Asm. Andrew Garbarino (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Colleen Burton (FL)
Rep. Tammy Nichols (ID)
Rep. Deanna Frazier (KY)
Rep. Edmond Jordan (LA)
Sen. Brian Feldman (MD)
Asw. Ellen Spiegel (NV)
Rep. Wendi Thomas (PA)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Rep. Martin Carbaugh (IN) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 15, 2019 meeting in Nashville, TN upon a Motion made by Asw. Maggie Carlton (NV), and seconded by Rep. Carbaugh.

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL DRUG PRICING TRANSPARENCY MODEL ACT

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that before beginning he would like to provide the Committee with an update on how the Model has changed since the Committee's last meeting in March. The changes made were a direct result from Rep. Oliverson's experience in Texas with TX HB 2536 which itself changed dramatically when navigating between both chambers but at the end of the day emerged as a bill that everybody is proud of and meets the objectives of ensuring that

policymakers are doing everything they can to help states understand why prescription drug prices are increasing.

Rep. Oliverson stated that in in Section 4(b)(1) of the Model he changed the thresholds which trigger reporting requirements for drug manufacturers. The thresholds have been changed to 60% or greater over the preceding five calendar years or 15% or greater in the preceding twelve months. The dollar threshold for the wholesale acquisition cost which triggers reporting requirements has also been changed to $70 or more for a thirty-day supply. Language was also added to what is now Section 4(b)(1)(G) requiring drug manufacturers to include in their report a statement of rationale regarding the factor or factors that caused the increase in the wholesale acquisition cost. The rationale could just be that the company wanted to make more money but there could also be the situation where maybe supply costs went up so it provides them an opportunity to explain the increase.

Also, in Section 5(a)(1)(D) – there is now language that requires a pharmacy benefit manager (PBM) to submit in their report the aggregated dollar amount of rebates, price protection payments, fees and any other payments collected from pharmaceutical manufacturers that were retained as revenue by the PBM as opposed to being passed to the plan subscriber. That was an issue that was gaining significant attention at the state and national levels so it was important to include that to ascertain where the price increases were coming from.

Rep. Oliverson noted that one thing that is not included in the Model but will be included in the final version is that in Section 5 and 6, as far as the requirement to submit a report to the commissioner, all of the data that is gathered from the PBMs and health plans need to be aggregated across the entire class before it gets reported to the general public. That is a good way to prevent disclosure of proprietary or confidential information that might incentivize one member of that class to essentially enter into an anti-competitive bidding practice with another member and would be like playing football and handing over your playbook to the other team before the game starts. That would not be fair for one PBMs' data to be published very specifically so that everyone else, not just in that group but also folks that might be engaging in negotiations with them to know what others are paying. That was not the intent of the legislation, so aggregating the information in a way that protects proprietary and confidential information is important.

Before turning it over to the panel, Asw. Pam Hunter (NY), Chair of the Committee, provided a story of a constituent calling her office last week saying that two months ago her prescription with her insurance cost $3.50 and now it costs $9.75. The constituent told Asw. Hunter that when she spoke with the insurance company it told her that the reason for the price increase was because it can. Asw. Hunter stated that is not an explanation that anyone should be told and accordingly, she is looking forward to having this discussion today to get more clarity on these issues.

Jim Parker, Senior Advisor to the Secretary of Health and Human Services (HHS) for Health Reform, stated that he cannot speak to the specifics of the Model but can share the general perspective that Secretary Azar and the current Administration has with respect to transparency generally, and with respect to drug pricing. The Administration and HHS have taken a number of steps to increase the efficiency and effectiveness of the prescription drug markets. The rebate rule that was proposed and recently been withdrawn was one example of that. Another example were efforts taken with respect to

disclosing the price of drugs that were advertised in direct to consumer advertising. Unfortunately, the courts have recently weighed in to say that HHS did not have the regulatory authority to do that but did not speak to whether or not that policy was something that could be achieved through Congressional action so the Administration will continue to move forward to explore ways that it can bring greater general consumer awareness of the cost of prescription drugs into the consumer marketplace.

Mr. Parker stated that the Administration believes that it is particularly important in today's market for many of the reasons mentioned in Asw. Hunter's anecdote. Individuals are being asked to play a much greater role in participating in the funding and financing of prescription drugs and their out of pocket expenses are much higher than they might have been in prescription drug benefits five, ten, of fifteen years ago. Mr. Parker stated that he has experienced this first hand with this children in that you can get into the rhythm of expecting what a prescription drug is going to cost and either because you move in or out of a deductible or because your plan changes or frankly just because the price of the drug from the manufacturer has changed, you can pay a significantly different and often much greater price for that drug than you did just the month before and it almost always comes without any awareness or understanding prior to being asked to pay that price. For all these reasons, the Administration believes that bringing greater transparency to prescription drug pricing is particularly important in this era in which consumers are paying a much greater out of pocket share for prescription drugs and the Administration applauds this Committee's work on these issues.

Steve Moore, PharmD, Legislative Chair and Incoming President of the Pharmacist Society of the State of New York (PSSNY), stated that the Committee's work on these has issues has great meaning, and thanked the Committee for its work regarding PBM model legislation. To date, six states have passed legislation based on NCOIL's PBM model act and legislation is pending in two more states. Mr. Moore thanked Asw. Hunter, Asm. Andrew Garbarino (NY), and Asm. Kevin Cahill (NY), for their work in passing what PSSNY feels is some of the strongest legislation in the country – it passed the Assembly 116-0 and PSSNY is incredibly excited about it.

Mr. Moore stated that Condo Pharmacy is the oldest independent pharmacy in Plattsburgh, NY and probably the oldest in Northeastern NY. In addition to traditional prescriptions, it fills specialty prescriptions, takes care of long-term care (LTC) patients, has a compounding laboratory on its second floor, and tries to take care of each individual patient's healthcare needs. The pharmacy offers delivery services to patient-charge accounts but also looks to the future and utilizes technology such as patient apps and a robotic counting device that handles 60% of oral solid medications. The pharmacy's pharmacists are some of the most accessible healthcare providers in Plattsburgh within its own walls but they also team with local physicians to see patients in the physician's offices outside of the pharmacy. Mr. Moore stated that the point is that the pharmacy is a true community pharmacy and tries its best to meet the healthcare needs of patients in and around Plattsburgh, but it is getting harder and harder to do that every day and that feeling is echoed by pharmacy colleagues in NY and also throughout the country.

Mr. Moore stated that he believes it is fair to say that most independents will tell you that the vast majority of their difficulties are related to the practices of PBMs. Restrictive distribution channels, overburdensome prior authorization practices, preferred networks, contractually mandated pharmacy gag clauses, artificially depressed professional

dispensing fees, below cost reimbursements, an assortment of misaligned incentives, and a lack of transparency associated with this industry have made providing patients with the care they both need and deserve incredibly difficult. While all of this is going on, patient deductibles are increasing, employer premiums are rising, and taxpayers are responsible for more and more dollars in the Medicaid and Medicare spend. Data gathered over the last year from NY tells a story that mirrors that of states around the country such as Ohio, Michigan, West Virginia, Texas, and Kentucky. This story is one of lower below cost pharmacy provider reimbursements that for some strange reason is not currently resulting in decreased pharmacy costs for patients, insurers, or taxpayers.

A January 2019 white paper commissioned by PSSNY and a subsequent NY Senate investigation regarding PBM practices has resulted in calls for the state's regulatory bodies to conduct a full audit of NY's Medicaid program and Mr. Moore is happy that the calls have been answered. Mr. Moore stated that as a healthcare provider, it is frustrating because we should not need these audits. That does not mean that we should not have oversight of prescription spending or healthcare spending, but as someone who is one the frontline of patient care, it is incredibly frustrating to see patients forego or delay care that they need due to unnecessary obstacles. Physicians and other prescribers who already deal with their own workflow issues, struggle to keep track of what medication is covered for which patient, and what it is going to cost for each patient. All the while, PBMs, at least in NY, are taking advantage of the lack of transparency to collect hundreds of millions of dollars through practices such as spread pricing. This is a practice that is so prevalent and egregious that this past May, CMS issued guidance to states regarding transparency and the reporting of spread pricing in an effort to curb its effort on Medicaid spending.

Mr. Moore stated that is why the work of this Committee is so important and the drug pricing transparency Model is so timely. It is incredibly rare, and for good reason it turns out, for an industry to have unlicensed and unregulated players with the ability to act as both price setters and price collectors. NCOIL model language and suggested best practices for individual states will allow for everyone to learn from one another and more quickly put into place legislation and practices that will effectively serve to align incentives and to hold all participants in the delivery of healthcare to the same standards of accountability and excellence. Mr. Moore stated that PSSNY has comments on the Model, which it will submit in writing, primarily in relation to the dollar amounts and unites suggested as triggers for reporting. Mr. Moore stated that as he has learned from his friends at 46 Brooklyn, it is best to err on the side of over-collecting data as it can tell a great story. Mr. Moore encouraged everyone to follow the work of 46 Brooklyn and the work they are doing regarding looking at the Medicaid spend. Mr. Moore stated that he and the National Community Pharmacists Association (NCPA) are ready to serve as a resource to this Committee on these issues going forward. Mr. Moore also encouraged everyone to tour their local pharmacy as it would be very beneficial to all.

Carl Schmid, Deputy Executive Director of the AIDS Institute, stated that the AIDS Institute is a national public policy and advocacy organization that focused on the wellbeing and health of people living with HIV and hepatitis and obviously access to medications is extremely important to those people and so many others living with chronic illnesses. Mr. Schmid stated that the most important thing he would like to emphasize is what concerns patients is what they pay at the pharmacy. There is a lot of focus on list prices but what is important to the patient is what they pay. It is getting harder for patients to pay as there is a greater use of deductibles, more coinsurance

instead of copays, and high cost-sharing that leads to drug abandonment and adherence, which really impacts people's health. Because of high copays, there is assistance and there is also efforts states can take to limit patient cost sharing.

Mr. Schmid then noted a study from Kaiser Family Foundation (Kaiser) that looked at people who said they or a family member have, in the past year, either postponed or put off care, treated at home instead of seeing a doctor, avoided doctor-recommended test or treatment, or did not fill a prescription or skipped doses. For the last situation described with people with a chronic condition, the percentage was 23%, but for people with a high deductible, the percentage was 35%. Mr. Schmid then pointed to data from Kaiser that focused on employer-sponsored insurance and 21% of those polled have a deductible of over $3,000 and for families it was $5,000. Looking at out-of-pocket costs for the different healthcare services, nationwide spending for the patient at the hospital is 3%. For doctor services, it goes to 8.5% of the total spent. But when you look at prescription drugs it goes to 14%. So, it is no wonder why people are complaining about the high cost of drugs as they are being saddled with a lot of the out-of-pocket costs.

Mr. Schmid then pointed to a Robert Woods Johnson Foundation study which looked at every single silver plan in the individual market. For preferred specialty drugs, 69% of the plans use coinsurance and that is a median of 40%. It is important to remember that patients pay the full price of a drug until the deductible is met. Mr. Schmid then pointed to an IQVIA study which showed that even with $40 to $50 of cost-sharing, 20% of people are abandoning their brand name drugs. When the cost-sharing goes up to $250+, about 70% of people abandon their medications. Mr. Schmid stated that people abandon their drugs mostly due to high deductibles. That is where co-pay assistance really comes into play as people are spending about $61 billion in out-of-pocket costs for prescription drugs. Co-pay assistance from manufacturers and others account for $13 billion. Mr. Schmid pointed to a study that stated if it was not for co-pay assistance, the drug abandonment rate would increase almost threefold.

With regards to what states are doing to address these problems, Mr. Schmid stated that NY prohibits specialty tiers, which is great. Several states have copay caps like CA, DE, LA, MD, and Washington DC – which are still a little high, but at least there are caps. The unfortunate thing is that they are all applicable after the deductible, which is a barrier to access. Some states like CA, have standardized medical plans with copay caps, separate drug deductibles, and they require plans to place at least one drug on tiers 1 to 3 when multiple drugs are available for chronic conditions. Some states have tinkered with benefit plan designs like CO, which requires that: not more than 50% of the drugs to treat a certain condition can be on the highest tier; at least 25% of the plans in each metal level must use copays; copays not be subject to the deductible; and that copays be spread throughout the year so that you are not paying a huge amount in the beginning of the year.

Mr. Schmid stated that with regards to copay assistance, he has heard in the past year the growing use of copay accumulators, which is when a patient's cost sharing they get from the manufacturers or others, do not count towards the deductible or maximum out-of-pocket cost. This is harmful to patients as they frequently don't know that it is happening to them. The AIDS Institute was pleased to see that the federal government stepped in, and in the 2020 Notice of Benefit and Payment Parameters, it is going to limit the use of copay accumulators and require copay assistance to count in most situations such as when brand name drugs have no generic, when access to a brand name drug

that has a generic has been gained through exceptions or appeals process, and maybe for a brand name drug when a generic exists. A couple states have stepped in and passed their own legislation that requires copay assistance to count: AZ, IL, VA and WV. Other legislation is pending.

With regards to transparency, Mr. Schmid stated that he believes the most important thing for patients is that they really need to know how much the drug costs when they go to the pharmacy. Copay is easy but when you are in the deductible phase you really need to know how much that drug is going to cost so the list price is important there. The most important thing is because of the use of coinsurance, people need to know what that coinsurance stands for – is it 50% of $100, $1,000, or $10,000? Mr. Schmid stated that it is good that the Model is looking at the increase in wholesale acquisition cost (WAC) prices but it would be interesting to see what the increases in net prices would be. Mr. Schmid stated that he supports the provisions of the Model relating to rebate information. With regard to the health plans, it is great that the Model is looking at the percent increase in drug spend in impact on premiums but it would also be interesting to compare that to other health services. In addition to utilization management, it would also be good for the Model to ask for the amount of drugs that have coinsurance and how many of them charge the list price until the deductible is met.

Leeanne Gassaway, Senior VP of State Affairs and Policy at America's Health Insurance Plans (AHIP), first thanked the Committee for its work on the Model and stated that it is a greatly improved version from the first version. AHIP has said from the beginning that reporting for reporting's sake is not great because it will not tell you much but if it is meaningful and useful then it does help legislators help empower regulators to understand what is happening in a particular state who can then bring solutions to legislators to enact further policy to address any issues.

With regard to the reporting thresholds, AHIP is pleased to see the changes that were made to the Model to bring it into alignment with Texas HB 2536, but AHIP believes the 15% threshold should be lower to align it with other states such as Oregon, Nevada, and California, in addition to being in alignment with commitments and pledges that pharmaceutical companies have made publicly to what they will raise their prices year over year. AHIP believes that price should be 10% as the threshold. In January 2018, several pharmaceutical companies publicly pledged that they would not raise prices more than 10% per year. AHIP believes the Model should hold them to that pledge. Moreover, Wells Fargo just published a report this week that said that drug prices have increased in 2019 10.5% which is four times the rate of inflation, and in June alone drug makers raised prices 27% on average. By putting the threshold at a higher rate we are basically saying "go ahead and raise this 14.9% every year which would be six times the rate of inflation and we are ok with that."

Ms. Gassaway stated that the Model should also address newly launched drugs. Most drugs have been on the market for a very long time but it is the newer drugs that are coming onto the market some of which have astronomical price tags to them. We now have a drug in the U.S. that costs $2.1 million and we have regular bread and butter cancer medications that come of the shelf at six figures or more. It is worth having a threshold requirement for newly launched drugs so we know where we are starting and why they are launching at the prices they are launching at. If the reasons are R&D costs or recouping company expenditures then at least those are explanations but to be able to put a $2.1 million drug on the market with no explanation is something that AHIP

believes policymakers have a right to know. Ms. Gassaway stated that other states have addressed this and AHIP would be happy to submit model language for consideration.

Ms. Gassaway thanked Rep. Oliverson for his comments regarding aggregating information. That is an important amendment to the Model because we do not want to manipulate the market any more than we need to. Ms. Gassaway then noted a suggested amendment to Section 4(b)(1) of the Model. There was a provision in the Texas bill that stated not only do you have to explain the factors that went into price increase but also the role that the factor played. For example, was it largely R&D costs and slightly a supply problem or vice versa? Just by saying the reason for the increase is R&D, which has been the common excuse up to this point, is not enough to really understand what is going on. Ms. Gassaway closed by stating that AHIP believes the Model is head in the right direction, and AHIP is prepared to work with the Committee as the Model gets adopted and brought to the states.

Saiza Elayda, Director of State Policy at the Pharmaceutical Research and Manufacturers of America (PhRMA), stated that PhRMA does have some concerns with the latest version of the Model and thinks that the changing of the threshold numbers are simply punitive and do not help the consumers and could create some significant compliance complications for companies. Lowering threshold numbers and requiring justifications really do not do anything for the patients and PhRMA feels that patients do need to have some transparency into what they are paying at the pharmacy counter but you also have to keep in mind that the manufacturers are not selling directly to the patient. There are very complex discussions and negotiations with insurers and PBMs who are also very sophisticated contractors who also have control over their benefit design and have P&T committees that look at the clinical side of things before they decide whether or not to put a drug on their formulary. They have a vast amount of data looking at their experience with drugs and enrollees.

Ms. Elayda stated that manufacturers already disclose a large amount of information publicly and have R&D expenses which include the clinical development costs, the cost of R&D through mergers or acquisitions with other companies, as well as information about drugs in the pipeline being worked on. Manufacturers also report the aggregated data cost on manufactured goods produced and sold, and have data on marketing costs, costs associated with patient assistance programs and ACA prescription drug fee. Manufacturers also report aggregate information on rebates as well as the cash discounts and other discounts. Lastly, manufacturers have information that they report on the gross and net sales and the net earnings and losses.

Ms. Elayda stated that while PhRMA does appreciate that there are PBM and insurer aggregate disclosures, the Model stops short of helping patients. The transparency should focus on supporting policies and reforms that work in the best interests of patients when they are at the pharmacy counter. PhRMA does believe that the system needs to be shaken up a little bit and states are the perfect area where that can occur. For example, PhRMA supports supply chain reforms that could align system incentives to deliver a greater share of the savings to patients – these are the savings that the insurers and PBMs gain through negotiations with manufacturers on where the drug is going to be put on the formulary, or if it will at all.

Lastly, PhRMA is willing to work with the various stakeholders present today and all

Committee members to pursue policies to decrease the legal or regulatory barriers so that stats can have voluntary alternative payment models that can be tested at the state level to see what works. PhRMA's member companies are open to discussing what can work to see what is a good policy and what is a bad policy. This is not going to be a quick fix and there will be failures in the various payment models that can be tested but PhRMA is happy to be part of working to find solutions.

J.P. Wieske, VP of State Affairs at Horizon Gov't Affairs spoke on behalf of the Pharmaceutical Care Management Association (PCMA) and stated that PCMA is appreciative of the work that Rep. Oliverson and the Committee have done on the Model, particularly with regard to the aggregating amendments mentioned earlier. The movement of this Model is important for transparency across the country and PCMA believes that this is a huge step forward and part of understanding where we are going to go in the future is starting with the data that is being proposed in the Model. Mr. Wieske stated that as we move forward, he believes we are going to see changes in how the industry operates. Technology will increase in health and every other line of insurance. Things such as real time benefit checks, which would allow consumers in the doctors office – not just in the pharmacy – to be able to understand all of their pricing options. There are some significant IT issues that are surrounding that and it continues to be worked on. As we sit here today, Mr. Wieske stated that this is an important transitional Model to get us to the next level and to understanding what is operating in the industry at large. PCMA is happy to work with the Committee moving forward.

Asw. Hunter thanked the panel for their comments and noted that medical costs are one of the leading causes of bankruptcy in the country. Asw. Hunter will return to the constituent she mentioned earlier to say that she is working on drug pricing transparency and costs but at this point she does not have an answer for her.

Rep. Oliverson asked Ms. Gassaway to elaborate on her comments regarding newly launched drugs, and also asked the rest of the panel to comment as well. Ms. Gassaway stated that there are a couple of different approaches that have been discussed. From an administrative perspective, one thing that NCOIL does in building a Model is allow multiple states to adopt it so there is one set of rules for companies to abide by which can reduce administrative costs. Looking at CA, OR, NV and VT which are four states collecting drug price information, they are collecting information on newly launched drugs and have set that threshold at the same definition as the Medicare specialty drug threshold which is roughly $670 a month which is roughly $8,000 per year. AHIP had previously suggested $10,000 which is not a magic number but there is a shock value to it of thinking that if there is a drug that is going to cost more than $10,000 maybe we should ask why. Accordingly, Ms. Gassaway suggested any requirements on newly launched drugs in the Model to be aligned with the states she mentioned in order to be less administratively burdensome.

Mr. Wieske stated that coming from an insurance department where he collected data and looked at how the department used it, the idea is that you need to have a baseline and understand where trends are going to go. Understanding where drugs are staring at will be important to understanding what is going on at the market at large. That has consistently been seen with insurance department's gathering of data.

Ms. Elayda stated that a lot of this information is already out there. When drugs are in the pipeline stage you can go to any manufacturer's website and see what they are

working on and see what stages of clinical trials the drugs are on and see if they have had to start over again. Accordingly, such information may be duplicative.

Rep. Oliverson asked Mr. Wieske and Ms. Gassaway to comment on Mr. Schmid's comments relating to cost sharing abandonment with respect to copay assistance counted towards the deductible. Ms. Gassaway stated that those are very important issues and health plans have been challenged with the deductible balance of premiums. Deductibles and premiums go in balance as we are trying to serve the customers that buy insurance or employers that buy insurance. Ms. Gassaway stated that she does not believe any health plan likes high deductible plans, they just realize that they have a purpose in the marketplace because there is a need from a premium perspective to give somebody that protection they need if they do have a medical issue.

Ms. Gassaway stated that it is important to step back a little bit from the deductible issue and talk about list price because list price does matter and that is one thing that is missing from this. AHIP had Milliman conduct a report on real rebate data for six health plans and the report stated that 64% of brand name drugs have no rebate being applied to them. If 64% of those drugs have no rebate, that is the price of the drug that the health plan, PBM, and customer is paying. When a lot of the talk focuses on the fact that the list price doesn't matter and the parties involved are sophisticated negotiators that are getting great discounts and not passing them on to patients, it is simply not true. AHIP is doing the best that it can to get the lowest net price it can for consumers but for 64% of the time, they may have a monopoly on the market and do not need to give plans a discounts – the drugs are going on the formulary and they can charge whatever they can and there is no control over that.

In the generic space there are no rebates so when you have a generic drug that starts at $3 and then the market moves and now the pharmacy is being charged $9 for that same drug, health plans and PBMs have no control over that – that is the market and list price the drug maker has set for that drug. That price matters and we have to stop thinking that it is somehow an illusory price because it is not. And you should not need a coupon to buy your drug. Coupons are a market manipulation to keep brand name drugs being prescribed when there are other cheaper alternatives on the market. Going back to the Milliman data, we are actually getting big rebates when there is brand to brand or brand to generic competition, but when there is only a brand out there they are going to try and hold on to that market share as long as they can. So when you have a coupon you are actually raising the price.

Ms. Gassaway stated that there was an incredible study done by Massachusetts and New Hampshire as MA banned copay coupons for a period of time. They looked at the dispensing of generic drugs between those two states and found that generic utilization went up in MA as it banned coupons because all of a sudden it was better for folks to take the generic version of the drug instead of taking the brand with a coupon. We need to stop market manipulation, and bring down the cost of the drug so that people can afford it because an unaffordable drug is not an accessible drug. We need to have reporting that matters but if I report that this many people used a copay coupon, most of the health plans have no idea those coupons are being used unless they have put a copay accumulator in place which has an amazing amount of technology behind it. The pharmacy processes the claim and for the health plan it looks like the member paid that full claim. The plan has no idea that the coupon was being paid for by the pharmaceutical drug maker. Accordingly, that data may not even be reportable since

half the time it is not known it is being used. Conversations moving forward need to focus on lowering the list price.

Mr. Wieske stated that from PCMA's perspective, this is a consistent policy in everything else in medical, not just drugs. There is an expectation that if a doctor or dentist advertises that they will give you a free exam then it will in fact be free and not be billed to the insurance company separately. There is a piece of that that makes sense. There is an expectation from an insurance standpoint that the deductible is the cost paid by you and in most insurance policies that is in fact how it is defined. If not defined that way, that is an issue with the insurance company and how they are issuing their policies but that is a fairly consistent definition in policies. Mr. Wieske stated that you have to be very careful if you are opening up that discussion that you are freeing up the type of issues that lead to fraud in the other areas we have seen where these sort of free things end up being charged significantly to the insurers down the road in a variety of ways – that is seen ad nauseum. It is intended to circumvent the system that the insurers have put together with the P&T committees and driving the drug formularies in order to lower the costs and those higher costs are being passed on to the insurer, they are not just being paid by the patient. Mr. Wieske stated that he is certainly cognizant of Mr. Schmid's comments and the issues his colleagues are dealing with as there are significant costs passed to them as well.

Mr. Schmid stated that he agreed with Ms. Gassaway that it would be if we did not have coupons but if we did not have them there would be greater drug abandonment and it is unclear who would pay for all of those costs in the deductible and high cost sharing. If we set lower copays then we would not have a problem. Most of the copay assistance goes for brand name drugs without a generic by far and also the plans are still collecting the money – if it is not from the patient it will then be from the drug manufacturer copay assistance so they are still collecting the money and with copay accumulators they are double dipping. Ms. Gassaway stated that plans do not collect that money – the money goes straight from the pharmacy back to the drug maker.

In response to the comments regarding the significant technological advances made and how a lot of data is already accessible, Asw. Hunter stated that there are still many people who do not have reliable internet access.

Asm. Kevin Cahill (NY), NCOIL Secretary, stated that the fact that the information is out there is sort of the answer to everything since the internet is so pervasive but what Rep. Oliverson is trying to accomplish is to transform that information so that it can be used by people. There is a benefit to people who are trying to hide things to make it confusing even if it is out there. Regarding Ms. Gassaway's comments that drug prices are real, Asm. Cahill recalled his first exposure to the average wholesale price (AWP) and saying it is not average, not wholesale, and not the price. That is where we are as consumers – we don't know what the drug prices are. By consumers, Asm. Cahill means states as well as NY's Medicaid program is the biggest drug buyer in the state.

Regarding the issue of the balance of premium versus deductible and copay, Asm. Cahill stated that most of the time plans will tell us that copays are a management tool and not necessarily a cost tool and that it is a way that they encourage people to be cautious when they are using their benefits and it is important to have some skin in the game. However, there does come a point where a copay or deductible is so great that in fact the benefit is illusory and does not really exist – it is just on paper. If somebody

cannot pay for something it is not a benefit. So the idea that we are balancing off a premium does not make sense if that premium is paying for a product they are not getting. Asm. Cahill asked Mr. Schmid and Mr. Moore to discuss the human element in this regarding what it really is like to tell someone that their drug has suddenly become unaffordable.

Mr. Schmid stated that healthcare is so critical to stay alive each and every day and access to drugs is more and more critical. Mr. Schmid stated that he represents people living with HIV and hepatitis and if they did not have their drugs they would not be alive. Coupons are extremely critical as Mr. Schmid stated that he has been doing this for 15 years and that is simply those with HIV get their drugs because of the high cost and high cost sharing. It really is an issue of life or death if they do not have access to their drugs.

Mr. Moore stated that it is the most difficult part of what he and his colleagues do. You have a prescription from a doctor that is covered by the insurance company and it comes back with a high copay that the patient is not able to afford. The patient says "what do I do now?" While copay cards and patient assistance are extremely important, Mr. Moore stated that he and his colleagues cannot use those cards for Medicare Part D patients. So if you have a patient who is in a federally funded plan those copay cards don't do any good so while they are important and do help you cannot overstate their role. Mr. Moore stated that every day he and his colleagues deal with patients who come in and they have come out of their deductible or have gone through the doughnut hole in Medicare Part D and are in catastrophic coverage and they are almost relieved that they have spent so much money and it is not a win-win for anybody at this point.

The beginning of the year is incredibly difficult when formularies and plans change and everybody comes in sort of wondering what the damage will be in January. Information is important and having it be accessible online is great but we have to remember that a large percentage of our population does not have meaningful, if any, internet access and therefore the information needs to get to them in a manner in which they are going to be able to utilize it and make something of it. With seniors in particular, Medicare Part D likes to put everything on line but it is not effective. During open enrollment every year patients come in to the store asking what they should do and what plan they should sign up for and they have to be very careful about how they answer those questions and the answer "go look it up online" just doesn't work for a lot of patients.

Asm. Cahill asked if the people walk out of the store when they are told that or do they do something else. Mr. Moore stated that they try to sit down with them and help them navigate the information the best they can and often they will set up appointments to bring them in to show them the CMS website with a plan finder but you have to be careful with how you present plans because it can be seen as steering by the pharmacy which can result in trouble if the plan pointed out is better for the pharmacy so it is a tough situation.

Asm. Cahill stated that during the Committee's discussions on PBMs, and elsewhere, it has been said that independent pharmacists are sometimes required to charge less than a drug actually costs the pharmacy. Asm. Cahill asked how that occurs in a contract or elsewhere and how might the Model effect that in a positive way. Mr. Moore stated that they are paid according to a contractual basis, usually on a list-minus model or an AWP-minus a certain percentage for a generic drug and as we know, AWP doesn't necessarily

have any correlation to the actual cost of the prescription and what the pharmacy pays. So if according to the terms of the contract I am reimbursing at AWP minus 80%, if my acquisition cost is higher than that I am still required to dispense that prescription. The difficulty with that is that it is an issue of being able to even afford stocking and carrying those prescriptions and it is becoming a greater percentage of the prescriptions seen – about 16% of Mr. Moore's pharmacy at this time.

Asm. Cahill asked if this is a situation where the dispensing fee can make up the difference or is it significantly more than that. Mr. Moore stated that in the case of Medicaid managed care the dispensing fee could make up the difference in a lot of situations with generics but for some of the brands it might not depending on the percentages and other numbers.

Rep. Martin Carbaugh (IN) stated that he has a lot of concern with copay and deducible coupons counting towards the deductible on a plan especially when you look at it from the standpoint of other concepts that are being brought forward. There was a bill in Indiana this year that would have limited the ability of the insurance company to switch people from a current drug to a different and maybe lower cost drug. Essentially, if you pull back and look at it from a 30,000 foot view, we want to help pay the upfront costs so the client has no out of pocket cost at the pharmacy counter, which sounds great for consumers. Then they get past their deductible because all of the coupons count towards it and then the insurance industry has no ability to switch the drug throughout the year to a lower cost if there is a lower cost drug that could work. So we have to be very mindful of the ramifications and some other concepts that are built around this.

In Indiana there was a Committee hearing and no vote about the idea of coupons counting towards the deductible and the Ranking Minority Member of the Committee, a Democrat, simply asked "why not lower the price? Why is the price setter offering a coupon and then now they want that to count towards the deductible?" Rep. Carbaugh stated that is very dangerous that and the fact that it is already occurring the industry may not know is something the Committee may need to look at because ultimately we cannot just concentrate on the cost at the pharmacy counter – we have to look at the actual cost of the drugs.

Asw. Maggie Carlton (NV) first thanked those on the panel that cited Nevada's work on these issues and then stated that she understands where PhRMA is coming from but Nevada has a great professional staff and people who have one of the most comprehensive health insurance plans – a union health and welfare trust in NV – cannot figure out the data and why insulin went up 700% over 20 years and became unaffordable. The data may be available but you need a Ph.D. to understand it. Asw. Carlton stated that she is proud of the drug pricing transparency legislation that was passed in NV in 2017, and in 2019, there is a similar game plan for asthma medications. With regard to the coupon issue, Asw. Carlton stated that they discussed it in NV and a Republican colleague of hers asked if it really matters who is paying the deductible, whether it is a coupon or a 30 year old who cannot afford it and asks Mom and Dad to pay for it. The deductible is being paying for either way. Coupons in some cases can save that 30 year old from making that call to their parents asking for an extra $600 to pay for a prescription.

Rep. George Keiser (ND) asked Mr. Wieske to elaborate on his earlier comment regarding the Model being a transitional bill, meaning that if this is a transitional bill, what

is the optimal bill? Mr. Wieske stated that he does not believe there is an optimal bill but in terms of where the industry is going technology-wise, in a number of years we may be able to see a doctor being able to figure out exactly what a specific drug for a specific patient on a specific plan costs both from inside their plan and if they were able to pay a cash pay price. Mr. Wieske stated that he does not believe we are that far away from that.

Rep. Wendi Thomas (PA) stated that it is her understanding that there are coupons that come from drug manufacturers and then there are coupons that other pharmacies distribute to get business. Rep. Thomas asked if we are only speaking about the drug maker coupons. Ms. Gassaway stated that by and large those are the coupons being discussed today. She noted that you can download them off the internet easily from a variety of websites, either from the drug maker or a third party, but they are all backed by the drug maker. The drug maker issues them and is basically paying the pharmacy to dispense that drug instead of the member. Put another way, this would be the equivalent of a hospital issuing a coupon to have your baby at that hospital instead of another hospital because they will waive your deductible because they will essentially pay the deductible for you. We don't allow hospitals or doctors to do that but we do allow pharmaceutical manufacturers to do that. Mr. Schmid stated that there are also a number of non-profits that also help with assistance.

Ms. Elayda stated that manufacturers do report the amount that they have provided per year in their SEC filings for patient assistance. Ms. Elayda stated that she cannot speak to what each individual company's patient assistance program looks like but they are all different and take into account various things. It is a little bit of a stretch to say that manufacturers are even paying for the third party and non-profits and all the coupon systems out there.

Asw. Ellen Spiegel (NV) stated that she has been noticing increased consolidation of pharmacies and PBMs and insurers are buying them and it is getting harder for an independent pharmacist to stay in business. Asw. Spiegel asked if when the insurers own the PBMs if they are looking at each line of business separately or looking at it in a consolidated way in which case there is more room to provide relief to consumers.

Ms. Gassaway stated that there has been so much consolidation in the industry but from an insurer's perspective, insurers have been by and large partnering with the PBM industry for at least the 25 years she has been doing healthcare policy work. The first plan that Ms. Gassaway worked for owned its own PBM and built it from the ground up because it needed that specialized expertise to administer the pharmacy benefit as it became more and more integrated into the medical benefit. Many forget that 15 years ago, prescription drugs were not a covered benefit in an insurance policy. You maybe got generics but you did not get brand name drugs. Now we have such comprehensive coverage which allows us to do whole person care. As health plans approach that from the care continuum they are looking to get those synergies and the companies that do have a common patent do have to have silos between their insurance business and their PBM business because their PBM typically has business with other insurance companies that their insurance company cannot know about. Ms. Gassaway stated that there are a couple of PBMs that own pharmacies or have the same parent but that is not the norm at least right now. The synergies between the health plan and PBM are growing more intricate because of the fact that the pharmacy benefit is so important to whole person care that you cannot treat it separately anymore.

Mr. Moore stated that it is the PBMs buying the health insurers in a lot of situations and there is a reason for that. Pharmacists have a lot of concerns with that and what is going on with the integrations. The exchange of data reports shows that patients have been contacted by the PBMs to transfer their prescriptions from not only independent pharmacies but smaller chain competitors within NY and those patients have never stepped foot in another chain. That is something that Mr. Moore and his colleagues are very concerned about as providers and healthcare professionals and the PBMs are the ones coming up with the money to purchase the health insurers.

Rep. Oliverson thanked everyone for the comments and stated that it is important to remember that the Model is a transparency model and not a "thou shall not do this" bill. The purpose of the Model is not to tell stakeholders how the must conduct business – the purpose is to find out how their business practices effect the cost of prescription drugs. Legislators want to be armed with the facts before they start peeling back the onion and take any action to try and lower prescription drug prices. Rep. Oliverson stated that he and Sen. Dan "Blade" Morrish (LA), NCOIL President, look forward to working with everyone to make improvements to the Model and have it adopted at the NCOIL Annual Meeting in December.

DISCUSSION ON HEALTHCARE SHARING MINISTRIES

Rep. Carbaugh began by stating that in the interest of full disclosure, he does of a contract with a health care sharing ministry (HCSM) as an agent and has sold a couple of policies, although they are technically not "policies." When dealing with HCSM's, there is a lot of language to change because there are no claims and there is no premium and there is no contract. There are allotments and no deductibles and annual household portions. Many of them look and feel like health insurance but are not. Rep. Carbaugh stated that what prompted him to bring this topic forward for discussion was that a friend of a friend called him about some health insurance and asked about some options mid-year and he did not have many because of the enrollment period. Rep. Carbaugh mentioned a HCSM as a possible solution although he always prefaces that recommendations with all disclosures.

The friend said that they had already tried that and had an unpleasant and unexpected experience – his wife got pregnant and when the baby was born, the baby had some pre-existing birth defect conditions and all of the medical bills to treat the baby were not eligible to be shared with the HCSM they were working with. Rep. Carbaugh stated that as a Christian that did not seem very Christ-like but he also understands the concept of the no pre-existing condition language and that is why the monthly pricing can be competitive. Rep. Carbaugh stated that other stories are starting to come out and as in every industry of every kind there are going to some bad players and some well-established good players. Rep. Carbaugh stated that the story he shared was with one of the well-established HCSMs.

The Honorable Dave Weldon, former Congressman and President of The Alliance of Health Care Sharing Ministries (Alliance), stated that the Alliance now represents two HCSMs, as the third recently left to do their own gov't affairs work. The remaining two are Christian Care Medishare and Christin Healthcare Ministries. They represent close to 50% of Americans in HCSMs. When the third HCSM left, the Alliance was representing about 2/3 of Americans in HCSMs. Cong. Weldon stated that the work that

he does, which is gov't relations work at the federal and state level, ends up affecting all of the people who are using a HCSM as an alternative to insurance. Additionally, there are about 150,00 Mennonites using healthcare sharing and for them they do not believe in using insurance. Some of them are required to have car insurance in their state but if they get into an accident and they are at fault they typically pay cash to resolve it. One of the HCSMs that is Mennonite has about 10,000 members. The concept of healthcare sharing is also ancient and goes back hundreds if not thousands of years. Indeed, one can say the concept is rooted in the scripture and verses in the scripture.

Cong. Weldon stated that HCSMs are not businesses but rather 501(c)(3) tax deductible charitable institutions. Some of them are actually run by ministers and not businessmen per se. Cong. Weldon stated that he is a physician and served in Congress from 1994 – 2008 and was on a number of healthcare committees. He was asked to be on the board of Medishare and then later asked to step in and run their gov't affairs operation. The HCSMs are also religiously diverse in the sense that there are Catholics, Protestants, and recently a new HCSM that caters to Jewish people (mainly orthodox). Some HCSMs will accept multiple faiths but some are limited to one only. Regarding Rep. Carbaugh's remarks on pre-existing conditions, most of the HCSMs have temporary preexisting condition exemption and when talking about this issue it is well worth saying that pre-existing illness exclusions are there to protect the rate payers that are paying insurance from the people who wait until they get sick and then get health insurance. Cong. Weldon stated that when he practiced medicine he saw that firsthand and it drives everyone's premiums up. HCSMs typically have a temporary pre-existing exclusion, typically 2 or 3 years and usually never permanent.

Cong. Weldon stated that HCSMs have grown quite a bit and they do settle some very large bills. Some of the biggest payments when he was on the board of directors at Medishare were for premature babies and frequently they settled bills in six figures and occasionally seven figures. Recently, there has been a lot of concern about a HCSM called Aliera in the media and allegations have been raised that they have not been paying claims as they come in. Cong. Weldon stated that Aliera is not a member of the Alliance and it is not clear to him whether it is actually a HCSM. When he talks to the leaders of the HCSMs they have had a great deal of concern for a long time that somebody could get into this space and start engaging in a HCSM but not have the proper motives. By and large, there are mostly Christian HSCMs and if you go to their offices you will frequently hear people talking to others on the phone with illnesses and actually praying with them. The Christian roots of being engaged in the process of healthcare delivery are ancient. The concept of a hospital was an institution that was created by the Catholic church 1,000 years ago. For many years it was all rooted in charity and it was mostly led by the Catholic church and then the Protestants began to engage in it. In many regards it makes sense because a health crisis can be one of the biggest if not the biggest crisis one faces in their life and the involvement of the church has traditionally been a strong part of it.

Cong. Weldon stated that the President recently released an Executive Order entitled "Improving Price and Quality Transparency in American Healthcare to Put Patients First." In that EO, the President called for regulations to be promulgated by the Departments of Labor, Health and Treasury to allow participants in HCSMs to take advantage of section 213d of the U.S. code. There is also reference to members of HCSMs having access to an expanded form of health savings accounts. Cong. Weldon stated that the Administration is interested in this because we have seen tremendous

price inflation and there are serious concerns about pricing. Cong. Weldon has seen these problems firsthand when treating patients. Innovation is good and HCSMs represent a form of innovation. The HCSMs also help a lot of people who are very low income. One HCSM Cong. Weldon represents has 50% of its members at or below 400% of the poverty level. The Alliance feels that those in the HCSM sphere are providing a vital service and meeting the needs of critical Christina and non-Christian families that are struggling with healthcare needs. The Alliance is eager to make sure that consumers are protected and fully informed and that it is fully disclosed that this is not health insurance.

Joe Guarino, Health Care Sharing Consultant for Nelson Taplin Goldwater Group (NTG), stated that stated that health care sharing (HCS) involves families helping families pay their medical bills voluntarily with financial gifts. There are six large national HCSMs of variable sizes. There are also many very small church-based local or regional HCSMs that are mostly Mennonite. Mr. Guarino then walked through a hypothetical to explain how HCSMs work. In a given month 3,000 medical events come into one particular HCSM and after adding them up they total about $30 million dollars. They then divide that $30 million among the households that are participating in that ministry. The next month the HCSM will send out a newsletter with an insert that says “Joe, this month send your share (which is a gift to help pay for medical expenses) to Sally in Des Moines, Iowa." Joe then writes a check and sends it to Sally along with sending a get-well card and praying for Sally because in the newsletter there is a brief description about what the medical event is that Sally is experiencing.

For Sally, if her medical event cost $5,000, she will submit original bills to the HCSM and the HCSM divides that up between lets say 23 families in the HCSM. The HCSM sends a check list to Sally and Sally waits for those checks to come in. If there are any members that do not send a check, Sally will then inform the HCSM and the HCSM will re-allocate those shares to someone else the following month. Ultimately, Sally will get enough money to pay all of her medical providers. The process typically takes 30 to 60 days from the time someone submits a bill to receiving checks to paying the medical bills. HCS promotes fiscal responsibility. Kaiser puts out a yearly report on the cost of employer-sponsored health benefits and in 2018, the average annual employer-sponsored family premium was $19,616. One HCSM average annual share for a traditional family of three or more is $5,490.

Mr. Guarino stated that HCS also engenders personal responsibility because to participate in a HCSM you must abide by lifestyle requirements based on the Bible: sex within biblical marriage; no drunkenness; no illegal drugs; and no smoking. There were nine exemptions in the ACA and HCSMs received one of them which means HCSM participants did not have purchase health insurance and they would not be panelized for not having health insurance. With the penalty being eliminated in the federal tax code a few years ago some states have begun to reimpose a mandate to buy health insurance but that is another issue for another time.

The Honorable Glen Mulready, Commissioner of the Oklahoma Department of Insurance, stated that since HCSMs are not regulated, they may choose to cover or not cover almost anything. Several HCSMs have grown substantially of late and the difficulty in that is that we do not know that the impact is because they are not required to report data at all to anyone. Most recently, some regulators and Attorneys General have taken action against some HCSMs. The state of Washington has issued a cease

and desist order to Aliera. There was also requesting a temporary restraining order against Aliera, and Georgia has just recently started an investigation with the FBI. Cmsr. Mulready stated that when he started as OK Insurance Cmsr. six months ago, his concern was helping folks and if people called the department asking if a HCSM was insurance he was told that they should be told that the department does not regulate HCSMs so they need to call the HCSM directly. Cmsr. Mulready stated that within the week hopefully his department will be putting on its website a list of HCSMs that it knows of that are doing business in OK with a link to their contact information along with a disclaimer that they are not regulated by the department. Cmsr. Mulready also noted that as you can imagine, depending on what state you are in, views on HCSMs can fall on political ideological lines.

Cmsr. Mulready stated that he grew up in MA and had never heard of HCS despite being in the insurance business, but his father in law in OK who was sick at the time was not able to get individual health insurance (this was pre-guaranteed issue) and he was able to join a HCSM and have his costs covered. He had hundreds of thousands of dollars of medical bills with multiple open heart surgeries and multiple amputations. Cmsr. Mulready stated that in his state he believes it is about freedom of choice but noted that NCOIL is uniquely qualified to put forth some basic items for HCSMs to abide by and Cmsr. Mulready suggested a notification/registration process in each state with contact information and perhaps an annual report with information stating how many people are being served and what kind of healthcare expenses are being taken care of. Also, HCSMs are required to do a basic audit for CMS so requiring that to be submitted to the insurance department could be beneficial.

Rep. Oliverson stated that he is all for more choices in the marketplace but he is always mindful of the fact that regulation is developed not to regulate good actors but rather bad actors. Rep. Oliverson asked the panel if it would destroy the business model if HCSMs were brought into the purview of the insurance department. Cong. Weldon stated that when he began his current position at the Alliance he immediately began discussing with HCSMs both in and out of the Alliance that it would be really good to regulate themselves. That occurs in a whole host of areas with academic accreditation being a great example – you have some standards on educational accreditation but mostly, at least in the southeast – it is handled by the southeastern association. Getting the HCSMs to move forward with that concept has been difficult as some of them are quite small and have limited resources. The subject of registration has been brought up and discussed. Cong. Weldon stated that the vast majority of the players in this field are very much interest in working with legislators and the gov't to put in place some sort of regime to deal with the issue of credibility and accountability. What that is right now is not clear.

Cmsr. Mulready stated that in OK they are trying to set up a process of when a call comes into a regulator trying to get in contact with a HCSM, the consumer assistance area can connect the call to some sort of "elevated" call to that HCSM because if someone is contacting a regulator it is at an elevated level. Rep. Oliverson stated that his biggest fear in this is that he does not want to see it go the way of association health plans (AHPs) where they sort of came on the scene largely unregulated and had some pretty bad actors that did some pretty awful things so the ACA pretty much abolished them. The bad actors should not drag the whole market down.

Sen. Bob Hackett (OH) stated that he has been in the business a long time and when

things go bad, they go bad quickly. When things go bad and costs go way above average, the healthy people leave even though religious pressure may keep them. Sen. Hackett also stated that it is often easy to close one down and open up another and create some pre-existing condition provisions where you do not get bad claims. There was a case in Kentucky in the 1980s with a company which was a non-ERISA trust and the insurance commissioner gave them an award and a year later the insurance commissioner said any agent that put business with that company should consider having their license revoked. They didn't have the backup of being a fully-insured plan and when it turned bad it turned bad quickly. Accordingly, Sen. Hackett asked if there is any sort of system in place, analogous to the guaranty system, to guard against when things go bad because the rates look good but they can change overnight.

Cong. Weldon stated that is a broad question but to answer it narrowly, there was not a lot of controversy surrounding HCSMs two or three years ago and that is because they were sharing in everything they said they would share as when you join a HCSM you are told what will be shared and what wont. There were not a lot of complaints flooding in, and now because of one HCSM, which may not actually be one, there has been a lot of media reports about people having medical expenses that were not shared. Cong. Weldon stated that HCSMs have been talking internally about this sort of bad scenario for years. That is why Cong. Weldon feels that something needs to be done whether at a state or federal level. It is also important to keep in mind that most of the people in this space are good people and are sharing millions of dollars. Some actually refer to HCSMs as business trees because there is so much money coming in and out the door but notably there are no stockholders and they are run as a charity as a 501(c)(3) and most file 990s. The ACA requires that they issue an audit and make it accessible to the public so you can put audits and 990s on department websites.

Sen. Hackett stated that one problem is that someone may go without health insurance and then when a problem arises and they try to get it they have no records. Sen. Hackett knew a client who could not join a HCSM because he had no records and there was no way to determine any pre-existing conditions.

Sen. Dan "Blade" Morrish (LA), NCOIL President, asked if the dollars paid are paid through the individual or through the HCSM. Cong. Weldon stated that they all vary and the description Mr. Guarino gave was how Samaritan ministries work – they actually mail checks around though they are trying to do it in a different way. The money goes to the person with the claim who puts it in their account and then writes a check to his hospital. The biggest ministry, Christian Healthcare Ministries (CHM), actually pools all their funds and then ask the member if they want the money to be sent to them so they can pay the hospital or do you want us to pay them directly – most of the members request that they be paid directly. Medi-Share has a very unique operating system where every member opens a checking account at a credit union in CA called America's Christian Credit Union and if you have a medical event the money is moved electronically into that person's account and then transitioned out to pay the providers. There are other ministries operating of which Cong. Weldon stated he does not how they handle payment. Sen. Morrish stated that he passed legislation on this in LA in 2014 and at the time he believes it was set up like the credit union scenario described.

Asw. Hunter asked if HCSMs pre-screen applications with physicals to make sure they do not smoke or drink. Mr. Guarino replied no – it is self-attestation, however, you have to get your pastor to sign off saying that you do not live your life under those bad

lifestyles. Asw. Hunter asked if HCSMs cover mental health and substance abuse. Mr. Guarino stated that most do not.

Rep. Carbaugh stated that he believes this topic is worthy of discussion by this Committee with an eye towards possibly developing some type of model legislation. Rep. Carbaugh stated that the pre-existing condition exclusion are fine for someone like himself but not ok for a baby with a hole in its heart and he does not believe everyone understands that. Cong. Weldon stated that most HCSMs will pay those claims and noted the story referenced earlier by Rep. Carbaugh – if you sign up for sharing and you are already pregnant then the product of that pregnancy is not allowable to be shared on but if you join and then you get pregnant and that baby is born with a hole in its heart, most HCSMs will pay that bill. Cong. Weldon stated that one HCSM uses a 300 day rule so if your wife gives birth less than 300 days after you signed on then the product of the pregnancy is not shareable. That is to protect people who pay in every month from those people who wait until their wife gets pregnant and then joins a HCSM. Cong. Weldon stated that when he was on the board of Medi-Share he would be shocked at some of the share amounts, particularly for newborns with health problems and bills for $700,000 to $900,000 were frequently settled almost every few months.

Rep. Carbaugh thanked Cong. Weldon as he did not know of that 300 day rule and noted that to be fair, he has had people tell him that they have had large sums shared in HCSMs. Rep. Carbaugh stated that he does not believe HCSMs are bad and does not want to stifle innovation but does think overall disclosures, including already required audits, and registrations are a good thing. Rep. Carbaugh stated that he looks forward to working with everyone on this.

DISCUSSION ON DEVELOPMENT OF SHORT TERM LIMITED DURATION INSURANCE MODEL LAW

Rep. Carbaugh stated that the draft NCOIL Short Term Limited Duration Insurance (STLDI) Model Law (Model) is basically the bill that he authored and passed in Indiana. Before their session started in January, the federal gov't released guidance saying states could expand their short term health options and Rep. Carbaugh stated that that is a small piece of innovation healthcare that all states should look at. As the Exchange programs become more unaffordable, this could be a potential alternative and really it is something that can help people. Rep. Carbaugh stated that he has clients where one spouse is Medicare age and the other is in that two to three year time window where they have to keep working because the spouse at 65 is the insurance holder.

STLDI could fill the window in that example and could fill the window of a small business person not wanting to spend a ton of money on healthcare and instead put as much money as they can back into their business. STLDI can help college students as well and obviously those in between jobs or in jobs without benefits. The Model extends STLDI plan to the greater of 36 months or the maximum period permitted under federal law. The idea is that at the time of application you would declare how long you want the contract to last – anywhere from one month to three years and the underwriting would be done upfront because technically STLDI must be 364 days so it will renew but it will renew without further underwriting requirements if you declared a longer term than that.

Once that declared term is up, then you would have a new contract and you would have underwriting requirements. Rep. Carbaugh stated that his Ranking Minority Member

came up with the idea for disclosures about STLDI not covering the ten essential benefits of the ACA as it is important that consumers know what they are buying and what they are not buying. There has been a suggestion from Blue Cross Blue Shield (BCBS) to specifically list those benefits and Rep. Carbaugh stated that may not be a bad idea.

The Model requires the plans to require at least $2,000,000 in annual benefit which is a departure from current practice but it is important that if the plans are being bought for a longer period of time that there be a substantial sum there as we see healthcare costs continuing to rise. The Model also requires four benefits to be covered and when you think about STLDI traditionally, those four benefits are what you think about: ambulatory patient services; hospitalization; emergency services; and laboratory services. That does not preclude a company from offering more services and Rep. Carbaugh encouraged companies to do that and advertise and create a market for that but the more we make these look like ACA plans in terms of mandates, the more we take away some of the advantages that come along with them.

Mr. Parker stated that HHS promulgated a rule last year to make short term plans more viable as an alternative for individuals who, until 2016, could have used these policies in a much broader way but the last Administration as one of their final acts implemented a rule that significant restricted individual's ability to purchase these plans. You can now use these plans as a coverage vehicle for up to three years – that time duration was chosen because it is generally consistent with the amount of time available to an individual who might otherwise be on COBRA. Mr. Parker stated that one thing that HHS felt was particularly important was, because these plans are not ACA compliant and therefore not required to cover the ten essential benefits, that the notification and disclosure provisions be very strong. HHS believes that there is a need in the market for these plans - for people who have a need for short term coverage whether they be in between jobs or a student just coming into the workforce or for other reasons, these can be an attractive and more affordable alternative for someone who might otherwise go into an ACA compliant plan.

Mr. Parker stated that the unfortunate reality is that for some individuals who earn too much to qualify for premium assistance and who might otherwise choose to go without coverage entirely, the premium price point for these policies often convinces that perspective buyer to come in to the market with at least some measure of coverage whereas they would have no coverage if they could only choose from an a ACA compliant policy.

Jan Dubauskas, VP, Senior Counsel at Health Insurance Innovations (HII), stated that HII is a technology platform that resides between the carrier and broker or consumer and connects them. HII carries products on its platform. HII works with consumer directly and it has a online consumer website which is agilehealthinsurane.com and HII also has a free site which is healthpocket.com which offers medical and health information to consumers as a resource. HII conducted a survey aiming to find out how people were using STLDI because one of the big concerns was that it was being used instead of ACA plans. However, the survey showed that overwhelmingly people are using STLDI between jobs of if their employer does not offer a major medical plan. There are some people that choose STLDI instead of an ACA plan, along with people who are coming off a STLDI plan and buying another one, along with people who were uninsured and would prefer to have some coverage.

Ms. Dubauskas stated that there are many benefits to developing a STLDI Model Law. One of the things that is important is that consumers understand what they are buying and when every state has different disclosures and offerings then it becomes burdensome to figure out what to tell consumers, but when there is standardization we can improve efficiency and disclosures. Ms. Dubauskas noted that she was speaking to the NAIC about this last year and the CA insurance commissioner stated that he would like HII's brochure to be on its website. Ms. Dubauskas stated that is great but if the CA brochure is posted, she has to be careful about posting other state's brochures and a consumers in different states looking at the wrong brochure. Standardization can improve the communication to consumers and also improve efficiency across the states. Today the departments of insurance have approximately eight to ten carriers in each state that sell STLDI so standardization can help them review and approve flings and work with carriers if there are any issues. Brokers and TPAs would love to see standardization for many reasons and HII is very encouraged by this NCOIL Model.

Ms. Dubauskas stated that the typical STLDI policy today has a maximum limitation range of $500,000 to $1,000,000 which helps bring the cost down which is a big reason why people buy these policies. HII engage its actuarial team which stated that the price difference depending on the product could be 3% to 14% if we limit up to $2,000,000. Accordingly, it is worth considering with the Model that the $2,000,000 limit has an impact and may discourage some from buying the policy. Also, if you look at the claims there really are very few people who even get to the $1,000,000 amount. Ms. Dubauskas also noted that today we have a simplified underwriting process which is typically accept/reject. There are questions about heart conditions and hypertension and things like that. Then the rating will be based on age, gender and zip code. As STLDI progresses and companies become more innovative you may see it go to tiered underwriting. Today with life insurance you have the opportunity for underwriting and it can be guaranteed issue, tier 1 or tier 2 based on medical health. That is not currently happening with STLDI but could happen in the future so you could have even improved pricing for your very healthy and for those who may have otherwise been rejected maybe they have a guaranteed issue policy and it is all on the same application. That would be innovative and easy for the consumer – you answer these questions and this is what you get. Accordingly, the underwriting should leave room for that type of innovation in the community.

Jeff Smedsrud, President of Pivot Health, stated that he has been in the health insurance business almost 40 years, first setting up risk pool for those denied coverage for medical reasons. For the last 30 years he has run several companies including short term insurance companies. Mr. Smedsrud stated that it is important to dispel the myth that has become so prevalent that some think its true: short term insurance is junk insurance. As a cancer survivor who has been covered by STLDI, that is far from the truth. There are a number of niches for STLDI and the market at any time is about 1 million 1.25 million people – not as large as many people think and also not as small. Some myths about STLDI include that it is hard to get but the reality is that nearly nine out of 10 people that apply are accepted for coverage. A second myth is that STLDI tends to rescind coverage and deny claims after the fact but in the last year Pivot Health had just over 70,000 claims and just under 50 times in which there was material misrepresentation resulting in a rescission of coverage – that happens in every part of the insurance industry. There is also a myth that there are more complaints about STLDI but if you look at the NAIC's record of complaints you will find the opposite to be

true – there are more complaints about other types of insurance. That being said, one complaint is one too many and everyone needs to work together to improve the market. Lastly, another myth is that only young people buy STLDI. However, experience has shown that the fastest growing part of the market is the 60-65 age group which should not be surprising because the fastest growing segment in the self employed market and the fastest growing segment of those paying for their own insurance are those aged 60-65.

Mr. Smedsrud stated that markets are imperfect and noted some things that could be included in a STLDI Model law. Right now some states allow a five year look back to see whether or not a person had a medical condition that might disqualify them from coverage. Frankly, that has been a standard for a very long time and is not necessary to look back five years and would be more friendly to consumers to look back one or two years – more companies are starting to voluntarily do that. It is also important to have good disclosures but it should also be recognized that the way people buy insurance these days is on their phone and the display of information is equally important to the disclosure of that information because you have to display the relevant points very large and very simply. Mr. Smedsrud agreed with Ms. Dubauskas that a $2,000,000 limit may have the unanticipated result of increasing costs and an industry that likes to keep costs down will probably move to $20,000 deductibles to go along with that $2,000,000 and when you have that high of a deductible you are suddenly outside of the savings of 67% of the people who buy health insurance. Mr. Smedsrud also encouraged standardization because if we do not promote coverage in rural states you are going to have very few in the individual market and that is a discrimination against rural states that should not be allowed to stand.

Mr. Smedsrud then discussed the story of one of his clients: a 60 year old single Dad with 17 and 18 year old sons who was struggling to pay for health insurance. He looked at STLDI and at ACA plans for this two children. He bought a STLDI plan and three weeks later this 17 year old child was diagnosed with Leukemia. Pivot Health paid $700,000 in benefits. Accordingly, this is not junk insurance but priceless as he was allowed to make a decision that fit him.

Michelle Lilienfeld, Sr. Attorney at the National Health Law Program (NHLP), stated that NHLP is a national public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. STLDI plans were originally intended to fill short gaps when people transitioned between coverage but a 2018 federal rule changed the definition of STLDI and as a result, the plans which were limited to a three month contract can now be sold as a replacement for year-round comprehensive coverage. However, STLDI plans are not subject to the consumer protections of the ACA and can exclude people with pre-existing conditions. Therefore, the premiums for such plans can be significantly lower and draw healthy individuals away from the individual and small group markets leaving a costlier group behind and increasing premiums for traditional comprehensive health coverage.

Also, depending on how STLDI plans are marketed and sold they can be risky for consumers who buy them mistakenly believing that they are as comprehensive as traditional ACA plans and can expose consumers to financial liability if they have an unexpected medical event. States maintain primary authority to regulate STLDI so states do have the authority to set strong standards to protect consumers. Ms. Lilienfeld stated that among the ACA's coverage protections are guaranteed issue and community

rating but STLDI plans do not have to apply that and can deny coverage to any applicant for any reasons including current or past health status or risk of future health expenses. STLDI plans can also issue policies that exclude coverage for pre-existing conditions and can rescind coverage through post-claim underwriting and can charge a higher premium based on a persons' health status or a person's personal characteristics such as gender and age. In terms of rescission, if that were to occur, generally that is not going to be considered as qualifying for a special enrollment period to enroll in an ACA compliant plan so that individual would have to wait until the next open enrollment and potentially exposed to a gap in coverage.

The ACA contains several consumer protections related to benefits. STLDI plans do not have to cover the ACA's essential health benefits which are a core set of basic services. A 2018 Kaiser study found significant gaps in STLDI plans with 43% of them not covering mental health services, 62% not covering substance abuse disorder treatment, 71% not covering outpatient prescription drugs, and none covered maternity care. Given the attention and focus on issues such as rising drug prices, the opioid epidemic, and mental health awareness, these are plans that generally do not cover those services and individually who need those services would have to pay for them out of pocket or go without the care they need. Ms. Lilienfeld stated that preventive services are also critical for an effective healthcare system both in terms of health status and cost control, are also not required to be covered by STLDI plans. Such plans also do not have to provide a standardized summary of benefits and coverage which has shown to help consumers understand plan details and directly compare plan options. Research findings have shown that a lack of availability and clarity of plan documents for STLDI plans as being problematic in terms of knowing what is covered by the plan.

Ms. Lilienfeld stated that much of the money that consumers pay for STLDI plans goes towards plan administration, marketing, and profits rather than the enrollee's health care. A report from the NAIC last year showed that the top three companies selling STLDI plans based on premiums earned paid a low percentage of premiums collected from enrollees on actual medial claims. By comparison, the ACA requires individual market insurance plans to pay at least 80% of premiums on medical claims or health quality improvement. In terms of costs, the ACA has protections on annual and lifetime limits in cost sharing but those protections do not apply to STLDI plans which can include a dollar cap on covered services and stop payment on medical bills once that cap is reached. On the other end, STLDI plans do not have to cap an enrollee's out of pocket expenses which can result in high out of pocket costs for people who need care. STLDI plans also typically charge high deductibles and cost sharing for the benefits that are covered.

In terms of consumer understanding, Ms. Lilienfeld stated that a group of NAIC consumer representatives contracted with the Kleimann Communications Group to test consumers on their understanding of marketing brochures for a popular STLDI plan. The goal was to assess whether the consumer could understand the benefits offered by the plan, the limits on the benefits, and the out of pocket costs. Among the findings were that most consumers struggled to understand the STLDI plan's coverage of benefits and limitations, in part because they became accustomed to and now expect their health insurance to reflect the ACA's consumer protections. Another interesting finding was that the federally mandated disclosure went largely unnoticed and was not effective at reducing consumer confusion especially in warning consumers about the limitations of STLDI plans.

Ms. Lilienfeld stated that states have taken action to protect their consumers and insurance markets: 4 states ban the sale of all or most of STLDI; 22 states limit the initial plan duration of an STLDI plan to less than the federal limit of 12 months; 2 states requires coverage of the essential health benefits; 5 states prohibit rescissions; and 11 states have a minimum medical loss ratio requirement. With regard to the NCOIL draft STLDI Model, more robust standards to protect consumers are needed. For example, the Model would allow STLDI plans to last for longer than a short term and as mentioned earlier several stats have set limits at three or six months. The Model's section on renewal and underwriting can be more explicit in specifying that both pre existing condition exclusions and rescissions are prohibited so that once a person is enrolled in a plan they don't have to worry about suddenly losing the coverage or having treatment for a condition excluded from coverage.

Also, as drafted, the Model almost encourages people to stack coverage and buy multiple STLDI policies upfront in order to get the protection against underwriting. In terms of coverage requirements, it is great to require benefits that must be included as there are STLDI plans that do not cover hospitalization but there are still a lot of basic services missing including prescription drugs. Also, for the network adequacy section it is unclear why mental health and substance abuse treatment providers were carved out and excluded from that requirement. If those services are covered by a plan, having an adequate provider network for those services would be critical as well. In terms of disclosures, it is great to have strong consumer disclosures and it may be beneficial to possibly include something that says the disclosure has to be read to potential enrollees by agents and brokers or to require the consumer to sign a statement saying that they have read the disclosure. Ms. Lilienfeld also noted some other provisions that could be included in the Model that stats have implemented such as those relating to limiting stacking and adopting a minimum medical loss ratio.

Cmsr. Mulready stated that states still regulate STLDI plans and CA, MA, VT, RI, NY and NJ have banned STLDI plans so you can see political ideology has a role in this. OK passed STLDI legislation to match up with the federal STLDI regulations. The NAIC recently amended Model Act #170 to add language regarding STLDI plan notification requirements. The NAIC does not have a position on the length of STLDI plans but does require that notification. The NAIC is now working on Model Regulation #171 to establish minimum standards for STLDI plans and Cmsr. Mulready is co-Chair of that Working Group. The NAIC is also developing a data call that will likely take place in August seeking information from which carriers are selling STLDI plans, where and how they are selling them, and what benefits and protections are being provided.

Rep. Carbaugh thanked everyone for their comments and stated that he believes the Model addresses some of the concerns raised. You can go all the way down to a $1,000 deductible for a STLDI plan, maybe even lower. Rep. Carbaugh stated that when he has sold STLDI plans the clients typically choose deductibles much lower than what they can choose on the federal exchange. The Model also contains important and strong disclosures for consumers which is a big concern for Rep. Carbaugh and he would be open to discussing how to strengthen that section – requiring the consumer to sign off on the disclosure is not a bad idea. With regard to the $2,000,000 limit, Rep. Carbaugh stated that he ran a quote while the panel was talking: for a six month plan for a 59 year old female in Wisconsin, a $5,000 deductible, 60/40 coinsurance for another $10,000 out of pocket, a $250,000 max benefit for those six months is $175.20; the

same plan with a $2,000,000 benefit is $188.40. Rep. Carbaugh stated that in his opinion it is malpractice to sell $250,000 for that same period for that little price difference. Rep. Carbaugh stated that he strongly encourages the Model to maintain the $2,000,000 benefit especially as we extend terms – people need to have the coverage in case something happens. With regard to the $700,000 leukemia claim. Rep. Carbaugh does not want to stifle innovation but wants to make sure that the plans do not get a bad reputation. Rep. Carbaugh stated that he looks forward to discussing this further at the NCOL Annual Meeting in December.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations and International Insurance Issues Committee met at The Marriott Newport Beach Hotel on Thursday, July 11, 2019 at 4:30 p.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. George Keiser (ND)
Asm. Andrew Garbarino (NY)
Sen. Bob Hackett (OH)
Rep. Lewis Moore (OK)

Other legislators present were:

Rep. Austin McCollum (AR)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Sen. Shawn Vedaa (ND)
Asw. Ellen Spiegel (NV)
Rep. Wendi Thomas (PA)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Rep. Lewis Moore (OK) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 15, 2019 meeting in Nashville, TN upon a Motion made by Rep. Joe Fischer (KY) and seconded by Asm. Andrew Garbarino (NY).

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL INSURANCE BUSINESS TRANSFER (IBT) MODEL LAW

Rick Newton, CEO of International Solutions Services, LLC, and Luann Petrellis, Insurance Industry Consultant, delivered a joint presentation. Ms. Petrellis stated that she and Mr. Newton began to work together in 2014 and they worked very closely with the Rhode Island Department of Insurance and helped draft the RI IBT legislation. A couple of years after that, Ms. Petrellis worked very closely with the Oklahoma Insurance Department in drafting the OK IBT law. Ms. Petrellis stated that both the RI and OK IBT laws are based off of the Part VII Transfer which is legislation enacted in the U.K. in 2000 and since then there have been hundreds of successful transactions that have been completed. The Part VII Transfer is a proven business model. The existing NCOIL

IBT model law is based on the OK IBT law which Ms. Petrellis believes is a solid foundation for states to use when considering IBT legislation.

Ms. Petrellis stated that the relevant market for these types of transactions is very large. Based on a PWC survey of the global insurance market, U.S. property & casualty (P&C) runoff or legacy liabilities are estimated to be $335 billion dollars which is almost equal to the rest of the entire world. Almost all companies have some form of runoff or discontinued business on their balance sheets. The life market is even larger and in the May 2018 Moody's Investors Service analysis, it stated that insurers have over $420 billion dollars of annuity, life insurance, long term care and other liabilities publicly designated as legacy or run-off that are targeted for an exit transaction. Those numbers represent third-party transactions and it is important to note that of the hundreds of Part VII Transfers completed, at least half were completed for internal restructuring, not to a third party, for reasons such as corporate simplification or basic corporate restructuring.

Mr. Newton stated that it is important to understand that the market is massive. The $420 billion referenced by Ms. Petrellis was for third-party transactions and there is probably an even bigger number as to what companies can do to restructure. There have been massive restructurings such as MetLife and AIG and these situations will continue to come up more and more in the future. The legislation being considered by the committee would facilitate those restructurings. They are going to happen either way and at the end of the day they are recognitions from the companies that something needs to be done to stay competitive. It is very important for the insurance industry to continue to thrive and be competitive on a global basis.

Ms. Petrellis stated that she believes one of the reasons why the U.S. legacy liability market is so large is because there has not been an effective restructuring tool like an IBT as there is in most advanced countries. Companies hold these liabilities for discontinued business and they are looking for effective options to achieve finality, and operating and capital efficiencies. The options that exist currently and are most frequently utilized by companies to restructure or gain finality have been sale, reinsurance, loss portfolio transfers (LPTs), or assumption reinsurance. However, each of those options is limited in scope and effect and most importantly, they don't provide the level of finality that the company is looking for. A reinsurance transaction will give a company economic relief but no legal finality – it is still on their books and they still have the credit risk of the company that is reinsuring them. It is also a long term relationship that can be very costly for companies. Mr. Newton stated that over the course of time everything adds up as every quarter you send out statements and you reinsured your block of business 20 years ago but you are getting no benefit today. But because reinsurance does not bring financial or legal finality to the relationship, it is time consuming and resource consuming. Because the IBT can bring finality, it is a much more efficient vehicle to help restructurings.

Ms. Petrellis stated that the key in the marketplace is capital optimization as holding onto legacy liabilities is costly and inefficient. There are companies like Berkshire Hathaway and investment groups like Apollo that have capital to take on legacy liabilities perhaps more efficiently and give a better claims experience to the claimant. Ms. Petrellis stated that in many jurisdictions worldwide there are IBTs and as a tool to restructure business operations it is very effective. There are multiple layers of review so you have regulatory review as well as court supervision and you have an independent expert that is going to focus on security to policyholders. The independent expert's duty is to the court and to

the regulator and it is important to understand that the independent expert will look at all policyholders, not just the transferring policyholders so you are not going to have a good-bank/bank-bank situation since the non-transferring policyholders cannot be materially adversely impacted as well. Accordingly, the review process is very thorough especially with respect to protecting policyholders.

Mr. Newton stated that the IBT has more safeguards than the Form A and other transactions. It is a well-vetted transaction and it is because of the heightened level of review standards that it has been so successful around the world and will be here as well. The Form A is a great process but the IBT raises the bar even more. Ms. Petrellis stated that major industry groups have recognized the need for restructuring mechanisms. Ms. Petrellis stated that she was pleased to see that at the NCOIL Spring Meeting this past March, New York Life was very favorably commenting on the Part VII Transfer and that can be inferred to an IBT because that is what the IBT is based on. In addition to NCOIL considering an IBT model law, the American Council of Life Insurers (ACLI) has published guidelines for restructuring transactions which is a good first step to provide guidance to the industry for these transactions. Ms. Petrellis stated that the she believes the draft NCOIL IBT model law is a good framework and states need a consistent framework to work from and they need the flexibility to then perhaps pass guidelines and regulations that help them to address the needs of their state.

Ms. Petrellis stated that of the 285 Part VII Transfers completed in the U.K., at least 30% are for life and about half were for internal restructurings that did not involve a third party but rather just for corporate simplification. The same type of mechanism exists throughout Europe. Importantly, this law has stood the test of time as the guidelines and regulations have evolved over time and U.K. regulators have put out guidelines for the industry that are appropriate for their needs. What's important is that the regulators have the flexibility to regulate the transactions. Ms. Petrellis stated that this past Monday there was a conference call of the Restructuring Mechanisms Working Group that the National Association of Insurance Commissioners (NAIC) held and her takeaway from it was that regulators feel that they have the tools and experience to handle these types of transactions but they do want the flexibility to address the needs of their domestics.

Ms. Petrellis stated that it is important to understand why IBTs are important to states. IBTs can be a driver for economic expansion but it is also important to understand that it is not just a matter of expanding a state's market but also a matter of defending said market because if other states have IBT legislation they could be moving business outside of your state through re-domiciling and re-domestication. A good analogy is that IBT legislation is similar to what happened with captives. Vermont was first to market and they dominate it. Accordingly, being first to market is important.

Ms. Petrellis then discussed how an IBT works. You evaluate your options as to what is best for your company – is it reinsurance, an IBT, or something else? Then you move forward with submitting your IBT plan, getting regulatory approval, getting an independent expert report, and then getting court approval. Because this is a nonconsensual situation for policyholders, there are checks and balances that are designed to protect them which include: notice to all stakeholders, including policyholders; extensive financial disclosure; regulatory review; court review; and importantly, an independent expert report that does focus on security to policyholders.

Ms. Petrellis stated that many companies have runoff that is embedded in live business and there is no tool to extract it to separate it out for separate management or position it for sale. The IBT allows a company to segregate out, perhaps live, runoff, or different lines of business so they can be positioned or managed separately. The IBT can also allow a company to consolidate separately regulated entities to achieve operational or capital efficiencies. The IBT can also be used to transfer between third parties, either to obtain or sell business and it is more flexible than a sale because it does not involve an entire company but rather just focuses on a book of business. Ms. Petrellis stated that the key benefits of the IBT are finality for companies and having the opportunity to restructure their business so it is more efficient and able to provide a better claims experience for claimants because as legacy and runoff business gets older and older it is not the focus of management since they focus on core business. A runoff company that focuses on that can give the claimant a better experience.

Karen Melchert, Regional VP of State Relations at ACLI, stated that ACLI has recently finalized its principles and guidelines (principles) on IBT and corporate division legislation. Ms. Melchert noted that ACLI also recently submitted a marked-up version of the NCOIL draft IBT model law which reflects how ACLI believes its principles fit into said model. Ensuring that the regulatory review process is robust is the most important thing to ACLI. Accordingly, ACLI spent most of its energy on the proposed amendments to the model's regulatory review process section - Section 6. Ms. Melchert stated that ACLI went back and forth on whether or not their principles regarding the regulatory review process should be in the statute and it was decided that they should be included so that it is clear what must be considered by the regulator when reviewing these transactions.

Reviewing the financial condition of the companies both prior to and following the transfer is most important to ensure it does not result in a good-bank/bad-bank situation. Ms. Melchert noted that the ACLI did not have unanimity in setting forth its principles and therefore, going forward with any introduced IBT legislation, ACLI will oppose any legislation that does not contain its principles and remain neutral on any legislation that does contain its principles. Accordingly, ACLI would appreciate its principles being included in the NCOIL IBT model and would stay neutral if so. Ms. Melchert stated that ACLI looks forward to continuing work on these issues as it does believe these are important tools for companies to have and they need to be examined very carefully before being approved in order to determine what impact they could have.

Kevin Griffith, Partner at Faegre Baker Daniels, LLP and Counsel to the National Organization of Life & Health Insurance Guaranty Associations (NOLGHA), stated that when talking about doing a transaction under the laws of one state that impact the insurance consumers, NOLGHA wants to make sure there is an appropriate dialogue and assurance that consumers in the other states that are impacted by the transaction are not inadvertently burdened or inadvertently lose a critical piece of consumer protection that the guaranty system provides. Accordingly, the best way to do that is to explain how the system works, what it takes to be covered, and what it takes for consumers to remain covered. The reality is that if one of these transactions is completed, we won't know for 20 to 30 years whether or not it was successful and will not know whether the assuming carrier will actually be alive or ultimately have financial trouble and have to be liquidated. NOLGHA neither endorses nor opposes any IBT or corporate division proposal and just wants to make sure that consumers maintain the critical protections that they currently have.

Mr. Griffith stated that on the life and health side there are certain criteria that must be met for a consumer to be protected when their insurer becomes insolvent and is placed into liquidation. First, each person must be a resident in their state at the date of an order of liquidation finding insolvency. That is a threshold requirement so one person is going to be covered by one state's guaranty association and that will be driven by where that person resides when the insurer that issued the policy becomes insolvent and is placed into liquidation. Second, the product itself must be a covered policy under the laws of the state where that individual resides because it is that state's guaranty association that is providing protection. There are some products that are not covered and medical stop-loss is one that in many states is not covered. Most forms of individual life, annuity, health, long term care (LTC) are going to be covered in all of the states on the life and annuity side.

Third, the insolvent company must be a member-insurer of the guaranty association or must have been a member-insurer of the guaranty association. That is a fancy way of saying that the company has to be licensed in the guaranty association's state where the consumer resides. Mr. Griffith stated that starts to give NOLGHA some pause to make sure that those things are considered because if there is an IBT where the transferor was licensed in all states but the assuming company is not similarly licensed when they take over the business then you have destroyed one of the fundamental elements that is necessary to ensure the consumers in those states remain protected by the guaranty system. If that third criteria is not met, all states today – with New York being the last state to adopt it following the Executive Life Insurance Company of New York liquidation – have "orphan" coverage which means coverage falls back to the state of domicile of the insurance company.

Mr. Griffith stated that the orphan coverage is designed to be a stop gap to make sure there is not some type of disconnect which would allow a consumer to fall through the policyholder safety net. It rolls back to if the insurance company that becomes insolvent is not licensed in a policyholder's state, then the guaranty association in the jurisdiction where the receivership is going on where the insurance company was formed will pick up coverage for those individuals. This is never intended to be a nationwide coverage mechanism. In fact, when the guaranty association coverage statutes were first adopted by the NAIC in the early 1970s, the first guaranty association statutes did exactly that – the guaranty association of the state of domicile of the insurance company provided nationwide coverage for all of that insurance company's policyholders if that insurance company became insolvent. It took a couple of large insurance company failures to demonstrate that that is not a good way to spread the cost and it places a significant burden on a disproportionate number of insurance companies in one state if you are providing 50 state coverage. The NAIC quickly moved away from that model and today it is the state-based residency of the policyholder and NOLGHA wants to make sure that if OK has an IBT, the other state laws are not going to result in a loss of coverage or visiting an inappropriate amount of liability and risk back on a state should that company subsequently fail and cause a difficult failure to be shouldered by the industry.

Mr. Griffith then discussed an IBT/corporate division hypothetical that represents what NOLGHA is seeking to avoid. If the successor company - the transferee - was licensed only in OK and the business that was transferred to it was nationwide the problem is that it would not be a member-insurer of any guaranty association other than OK's. So if that company were ever to fail, then OK would be picking up the nationwide liability whereas the day before the transfer it would have been spread across the states and there would

have been a wider base of assessment capacity. It is also a problem in that if the company that takes on the business, particularly in the life and LTC space, is not a member insurer in each of the states then those states will lose assessment capacity because they will not be able to assess an insurer that is not a member insurer for other failures. Accordingly, both sides of the balance sheet are in play here: the consumer protection of the assuming company, should it ultimately fail; and in the interim if there are other companies that fail it is important to ensure that the premium and assessment base - and when taking about life insurance and annuities and LTC we are talking about ongoing premiums that will continue for decades after the IBT – remains intact and part of that state's assessment base to be able to protect consumers for other insolvencies.

Mr. Griffith stated that the guaranty associations perform an incredibly important and critical consumer protection role in society. NOLGHA is neither supporting or endorsing IBT and/or corporate division legislation but would ask that people be very thoughtful with regard to what amendments might need to be made not just in the state that adopts an IBT statute that permits the transfer to occur, but in all the other states to ensure the consumer protections remain intact.

Roger Schmelzer, President & CEO of the National Conference of Insurance Guaranty Funds (NCIGF), stated that NCIGF represents the P&C guaranty funds and that said funds are the last stop in the risk-sharing chain on which the entire business of insurance is built. Mr. Schmelzer stated that the public policy goal that everyone probably holds is that guaranty fund coverage cannot be disrupted by any IBT/corporate division transaction. We won't know for many years after such a transaction is consummated whether it worked or not and we don't know what works or not right now. That is not a reason not to try but we do not have the answers to those questions right now. Mr. Schmelzer stated that all language in an IBT/corporate division statute should reflect that coverage should not be disrupted and it should not be inconsistent with that. The whole point is that we have a lot of people right now who by matter of public policy are already covered by the guaranty funds if indeed their insurance company were to fail and you do not want to take that coverage away. Nor do you want to cover new people who have not been covered previously. IBT/corporate division transactions should not have the effect of undoing or providing new coverage.

The emphasis is on the priority of the guaranty fund coverage and NCIGF's objective is to serve as a resource to public policymakers as they make decisions. Mr. Schmelzer stated that whatever the solutions are must respond to challenges that are fully identified and fully defined. P&C guaranty funds are funded through assessments but that is not the first place the money comes from however when an insurance company fails – it comes from the failed company itself as the assets are usually very substantial. In some states there are deposits that are statutory for a company to write a line of business in that state. The last place is assessments to go to the live market to bring in money there in order to pay policyholders. P&C guaranty funds probably recover 60%-70% from the failed company and the rest is made up from those other sources. A P&C guaranty fund more or less adjusts and pays claims just like an insurance company would. Mr. Schmelzer noted that it is important to know that P&C guaranty funds protect people, not companies. Also, a key difference between P&C and life and health guaranty funds is that life and health has orphan statutes while P&C does not which means in extremely rare and fact sensitive occasions you could have a situation where there is no guaranty fund coverage available. That is something that the P&C guaranty funds have been working on for years in trying to fix as even one orphan claim is not good.

Mr. Schmelzer stated that NCIGF has flagged two critical issues relating to guaranty fund coverage and IBT/corporate division transactions. The policy has to be issued by the same insurance company that becomes insolvent – that is the way the statute reads today. Since we won't know for some time whether the restructuring will work or not it is hard to know exactly what you would have if indeed there was a failure, which is not to say there will be. The insurer also must be licensed, but they may not be licensed when the policy is issued and may not have been licensed when the injury occurred. Those are timing issues but need to be taken into account when looking at restructuring legislation.

Mr. Schmelzer stated that NCIGF does not have the answer to all of these questions and issues but they are working very hard and the process is ongoing. Above all, NCIGF wants to make sure that the guaranty fund coverage that is in place remains in place and that new guaranty coverage not be generated by a potential failure by a restructured company. These are matters of public policy that NCIGF looks forward to updating NCOIL on as its work in examining the issues progresses.

In response to Mr. Schmelzer's comment that the guaranty association is funded by assessments, Ms. Melchert noted that he did not follow up with who specifically is assessed and that is the remaining solvent insurers have to pay for that 30% that is not recovered from the entity that has gone insolvent. That is why that is a huge issue for insurers because they are left holding the bag if a restructured company goes insolvent and it is important to note that there should be no need for a "bag holder" if there are enough protections built into the review process so that it is highly unlikely, as you can never guarantee, that an insolvency will not occur. All measures need to be taken to prevent that from happening.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that he has had the experience of surrounding these issues as when they first came out in RI and Vermont, APCIA's predecessor organizations were opposed to them but they have now come full circle and are not opposed to these types of transactions. APCIA believes that these types of transactions do serve a place in the market as there is a tremendous amount of value locked away in some of these underperforming or nonperforming books of business that can be freed in these types of innovative transactions. The transactions are innovative only in the sense that the U.S. did not invent them as they are based on the U.K.'s Part VII Transfer and they have been used in the European Union for a long period of time. Having said that, the transactions are very complicated and sophisticated that have their own unique set of regulatory and statutory terms such as a novation.

Mr. O'Brien stated that when looking at these issues public policymakers need to move very carefully and methodically so that there can be put in place the type of financial and consumer protections which will provide a certain measure of certainty as well as a certain measure of reputational risk protection for the insurance industry. One of the worst things that you can do when you are running an insurance company is to have it go insolvent. Nobody wants a restructuring transaction to go bad and in order to do that you must have very robust, transparent, and rigorous reviews in consumer protection. The debate is beginning to center on what constitutes that level of review.

Mr. O'Brien stated that RI has had a lot of experience with these particular types of transactions and OK is moving in that direction. As we move forward with these types of

transactions - and we are going to see more - they are going to have to be reviewed almost with a jaundiced eye. That means that as NCOIL moves forward with its draft IBT model that is based off of OK's IBT law, NCOIL needs to ask whether the OK IBT law provides the right level of consumer protection. There are some who think that it does while others would like to see additional consumer protections added which merits debate. APCIA will be part of that debate as it has a number of members who would like to take advantage of these types of transactions as well as members who participate in them.

Mr. O'Brien stated that these issues will be present for a number of years and if conducted properly, the restructuring mechanism will free up a lot of entities with a lot of capital that can be put to more efficient uses and provide a solution to a number of other vexing problems in other areas of the insurance industry but it needs to done carefully and methodically.

Dennis Burke, VP of State Relations at the Reinsurance Association of America (RAA), stated that with exception of maybe the two guaranty association representative on the panel, no one has mentioned the best interests or the expectations of consumers when they enter into an insurance transaction. That is the role of legislators and regulators – to defend consumer's expectations. Mr. Burke stated that reinsurers have interest in these types of transactions that are largely trampled in the NCOIL draft IBT model law. Because these types of transactions traditionally prejudice the rights of reinsurers RAA has opposed them. The RAA, like everyone else, is evolving in its evaluation of these transactions and would like to work with NCOIL to see if there is a way to move forward on the model. There is an independent evaluation and fairness opinion that is involved in the OK IBT law and RAA would like to see that expanded to include an evaluation of whether or not the transaction is fair or prejudicial to reinsurers' interests amongst all of the other interested parties involved in the transaction.

Mr. Burke stated that part of what these transactions do is circumvent the will of state legislatures who have said that there should be consumer consent for these transactions. That clearly interferes with the ease of changing or entering the transaction from an insurer perspective and that is recognized, but that is something that needs to be considered – should a body like NCOIL be actively supporting a provision that arguably circumvents if not tramples on the will of another state.

Mr. Burke stated that with regard to the orphan issue with guaranty funds, one of the questions about that is how are claims actually handled? So if you wind up with, for example, the transferee company being licensed in one state but it has 50 state obligations, handling claims is the business of insurance and if they are not licensed in the other 49 states how do the handle that? Surplus lines is an analogy but those people are eligible to write surplus lines in advance. So you could have a company thrown into a 50 state claims handling obligation yet it is unlicensed and arguably not permitted to handle claims. Mr. Burke stated that is an issue that, to him, no one has explained well – the best explanation being that there is thought to be a provision out there that will permit it and they can use independent adjusters, but that is not fully settled. Mr. Burke urged NCOIL to explore that issue.

The Honorably Glen Mulready, Commissioner of the Oklahoma Department of Insurance, noted that he was the House author of the OK IBT law during his time as a legislator, and stated that the overriding factor throughout this process is to ensure that

policyholders are not materially adversely impacted. While this is in effect plowing new ground in the U.S., over 200 of these transactions have taken place over the past 20 years with no failures in the U.K. Cmsr. Mulready stated that when talking about the independent expert, both of those words are very important as the person must be truly independent and be an expert, and it is vital to the review process. With regard to the licensing scenarios discussed, Cmsr. Mulready stated that they are accurate but noted that he believes they would not occur as you would be materially adversely impacting those policyholders and would therefore be kicked out during the review process.

Cmsr. Mulready stated that the whole idea of these transactions is to provide a tool that is needed. When talking to national and multi-national companies, they stress that these transactions are a tool to reactivate capital into the marketplace into areas that they want to grow and that they want to focus on. Cmsr. Mulready stated that he believes ACLI's principles are excellent but they do not belong in statute and should serve as a guiding principles document which was what was done in the U.K. so that regulators are not backed into a corner. Cmsr. Mulready also noted that the NAIC has a Restructuring Working Group that is currently researching these issues.

Asm. Andrew Garbarino (NY) stated that it sounds like there is general agreement that IBTs can be valuable as long as they are done properly with the right level of consumer protections. Asm. Garbarino stated that consumer protection is something that the Committee needs to consider and that a lot of great points were made by the panel today. Asm. Garbarino stated that perhaps the Committee should have an interim conference call meeting before the NCOIL Annual Meeting in December to determine if the ACLI's and any other proposed amendments should be included in the NCOIL IBT Model Law. Rep. Lewis Moore (OK) agreed with Asm. Garbarino and thanked everyone for the valuable information.

Rep. George Keiser (ND) stated that the guaranty funds are really not paid for by assessments – they are paid by premium increases and that should be recognized. In the case of LTC, that was paid by the states because they were given a credit on the premium tax so that is coming right back to the consumer. Rep. Keiser asked why courts should be involved in these transactions and what does the court bring that the regulator would not provide? Rep. Keiser stated that court involvement implies that the consumer is being harmed. Ms. Melchert stated that in ACLI's principles for the corporate division process they do not require court approval but do require it for the IBT process because you are doing a novation of a contract without the consideration or approval by the policyholder. Rep. Keiser asked why the regulator cannot do that instead of the court. Ms. Melchert replied because it is a legal novation and regulators do not have the authority to do that. Ms. Melchert also noted that it is a form of protecting the transaction so that it cannot be challenged down the road. If a policyholder believes that this was done without their consent and there was no approval of it by a court of law they could challenge it and undo the whole transaction. The process is different in a corporate division transaction.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that it is interesting that the entire concept of novation is based on consent. When done at scale, which is what we are talking about when discussing these transactions, it is very complicated. Guaranty funds are there to protect people and it is therefore important to keep an eye on that when discussing these issues. The rating statutes are the first line of defense for a policyholder's expectancy and the last of line of defense is access to a guaranty fund.

Asm. Cooley noted again that it is interesting that this process calls for a novation but it is not actually predicated on consent but rather something that the court is going to do and therefore outside the typical use of novation.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL MARKET CONDUCT SURVEILLANCE MODEL LAW

Paul Martin, Regional VP – Southwestern Region at the National Association of Mutual Insurance Companies (NAMIC), discussed the proposed amendments submitted by NAMIC on the NCOIL Market Conduct Surveillance Model Law (Model). The goal is to create a substantive and robust analysis and to assure all parties that the least intrusive and most cost-effective way is used to do that. There are a number of amendments that NAMIC is suggesting including incorporating a demonstrated material risk standard as opposed to a potential risk or a significant deviation. The idea is to judge decisions and actions of companies based upon true risk in the marketplace as opposed to just mere technical violations. NAMIC is also suggesting that a corrective action plan provision be placed into the model statute, the idea being that if there are opportunities for companies to work with the regulator to address problems in a proactive fashion, they should be able to do that.

NAMIC is also encouraging through amendments to the Model that companies be encouraged to self-report violations and that when they are doing so, the self-assessments be used in lieu of significant penalties and that they work further with the regulator to sort those out. There have been some ideas and suggestions about excluding multiple de-minimis violations from the definition of pattern or practice in order to get away from technical violations as opposed to substantive violations of statutes and regulations. Mr. Martin stated that NAMIC's proposals also include provisions for regulators concerning time parameters and schedules for regulators as some companies have reported that some market conduct exams go on for multiple years and are very expensive and NAMIC believes there is a way for regulators to at least set some sort of scope so that the company that is going to be examined has an idea of how long it is going to take and how much it is going to cost. Lastly, Mr. Martin stated that to ensure meaningful analysis performed by the regulators, ascertaining any conflicts of interest with the vendor and the department and the industry should be required.

The Honorable Dean Cameron, Director of the Idaho Department of Insurance and NAIC Secretary-Treasurer, thanked NCOIL for being involved several years ago then the NAIC was seeking to improve market conduct surveillance processes. There is always room for improvement and there needs to be an appropriate balance of an efficient market regulation for both the regulator and the company while maintaining an effective consumer protection. Much of what the NAIC has concerns with regarding the proposed amendments to the Model would violate that premise.

Dir. Cameron stated that it would obviously be great if there were no market conduct processes as there would be carriers always paying their claims appropriately and handling everything else appropriately but that is not always the case. Dir. Cameron then discussed three of the NAIC's concerns with the proposed amendments to the Model. One proposed amendment states that "…nothing in this act shall authorize a market conduct examination of the insurer's cybersecurity protection measures which is otherwise provided for in domiciliary state financial examinations consistent with the NAIC's coordinated approach to examinations." Dir. Cameron stated that everyone is in

favor of efficiencies but it is important to think about what could happen under that provision - particularly after the Anthem cybersecurity attack - and what would happen with consumers if they felt like their state Insurance Commissioner was unable to ask the appropriate questions to determine whether or not Anthem was handling that situation appropriately. That is a step too far – state Insurance Commissioners should be able to ask and examine companies to see that their cybersecurity approaches are effective and efficient.

The second concern is that the proposal creates some uncertainty and would create some additional disagreements between regulators and carriers and the industry. The proposal uses references like “material violations of state laws” but “material” is not defined; and “reliable and credible sources” but that term is not defined. Lastly, the proposal ties the hands of the regulator to three months from issuing the warrant which seems to be extremely unfair especially since the carriers have sixty days to respond to many of the allegations so that would make it extremely difficult and the entity that ends up getting hurt in the process is the consumer.

Dir. Cameron then provided an example of when his department received word of a carrier in Idaho disallowing preauthorization of in-patient mental health treatment which is a serious allegation because it is violation of state and federal law. Accordingly, the department started to investigate and the carrier was less than willing to share information and, while not proud of it since the department likes to be “in and out” with market conduct exams, it took over two years and ultimately over 30 consumers were found who were harmed and denied coverage and several thousands of dollars that were denied. Therefore, a limit of 90 days would be extremely detrimental to consumers.

Dir. Cameron stated that the NAIC is certainly open to discussing how the market conduct surveillance process can be improved and would encourage NCOIL, NAMIC and other organizations to come forward with any concerns in order to determine what the underlying problems are.

Rep. Keiser stated that with regard to Dir. Cameron’s statement about how the 90 day timeframe would be unfair, the proposed amendment allows for extensions at the direction of the regulator. Dir. Cameron stated that the NAIC does not believe that the extension language cited by Rep. Keiser is adequate and consumer protection needs to be the overarching goal. If a carrier has committed a promise and is not fulfilling that promise and it is found to be a systemic problem which requires review of records dating back several years a 90 day timeframe is unreasonable.

The Honorable Tom Considine, NCOIL CEO, stated that he understood Dir. Cameron’s statement regarding how “material” can be vague if not defined, but noted that the current version of the Model requires no departure of any regulation or law in order for any action to be taken. Cmsr. Considine asked for Dir. Cameron’s thoughts on that. Dir. Cameron stated that most departments are undermanned and overworked and there is almost an inference in the wording referenced by Cmsr. Considine that somehow the department would be looking at something that is not a violation of law which is not the case. If the department has a complaint or some reason to believe that a company is not appropriately paying claims and it is a systemic problem then that is where the surveillance process is important.

Dir. Cameron stated that he doubts that there have been instances where a market

conduct examination is being done on something that is not a violation of federal or state law. Cmsr. Considine asked if the Model's current phrase "deviate significantly form the norm" should be enough to constitute the basis for an action taken. Dir. Cameron stated that they can certainly take that back and the NAIC is willing to work with NCOIL to ensure an appropriate standard is in place but noted that of the problems the NAIC deals with he is not sure it sees this as something there are a lot of complaints about. If ACLI, NAMIC or other organizations are having concerns with the process the NAIC is certainly willing to talk about it and determine how it can improve its approach.

CONSIDERATION OF AMENDMENTS TO NAIC CREDIT FOR REINSURANCE MODEL LAW AND REGULATION IN CONJUNCTION WITH NCOIL RESOLUTION OF JULY 17, 2016 ENDORSING MODELS

Cmsr. Considine referenced the famous incident of Robin Ventura charging the mound and fighting Nolan Ryan. With reinsurance, this is an example of how if the states do not take action it will be the equivalent of charging at the federal government and saying "go ahead and preempt state law in the area of reinsurance." Accordingly, it is time for states not to be the Robin Ventura to Nolan Ryan. Cmsr. Considine stated that several years ago the NAIC passed its Credit for Reinsurance Model Law and Regulation (Models). There has been a lot of discussions between NCOIL and the NAIC regarding how duplicative model laws are not beneficial so in this area NCOIL made the decision to endorse the NAIC models and not pursue developing its own models even though there was interest in doing so.

NCOIL formally endorsed the NAIC models in a Resolution dated July 17, 2016, sponsored by Rep. Joe Fischer (KY). Because of the Covered Agreements, the states really have to pass amended versions of the NAIC's Models that are consistent with the Covered Agreements or else the states will be preempted. The NAIC has formally amended its Models and therefore NCOIL supports states taking action to amend their respective laws.

Rep. Fischer stated that while he and NCOIL opposed the Covered Agreements as an intrusion by the federal government into the state based system of insurance regulation there is no way to avoid federal preemption in the area of reinsurance if state laws are not amended to conform to the Models which now conform to the Covered Agreements.

Accordingly, Rep. Fischer made a Motion to adopt his "Resolution in Continued Support of the NAIC Credit for Reinsurance Model Law and Regulation." Sen. Bob Hackett (OH) seconded the Motion. The Committee then voted without objection to adopt the Resolution by way of a voice vote.

ADJOURNMENT

There being no further business, the Committee adjourned at 6:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 13, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Marriott Newport Beach Hotel on Saturday, July 13, 2019 at 8:45 a.m.

Representative Joe Fischer of Kentucky, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Bart Rowland (KY)
Rep. Michael Webber (MI)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asm. Andrew Garbarino (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Tammy Nichols (ID)
Rep. Deanna Frazier (KY)
Sen. Paul Utke (MN)
Asw. Maggie Carlton (NV)
Asw. Ellen Spiegel (NV)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Sen. Jerry Klein (ND) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 16, 2019 meeting in Nashville, TN upon a Motion made by Rep. Matt Lehman (IN), NCOIL Vice President, and seconded by Rep. Martin Carbaugh (IN).

ANNUITIES FOR THE 21ST CENTURY

Ann Farley, AVP Innovation Management – Retirement Solutions, at Pacific Life Insurance Company stated that consumer use of technology is growing at an exponential rate and it is hard to go anywhere and not see people using their smartphone. Businesses are starting to change how they operate as a result of that. Pacific Life began a journey to explore the digital world and in 2016, Pacific Life's innovation team began looking at how rapidly changing technology might impact retirement planning.

Ms. Farley stated that when you look at financial services broadly, you are seeing how segments of the industry have gone through digital transformations. Banking and

property & casualty insurance are examples of such transformations. In the life insurance industry specifically, there are some product lines that have been making that transition as well. Further, for financial services digital transformation has really created an ecosystem. Consumers have a range of financial services that they can access digitally from information and education to savings, investments, banking, lending refinancing, early insurance needs and robo-type advice. Ms. Farley stated that Pacific Life saw that as an opportunity to look at its entire value chain and re-evaluate what digital transformation could mean for the company and for how products are developed, distributed, serviced, as well as for its existing technologies and procedures surrounding it. Additionally, it was important to re-evaluate how digital transformation would change how the company interacts with consumers. That is a key component for Pacific Life as it does not believe the digital world will fully replace financial professionals. Above all, Pacific Life knew it had to conduct research to provide answers to evaluate the aforementioned issues in order to better understand the digital world.

Ms. Farley stated that Pacific Life conducted qualitative research by talking with financial professionals and consumers, in addition to talking to financial institutions within the digital ecosystem and other digital companies outside the financial services industry. Pacific Life wanted to understand how digital was changing or impacting financial professionals, consumers, and businesses looking for retirement planning. Ms. Farley stated that as a result of synthesizing all of its research and the insights gained, Pacific Life concluded that the best way it would learn the digital world is to build something within it and start to explore it.

Ms. Farley stated that Pacific Life started to explore what digital intermediary partners might make sense for the digital space. Pacific Life spent time thinking about product solutions and what they might look like if built for the digital platform; as well as what new product concepts might be explored and what, if anything, would be different about them. Further, Pacific Life started to explore, craft, and test the digital end-to-end experience. For example, how would purchasing and applications be fully digital and what might be different in servicing clients in digital ways? What could we learn about the technology systems we are going to need and how they are structured in order to integrate with other digital partners?

Ms. Farley stated that after about a year of research, Pacific Life identified Blueprint Income as its initial digital distribution partner. Blueprint Income is an online consumer marketplace for fixed and income annuities. Blueprint Income allows customers to compare products, check rates, and purchase products online. Their digital-first mindset made them a perfect partner for Pacific Life to explore integrating into the digital world. Ms. Farley stated that Pacific Life built a deferred income annuity with a lower purchase payment of $100 which is what Pacific Likes to think of as “subscription style” which means that a customer can set up monthly recurring payments for $100 or more. The product was also designed to be flexible so customers could increase that amount, decrease it, stop it, start it again, or add one-time payments if needed.

Ms. Farley stated that digital end-to-end experience was built so that the application and purchase process could be completed on-line. In December, “Next by Pacific Life” (Next) was launched and the main thing to take away from it is that valuable insights will be able to be obtained from being in the digital world which can then be applied across the enterprise to core markets. Ms. Farley stated that the sub-brand Next was created as a way to make a distinct entrance into the digital financial ecosystem but at the same

time stay aligned to the strength and recognition of the Pacific Life brand.

Ms. Farley stated that additional products will be added to the Next platform as Pacific Life wants to support the protection and retirement needs of consumers over the course of their lives. Pacific Life's life division is currently working on a pilot it recently launched on a term-life product that will become part of the Next platform. Ms. Farley stated that the future vision for Next is to further become part of the digital financial ecosystem as Pacific Life believes that future consumers will have the traditional avenues of working with financial professionals like the ones Pacific Life currently partners with in its core businesses as well as more digital avenues to utilize. For Pacific Life that means continuing to support and provide products for its traditional financial service partners and professionals and provide outstanding service for its clients. Next will continue to explore new digital distribution avenues that provide that same support for financial professionals and their clients in the digital space. Pacific Life wants to expand the products that it offers digitally and take its core service strength and master that in the digital world. The long term goal is to, in this changing and increasingly digital world, show up where financial professionals and clients are having their retirement and financial planning conversations and decisions. Whether it is in the traditional or digital financial planning avenues, Pacific Life wants to be there for those moments and support them on their journey.

UPDATE ON FEDERAL RETIREMENT SECURITY LEGISLATION – THE SETTING EVERY COMMUNITY UP FOR RETIREMENT ENHANCEMENT (SECURE) ACT AND THE RETIREMENT ENHANCEMENT AND SAVINGS ACT (RESA)

Elizabeth Kelly, SVP of Operations at United Income, stated that United Income is a new FinTech company that aims to use technology to provide more wholistic and personalized financial planning and investment management targeted at individuals nearing or entering into retirement. United Income strives to help its clients build wealth by minimizing taxes, increase government benefits, generate higher equity premiums and provide more personalized advice through high performance computing. Ms. Kelly stated that before she joined United Income she spent three years as Special Assistant to the President at the White House National Economic Council where she oversaw retirement and pension policy.

Ms. Kelly stated that she worked on the SECURE Act in 2016 and is just now is finally moving through Congress. On May 23, 2019 the U.S. House of Representatives passed the SECURE Act with an overwhelming bi-partisan majority of 417-3. The SECURE Act mirrors RESA which had passed the Senate Finance Committee in December of 2016 and was reintroduced this year by Senators Grassley and Wyden, the Chair and Ranking Member of the Senate Finance Committee. If passed, the SECURE Act would be the most significant legislative change to defined contribution plans since 2006 when the Pension Protection Act made it easier for companies to automatically enroll their workers in 401(k) plans. With that context, Ms. Kelly stated that her remarks would focus on providing an overview of the SECURE Act, including areas where there may be some pushback or disagreement, the legislative prospects for the bill, and a quick overview of other legislation out there that intersects with the SECURE Act.

Ms. Kelly stated that problem the SECURE Act is trying to solve is that older adults are living longer – a trend that will continue. By 2040, someone who makes it to age 60 will be expected to live, on average, another 28 years. Yet American men are still retiring

around the same age of 64. While Americans will need more money - about 49% more than 20 years ago – the personal savings rate has fallen to about 6%. The net-net is that American households in many cases are not saving adequately for retirement and about half of retirement-age households will rely almost exclusive on Social Security and Medicare to pay for their retirement.

Ms. Kelly stated that the SECURE Act aims to solve or at least help address that problem in three primary vectors. The first is to increase access to workplace retirement savings plans. The second is to reform contribution and withdrawal rules in response to increasing longevity. The third is to increase the take-up of annuity and lifetime income products. The vast majority of the SECURE Act's provisions fall into one of those three vectors.

With regard to efforts to increase access to workplace retirement savings plans, the best way to get people to save is to offer them a workplace savings plan like a 401(k) and to automatically enroll them in that plan. However, approximately 1/3 of private sector workers do not have access to a workplace retirement savings plan. Among companies with fewer than 100 employees, 47% lack said access. The SECURE Act's primary mechanism for increasing access to workplace retirement plans is through the allowance of open multiple employer plans (MEPs). The rational behind open MEPs is that small employers are less likely to offer workplace plans in part because of the higher per-worker cost as well as lack of expertise, administrative overhead, and the need to focus on their core day-to-day business activities. Currently, small employers are not able to band together and create a shared 401(k) plan because current law requires that the employers have a common bond. The SECURE Act would get rid of the common bond requirement and would allow small businesses to band together to create open MEPs. Employers will be able to delegate important fiduciary-like responsibilities such as plan investments to the pooled provider or another fiduciary that would still be required to act prudently and loyally in selecting and monitoring the MEP.

Ms. Kelly stated that it is generally anticipated that open MEPs will really only move the needle in terms of increasing coverage if entities other than employers like asset managers, record keepers, and plan advisors – so-called "pooled plan providers" – will offer ERISA-governed open MEPs and market them to small businesses. There is some concern about the trade-off between greater financial incentives to work to expand coverage, and protecting workers against conflicted investment advice, high fees, and expenses, but Ms. Kelly stated that there has been general bi-partisan agreement that open MEPs are a good way to increase small business offering of plans and getting more workers to save. President Obama proposed open MEP legislation in his FY 2017 budget and the Department of Labor (DOL) is currently working on similar regulations pursuant to President Trump's August Executive Order.

Ms. Kelly stated that there are two other provisions in the SECURE Act that aim to increase access to workplace retirement savings plans, both of which were also in the aforementioned Obama budget. The first is a tax credit for small employers to defray the costs of offering a workplace retirement savings plan with an additional tax credit if they include automatic enrollment. There is also a provision enabling long term part-time workers to contribute to their employer's workplace retirement savings plan. Under the bill, any employee who has worked for at least three years and at least 500 hours a year could participate in a workplace retirement plan if offered by their employer.

Ms. Kelly stated that with regard to changes in the contribution and withdrawal rules, the SECURE At would allow older Americans still in the workforce to continue making tax-deferred contributions to traditional IRAs after age 75 rather than just post-tax contributions to Roth IRAs and brokerages. While that is intended to help older Americans who are still working and respond to increasing longevity, it is a relatively small percentage of the population. About 14% of the population ages 71-80 report being in the labor force according to the latest labor population survey. On the withdrawal front, the legislation would increase the age at which older Americans must start making RMDs from 70.5 to 72 years old. This makes sense given that life expectancy has increased substantially since the 1960s when the 70.5 threshold was put into place. There is bi-partisan agreement that the RMD rules need to change as it was in the Obama budgets and in President Trump's Executive Order.

Ms. Kelly stated that the bill would also raise revenue some $16 billion dollars over the next decade according to the Joint Committee on Taxation by requiring inheritors of 401(k) plans and IRA balances to withdraw the entirety of that balance within 10 years of the account owner's death. That is the so-called "stretch IRA" provision and is popular among tax wonks and policy professionals, many of whom believe that tax-preferred retirement savings should be used for retirement. However, the provision is very unpopular among financial planners and others who have helped families choose the estate planning provision.

Ms. Kelly further stated that there are efforts in the bill to increase annuity take-up. The SECURE Act would protect defined-contribution plan sponsors and other fiduciaries from potential liability under ERISA for their selection of a lifetime income provider for their plan. There has been general agreement that small businesses are not really equipped to assess whether or not an insurance provider has the financial solvency to be able to make payments many years in the future and it does not make sense to allocate that burden to the individual which is what the SECURE Act seeks to take away. However, there has been some pushback on the scope of provision. For instance, it is not limited to the selection of the annuity carrier as it also extends to the selection and negotiation of contract terms like cost that a small business could perhaps take on. Additionally, it covers a broad range of products – not just fixed income annuity contracts but also variable and other types of annuities.

Ms. Kelly noted that there is also a provision regarding disclosure on lifetime income. The SECURE Act would require benefit statements given to 401(k) participants to include a lifetime income disclosure at least once during the 12 month period. The idea is that the plan participant could see what their total account balance would be in terms of a lifetime income stream both for a qualified joint survivor annuity, single life annuity and other different forms.

With regard to the bill's prospects, Ms. Kelly stated that she does not have a crystal ball and even Senator Grassley, the Chair of the Senate Finance Committee, when asked about the timing stated that "I wish I could give it to you." The expectation had been that the SECURE Act, after having passed the House would pass the Senate on unanimous consent but it is actually being held up by Senator Cruz and some other members over a provision allowing 529 accounts to be used for homeschooling, private elementary and high school expenses. That provision was included in earlier versions of the House bill but was removed by Democrats at constituents' requests. Because of the opposition to move forward the SECURE Act without that provision it is unclear if the Senate will be

able to pass the bill on unanimous consent. The second option would be a very short debate and amendment process but it seems unlikely that Leader McConnell would bring it up under those circumstances because of the desire to not open up other issues. The last possibility would be to attach the SECURE Act to another piece of legislation, such as legislation regarding the debt ceiling in September, end of year appropriations and whatever else happens to move through the Senate.

Ms. Kelly stated that if the SECURE Act is part of an end-of-year deal, there are other pieces of retirement legislation on the Hill which might be incorporated. RESA is largely identical to the SECURE Act. Senator Wyden has also pushed the Retirement Parity for Student Loans Act which is also included in a Portman-Cardin bill. Essentially, it would allow employers to make matching contributions to a retirement plan while their employees make student loan repayments. The idea is that millennials are not able to contribute to their retirement plan because they are making student loan payments and should not lose the employer match that older employees are able to benefit from. That is a widely popular provision because when members go home oftentimes they are asked about student loans and healthcare and being able to include something that addresses the student loan problem as part of a broader retirement effort would likely be very popular. Ms. Kelly stated that parts of the Portman-Cardin bill could advance such as increases in the catch-up contribution limit from $6,000 to $10,000 for those over 60 years old, expanding the “saver’s credit” for low income savers, and further changes to the RMD rules as there is debate over whether the SECURE Act’s RMD provisions go far enough. There is some support for raising the RMD age to 75 and even eliminating it for individuals with very low retirement savings balances. Ms. Kelly noted that the Kloubchar-Coons sponsored Savings for the Future Act is unlikely to see any action.

Bruce Ferguson, Sr. VP of State Relations at the American Council of Life Insurers (ACLI), stated that as we sit here today an additional 10,000 Americans will reach the age of 65 and that will happen each and every day between now and 2030. As we think about that retirement population, many of them might expect to live 25 or more years in their retirement years and there are a lot of very important studies which state that individuals are woefully under-saved for retirement. From the policymaking perspective, that has an effect on state budgets and the demand for public services will only increase unless there are some important steps taken at the federal level and in individual states to help individuals plan for their retirement years.

Mr. Ferguson stated that as he looks at the group of legislators present, he sees many small business owners who certainly understand the pressures of meeting payroll and trying to attract and keep talent. In terms of trying to attract and keep talent, retirement planning is something that will be at the forefront of perspective employee’s interests. From a business owner perspective, in addition to meeting that interest, you also have to consider taxes and mandates and when taken together it can be a struggle. Some of the SECURE Act’s key provisions are designed to provide some support and relief to small business owners. The idea of open MEPs has been in existence in other countries for many years and is something that should be seriously looked at as it would provide the economies of scale for small businesses as they look to make efficiencies with the administration process. In ACLI’s estimation, all of that could lead to an estimated 700,000 workers with access to workplace retirement savings plans that they don’t now enjoy.

Mr. Ferguson also noted the SECURE Act’s provisions allowing for a $5,000 credit that

would be provided to small employers for establishing a plan. When struggling to make ends meet in running a small business, that type of startup credit would be very helpful. An additional $1,500 credit could also be provided for auto enrollment to a new or existing plan which is another incentive for establishing or enhancing a retirement workplace plan. There is always the opportunity for an employee to opt out if they are not in a position to save through the workplace but evidence suggests that through auto enrollment we will see more individuals choose to plan for their retirement years. The current annuity selection safe harbor allows for more information so an employer can understand and provide to employees the information that they need when it comes to reflecting the status in relation to the state insurance regulation and enforcement of the company that they are choosing to do business with.

Mr. Ferguson stated that lifetime income disclosure is something that is very important to improve financial literacy. An illustration provided to individuals showing how their account balance translates into monthly lifetime income during their retirement years is very valuable as we think about low to moderate income savers who would be the prime beneficiaries of the SECURE Act. That type of basic information will go a long way toward helping individuals plan for their retirement years. Providing lifetime income portability is another key aspect of the SECURE Act.

Mr. Ferguson noted that Senator McConnell has established a procedure called a hotline vote which is a vote done by consensus rather than moving it to the floor for debate. If consensus is not reached, the SECURE Act could easily get caught up in the 2020 Presidential election and no action could be taken until afterwards. July is the key month for something to happen and ACLI has sent a group of CEOs to meet with Senator McConnell in an effort to advance the bill particularly given the bi-partisan support it has. Rep. Joe Fischer (KY), Chair of the Committee, thanked Ms. Kelly and Mr. Ferguson for their presentations and said that as someone who is approaching age 65, the issue of retirement security is very important to him. Rep. Fischer then asked for the names of the three Senators who voted against the SECURE Act. Ms. Kelly stated that it is her understanding the Senator Cruz is the primary opponent and his longtime Chief of Staff is one of the Representatives who voted against it. Ms. Kelly stated that she would have to check who the other two House members were that voted against it.

Rep. Martin Carbaugh (IN), Vice Chair of the Committee, asked with regard to the RMD age being increased from 70.5 to 72, if the schedule moves with it. In other words, the dividing factor at 70.5 right now is 27.4 and at 72 is 25.6 so you gradually have to take a higher percentage out. Accordingly, would you have to take out 27.4 at age 72? Ms. Kelly stated that she believes the schedule does move along with the increase in age.

Rep. Carbaugh then asked with regard to the matching student loan provision referenced by Ms. Kelly, how is that different than being able to make voluntary contributions for everybody without the requirement of a contribution? Ms. Kelly stated that is a provision proposed by Senator Wyden and is not yet part of the SECURE Act.

Ms. Kelly further stated that she believes the hope is that this will provide an additional nudge to employers to in fact make contributions as the number of employers having made voluntary contributions is small. Rep. Carbaugh then asked if the 529 provision is the lynchpin for Senator Cruz. Ms. Kelly replied yes. Rep. Carbaugh asked if the 529 provision allows that money to be used to repay student loans. Ms. Kelly replied yes and that has not been taken out of the SECURE Act. Rep. Carbaugh stated that he

agrees with what Senator Cruz is trying to do regarding the 529 provisions but hopefully the entire bill will not die in the process.

Senator Bob Hackett (OH) referenced the SECURE Act's provision requiring inheritors of 401(k) plans and IRA balances to withdraw the entirety of that balance within 10 years of the account owner's death and asked if inherited IRAs are essentially being eliminated. Ms. Kelly stated that under the bill as currently crafted you can inherit the IRA and there are not the same limitations on when you have to make withdrawals. Under the bill you would have to withdraw the entirety of the IRA balance within 10 years of the primary holder's death if you are not a spouse or minor child – so the effect would be to limit but not eliminate inherited IRAs. Sen. Hackett stated that will have the effect of adults aged 40 to 50 of being forced to take the money out within 10 years or pay the 10% penalty on top of paying taxes on the withdrawal. Sen. Hackett stated that the inherited IRA has been a godsend. Ms. Kelly stated that there has been staunch opposition to that provision. Sen. Hackett stated that in his mind they are looking for a way to pay it but they should be patient as every IRA has to have tax paid so all they are doing is pushing up to a time where the IRA will be taxed. That will create a hardship on adult children that are aged 40 to 50. Ms. Kelly noted that this provision was not included in RESA and has been added within the past few months.

Rep. Tom Oliverson, M.D. (TX) asked why the homeschooling provision is so controversial as it should not be a problem to members of Congress if people want to utilize their 529 contributions for such purposes. Ms. Kelly stated that she believes Senator McConnell will be sympathetic to that provision but he is also governed by Senate rules and if he adds in a provision that was not in the House bill then it is difficult to move the bill by unanimous consent because they are not able to change the wording of other things.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 12, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Marriott Newport Beach Hotel on Friday, July 12, 2019 at 11:30 a.m.

Representative Matt Lehman of Indiana, NCOIL Vice President and Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Rep. Joe Fischer (KY)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Colleen Burton (FL)
Rep. Richard Smith (GA)
Rep. Kevin Ford (MS)
Asw. Maggie Carlton (NV)
Asw. Ellen Spiegel (NV)
Asm. Kevin Cahill (NY)
Rep. Wendi Thomas (PA)
Del. Steve Westfall (WV)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Sen. Jerry Klein (ND) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 15, 2019 meeting in Nashville, TN upon a Motion made by Asw. Maggie Carlton (NV) and seconded by Rep. Martin Carbaugh (IN).

DISCUSSION ON AMENDMENTS TO NAIC CREDIT FOR REINSURANCE MODEL LAW AND REGULATION

Rep. Matt Lehman (IN), NCOIL Vice President and Chair of the Committee, asked for an update and timeline relating to the NAIC's recent amendments to its Credit for Reinsurance Model Law and Regulation (Models), and what legislators should expect in their upcoming sessions. The Honorable Eric Cioppa, Superintendent of the Maine Bureau of Insurance and NAIC President, thanked NCOIL for the Resolution passed yesterday in continued support of the Models, and noted that just last month on June 25,

the NAIC adopted amendments to the Models. The clock is ticking as the U.S. – EU Covered Agreement was signed by the USTR and EU in September 2017 and it gives the U.S. five years to conform to the Covered Agreement of face possible preemption. There is a lot of work to do in the remaining three years with state legislatures.

Supt. Cioppa stated that the fundamental thing that the Covered Agreement did was eliminate reinsurance collateral for EU reinsurers if they meet certain criteria relating to the amount of surplus they have ($250 million dollars), and a capital-solvency ratio of 1.0 under Solvency II. If they meet those standards, they will be entitled to the elimination of collateral in the U.S. One of the things heard from other interested parties such as Switzerland, Japan, and Bermuda is that they want a level playing field and therefore an elimination of collateral as well.

Supt. Cioppa stated that the NAIC did not want more Covered Agreements being entered into by the USTR and instead wanted to take matters into their own hands by amending its Models to bring before state legislators. Accordingly, the NAIC developed what is called a “reciprocal jurisdiction” whereby other countries can qualify for elimination of reinsurance collateral if certain standards are met in addition to requiring the EU and UK to recognize the NAIC Group Supervision and Group Capital Models. The NAIC does not want U.S. insurers subject to either Solvency II or the IAIIAS capital ratios – such insurers should be subject to U.S. capital ratios and group supervision scheme. Supt. Cioppa stated that has been clarified through a letter from Treasury that such recognition is required by the EU and UK and it is also being hardwired into the Models. If countries want to be termed a reciprocal jurisdiction, part of the price they are going to have to pay is to affirmatively recognize the U.S. system of group supervision and group capital.

Supt. Cioppa noted that amending the Models was an arduous process that involved multiple rounds of revisions and reviewing comments from interested parties in order to make sure everything was correct and would not have to be revisited. A lot of work with state legislators remains but the NAIC feels good about what was adopted and about the process moving forward.

Rep. Lehman noted that the bottom lines seems to be that we need to act quickly. Supt. Cioppa agreed and added that the final work product works for the U.S. insurance and reinsurance industries and most importantly for U.S. consumers

DISCUSSION ON CREATION OF NAIC LONG TERM CARE INSURANCE TASK FORCE

Rep. Lehman stated that long term care (LTC) insurance is a tense issue and one that is being dealt with in almost every state. Rep. Lehman asked for an update on the NAIC’s LTC Insurance Task Force and what its goals and timeline are. Supt. Cioppa stated that LTC is one of the most vexing problems in the industry today. The NAIC went through a process in which it laid out its strategic priorities for 2019 and LTC insurance was first on the list. The closed block issue is a huge issue and the task force is trying to specifically deal with that by developing several work streams. It is recognized that there is not a more vulnerable population than the elderly that purchased LTC insurance thinking it was a level-premium product and then 20 to 30 years later experienced tremendous rate increases. Supt. Cioppa noted that, having said that, he has not seen a LTC insurance policy that does not allow for those rate increases and regulators are very aware of Penn

Treaty. Penn Treaty was a $3 billion dollar insolvency that was largely the result of LTC inadequacy in pricing and reserving. Accordingly, a balance needs to be struck and it is a very difficult problem.

Supt. Cioppa stated that one of the issues encountered when dealing with the closed block issue is the multi state rate review process. Frankly, there has been a lot of frustration among states in an effort to get more consistency to make sure each state is looking at and reviewing LTC insurance rate increase filings in a consistent and equitable manner. That is one of the most important workstreams for the task force because you cannot have one state looking at the same data coming up with substantially and significantly different results in terms of rate increases.

Supt. Cioppa stated that another workstream for the task force is to explore possible alternatives to protecting policyholders from guaranty funds. That is less defined but in effect if a policy does go into insolvency, the task force will examine whether there are other avenues to look at. The guaranty fund is the worst possible outcome because a consumer may have a policy that is worth $600,000 - $700,000 and most states have limits on guaranty funds (i.e. Maine's is $300,000). It is the job of regulators to keep companies out of the guaranty funds but unfortunately at some level that does include rate increases

Supt. Cioppa stated that the next workstream the task force will examine is reducing benefit options in consumer notices. Consumers need to be given options rather than just being forced to accept a rate increase. Another workstream to be explored is the valuation of reserves. LTC insurance is still a relatively new product so it is important to make sure carriers are reserving adequately and regulators need to know the magnitude, if any, of under-reserving. Last year, the General Electric reinsurer had a $14 billion dollar reserve adjustment for LTC. Supt. Cioppa stated that the task force is looking at something called "AG 51" to look at the reserving of each carrier at a granular level, and the financial analysis working group is looking at the domiciliary state regulator to make sure the carriers are properly reserving for LTC.

Supt. Cioppa also noted that the task force will engage in a workstream to identify an actuarial firm to help analyze the data regarding rate reserves and rate increases. The main takeaway that legislators should be aware of regarding the task force is that LTC insurance is a big problem and the NAIC is devoting a significant amount of resources to get its arms around the magnitude of the problem and develop procedures to protect consumers. Some of those procedures may involve rate increases but it is also important that the carriers not be able to walk away. They sold the product and if they lose money, so be it, but that needs to be balanced with making sure they are financially viable.

Rep. George Keiser (ND) stated that eight to ten years ago the NAIC with the life insurance industry created the LTC Partnership program which Congress passed. It was designed to enhance portability of LTC insurance. Rep. Keiser stated that he believes it has been a failure and has not achieved the objective for which it was designed but the unfortunate thing is that many states, including North Dakota, has twice passed innovate legislation that was designed to dramatically and positively effect the enrollment in LTC insurance among younger people. However, each time the legislation passed it went to CMS and the waiver request was rejected because of the Partnership program. Rep. Keiser stated that he has heard no discussions from the NAIC as to

whether the program has failed, but it certainly has succeeded in stopping states from developing innovative strategies to address LTC insurance solvency.

Supt. Cioppa stated that it is important to note that the market went from over 100 carriers selling LTC insurance to less than 15. The NAIC also tried to come up with some innovative products that would help the LTC market and provide meaningful benefits and a list of 10 recommendations was created, a lot of which involved tax restructuring at the federal level. Supt Cioppa stated that he spoke to Senator Susan Collins of Maine regarding those recommendations and she is interested. Hopefully if Congress starts looking at this issue it can also look at the Partnership because if that can function in conjunction with new and innovative products it would be a win for the states. Rep. Keiser noted that the solutions developed in North Dakota were not related to taxes and that it is a big problem for states to be denied waivers when trying to develop such solutions. The Partnership was created to solve problems related to LTC insurance but it has not done that and it needs to be addressed.

UPDATE ON NAIC PHARMACY BENEFIT MANAGER WORKING GROUP

Rep. Lehman asked for an update on the activities of the NAIC's Pharmacy Benefit Manager (PBM) Working Group (Working Group) and what work product might be developed. The Honorable Glen Mulready, Commissioner of the Oklahoma Insurance Department, first stated that under Supt. Cioppa's leadership a commitment has been made for the NAIC to be very regular participants at NCOIL. Accordingly, Cmsr. Mulready stated that at least he or The Honorable Dean Cameron, Director of the Idaho Department of Insurance and NAIC Secretary-Treasurer, will be attending future NCOIL meetings in an effort to build bridges and work more closely together.

With regard to the Working Group, Cmsr. Mulready stated that last year there was a consensus reached at the NAIC to move forward and potentially develop a new model on PBM regulation. The PBM Regualtory Issues Subgroup was created under the Health Insurance (B) Committee and has met via conference call both in regulator-to-regulator and open session format. A 2019 charge has been adopted to develop a new NAIC model that would establish a licensing and registration process for PBMs, as well as to consider including in the model provisions on prescription drug pricing and cost transparency. A workplan has been developed to guide them which will be voted on at the upcoming NAIC Summer Meeting during the B Committee's meeting. The Working Group will survey all state insurance regulators.

Cmsr. Mulready thanked Senator Jason Rapert (AR), NCOIL Immediate Past President, for his leadership on PBM issues and stated that it is the NAIC's hope that as it moves forward it can take advantage of the leg work already done at NCOIL and also have someone from NCOIL present to the Working Group on the work it has done. Cmsr. Mulready stated that the Working Group still has a lot of work to do and looks forward to using the work that NCOIL has already done to further its efforts.

Rep. Lehman stated that during efforts to try and pass PBM legislation in Indiana there was a lot of pushback as to who the regulator should be such as the department of insurance, attorney general, or pharmacy board. Cmsr. Mulready stated that he is not certain but believes that most states have designated the insurance department as the regulator. Cmsr. Mulready also noted that Oklahoma passed PBM legislation as did several other states. Sen. Dan "Blade" Morrish (LA), NCOIL President, noted that LA's

PBM legislation designed both the insurance department and pharmacy board as the regulator. Rep. Lehman stated that in Indiana there was some push to designate the pharmacy board as the regulator but concerns were raised.

UPDATE ON NAIC ANNUITY SUITABILITY WORKING GROUP/SEC REGULATION BEST INTEREST

Rep. Lehman asked for an update and timeline on the NAIC's Annuity Suitability Working Group (Working Group), and for comments on how the SEC's recently adopted Regulation Best Interest affects the Working Group. Dir. Cameron stated that it is first important to acknowledge that the Annuity Suitability Model Regulation (Model) has worked over time. Consumers are being protected and for the most part consumers are able to choose the product that best fits them. It should also be acknowledged that most agents and carriers want to do what is in the best interest of the customer as they do not stay in business very long doing otherwise. The NAIC believes that the consumer is best protected when there is a level playing field where the agent and carrier know the rules in which they have to operate under.

Dir. Cameron stated that to the extent possible, the desire of the NAIC and the Working Group is to provide some uniformity between the amendments to the Model and the SEC's regulation, and potentially what the Department of Labor (DOL) may propose. The DOL's initial regulations were rejected but there have been indications that they will return. Dir. Cameron stated that with a lot of pain and effort, the Working Group drafted some changes that, in the Working Group's opinion are very reasonable, but stop short of calling it a "best interest." For lack of a better term the Working Group called it a "consumer first" approach whereby agents are required to disclose certain material facts, conflicts of interest and compensation. Agents also must document how they came about making the recommendation to the client and how the client chose the product.

However, that is not what the SEC passed. The good news is that the SEC passed a best interest standard and they did not define what that meant. The NAIC had shied away from that term because it was undefinable and difficult to determine whether in a scenario of a consumer choosing a product with the best interest rate but also paying the agent the most commission if that would be in the consumer's best interest. Similarly, if the consumer chose a product with the longest surrender penalty over one with the shortest penalty, it would be difficult to determine whether or not that was in the consumer's best interest.

Dir. Cameron stated that it is paramount to the Working Group that there be appropriate documentation and noted that the Working Group is starting to work towards defining "best interest." Dir. Cameron stated that he is not sure anyone loves the term but it is in fact the term that is out there and unfortunately perception becomes reality and the perception of the "consumer first" approach was that it was a lighter standard than "best interest." Since the SEC revealed its Rule, the Working Group has had one in-person meeting and two more are scheduled before the NAIC Summer Meeting. At the Summer Meeting, the Working Group hopes to move rapidly into making adjustments to the Model. Dir. Cameron stated that part of that discussion will be how to define "best interest" and he welcomed NCOIL's participation. Hopefully it will look a lot like what the Working Group had previously defined. If an agent is operating in a manner that is putting the consumer first, they are operating in the consumer's best interest. If the agent documents that the product was suitable in addition to the other products that they

are offering and whether there are any conflicts of interest and how they are going to be compensated, hopefully that will be deemed to meet a best interest definition.

Dir. Cameron stated that the Working Group has to determine specifically what a material conflict of interest is and how much of it has to be disclosed. There is a big difference between the Working Group and the SEC on non-cash compensation. Many members of the Working Group believe that non-cash compensation should be disclosed so that will have to be worked through. The SEC does not include non-cash compensation in its Rule because they don't allow non-cash compensation such as trips and compensation to help finance an office computer system. There is also a very contentious discussion regarding whether the Model will affect only new sales or impact current customers such as someone with a periodic deposit into their IRA. Dir. Cameron stated that he believes the majority of the Working Group members believe that it should not apply to current customers and that is the direction the SEC went, but Dir. Cameron noted that as a former agent, anytime someone brought additional funds to him he reviewed whether or not their current investments were suitable and which direction they should go in with their future investments. Dir. Cameron stated that immediately after the NAIC Summer Meeting, the form of the amendments will hopefully be finalized and the hope is that by the NAIC Fall or Winter meeting the amendments will be adopted.

Rep. Lehman stated that when Dodd-Frank was passed there was a condition that if states adopted the NAIC Model then that type of regulation would rest with the stats, but now the SEC has adopted its Rule. Accordingly, Rep. Lehman asked if this is setting up to be similar to what we saw with the DOL Fiduciary Rule in terms of contentious legal battles concerning state v. federal authority. Dir. Cameron stated that the hope is no and that the SEC has its role to regulate certain registered representatives but in some cases they are regulating the same representatives that the states do. The DOL is regulating ERISA plans and retirement plans so they have a regulatory arm that overlaps with the states. Dir. Cameron stated that while some may disagree, he felt that DOL overstepped with its Fiduciary Rule. The SEC's Rule is a little more reasonable as it is helpful to consumers if dealing with an agent vs. a registered representative/agent vs. something else that they know they are being treated essentially the same. It is also helpful to the industry that there not be one set of rules for one side of the line and another set for the other side.

Dir. Cameron stated that during his time as an agent he sold a lot of annuities and did a lot of retirement planning and there were times that even the suitability standard was a little bit of a pain but the reality was that you always wanted to do what was in the consumer's best interest anyhow. The term has been politicized and is not preferable but in reality, Dir. Cameron stated that he believes agents can adopt it as long as there are reasonable expectations. Everyone expects that the agent will be compensated somehow so disclosing that not to the exact cent is reasonable, as is disclosing conflicts of interest. It is also very reasonable if the agent has to document how they came to the conclusion that the three of four products are the best choice for the consumer and that the consumer chose "x" product for the following reasons. Dir. Cameron stated that if those disclosures were documented, he does not see how a regulator could determine how an agent did not act in a consumer's best interest.

Rep. Carbaugh stated that as an independent agent the issue of best interest to the consumer for all products available makes him uneasy since through brokerage houses he can sell a myriad of companies that he has no idea what all of the contracts out there

are. The litigation involved can be very worrisome, particularly when the families of a deceased consumer come after the agent questioning the agent's decision. Rep. Carbaugh stated that he agrees with Dir. Cameron's statements regarding requiring the explanation he mentioned about certain products but that sounds like "suitability" more than "best interest" and is therefore troubling. It is particularly concerning as an independent agent as opposed to captives as independent agents should not be expected to know every contract available.

Dir. Cameron stated that draft of the NAIC's Model would not require agents to know all products that are available. Agents are not expected to know competitor's products and products for which they are not licensed or appointed to sell. Dir. Cameron stated that first and foremost you are expected to know the products that you are licensed and appointed to sell and you are expected to disclose if you have a material conflict of interest. Most agents, particularly those in the P&C realm, are not willing to walk away from the P&C side of the business in order to market an annuity for which they would make very little compensation and jeopardize their relationship. Dir. Cameron stated that he could see situations where agents could collaborate with other entities. Some consumers will also not care. The important thing is that agents should document why the product was chosen and why the consumer made the choice. An agent may even want to have the consumer sign something stating that "I chose the following product for the following reasons…" Dir. Cameron stated that when he would sit down with customers sometimes there were good companies with great opportunities but he did not have any relationship with that company so he would say to the customer that the company is available but he does not know anything about it. Dir. Cameron stated that he believes that if you disclose that type of information you will be acting in the consumer's best interest. Dir. Cameron stated that he hopes the Model will be that transparent and invited NCOIL's comments.

Sen. Bob Hackett (OH) stated that the DOL Fiduciary Rule really related to variable annuities. Sen. Hackett stated that he does a lot of mutual funds and he saw that broker dealers were pushing him and others to do brokerage accounts as they get a fee on every brokerage account transaction and there is not a fee on every mutual fund transaction other than the initial fee. Sen Hackett stated that he is not sure what the SEC's Rule states regarding variable annuities but asked if there will be a fight involving said annuities over the next five to ten years. Dir. Cameron stated that he does not believe you will see a fight because the SEC's Rule will encompass variable annuities and in some cases the NAIC's Model will as well along with indexed annuities. Dir. Cameron stated that not every regulator regulates variable products and the Model that the NAIC hopes to come forward with will create as much uniformity as possible between the NAIC and the SEC. It remains to be seen what the DOL will come back with.

Rep. Lehman asked Dir Cameron if the NAIC sees any issues with proceeding with a Model Regulation for these issues as opposed to a Model Law. Dir. Cameron stated that he is not certain but believes some statutory changes may be necessary and noted that the industry has done a pretty good job of working these issues. Thousands of pages of comments have been submitted and for the most part everyone is on the same page. There are some that do not like the term "best interest", including Dir. Cameron, but as long as the Working Group can define it as a reasonable standard he can live with it.

Rep. Lehman followed up on Rep. Carbaugh's statement regarding potential litigation from family members of a deceased client and asked if that will be an issue down the road with the Model and the SEC's Rule. Dir. Cameron stated that it is certainly not the Working Group's intention for that to take place. As regulators, if called to look upon a situation like that they would really be looking at whether the agent documented recommendations and whether the recommendation was reasonable. No one is expecting the agent to have a crystal ball and predict what will be the best rate of return down the road. Dir. Cameron stated that he and other agents have had experiences where they sold a product and then the company gets bought and all of sudden they are not as responsive and good to work with – the point being that things change. Dir. Cameron stated that he believes the Working Group has circumvented the issue raised by Rep. Carbaugh and will not be looking at just returns to cause litigation issues.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that he appreciates the comments regarding the potential for litigation because he believes the term "best interest" is something that anyone sitting in a jury will think they know what it means. At that moment, the operative word will be "best" and when you present a phrase as simple and well understood like that to any person, no matter what hedges you put around it the public will supply their own understanding.

UPDATE ON AFFORDABLE CARE ACT LITIGATION: TEXAS V. U.S.

Rep. Lehman asked for an update on the most recent Affordable Care Act (ACA) litigation, Texas v. U.S., and asked if the NAIC is seeing any states take action regarding preparations for the ACA being dismantled and/or struck down. Supt. Cioppa stated that Maine hardwired some provisions into state law that it felt were appropriate to include in case the ACA went away. A number of states have also done that and others are looking at that as an option. In term of the litigation, the NAIC is following it and will act appropriately but it is not preparing for it to be struck down at this point.

Dir. Cameron stated that, after the ACA passed, states went through and repealed certain provisions of their insurance code. Therefore, perhaps it is wise for states to review what was repealed and consider whether those provisions should be put back in place. For example, if a state had consumer protection provisions that were repealed because they were duplicative of the ACA's, such provision may want to be put back in the code. Or if states had high risk pools or high risk reinsurance pools that were repealed because of the ACA, they may want to be enacted again.

Dir. Cameron stated that the NAIC is waiting like everyone else to see the result of Texas v. U.S. and in the meantime the states are also working very diligently to stabilize their own marketplaces, and encourage companies to participate since the more carriers that participate the better it is for consumers and competition. Not everything that works in one state will work in every other state but states should always have the ability to try different things without necessarily asking the federal government for permission. Idaho will soon be releasing the second round of its state-based plans and some will like them will others will not. Idaho also passed legislation regarding enhanced short term insurance plans and it was wise to place it in the consumer protection chapter of the Idaho code so the plans will have to comply with certain Idaho mandates. Dir. Cameron stated that it is important to foster innovation and the NAIC will continue to advocate for that.

Rep. Lehman stated that in Indiana they put their high risk pool back in place in case the ACA was struck down and noted that Rep. Carbaugh enacted important short term insurance legislation. Rep. Lehman stated that an argument he heard regarding short term insurance plans was that it is a great product for someone like a 62 year old single farmer who wants minimal coverage but is told they must buy a product that has maternity and pediatric dental coverage. That may run contrary to the ACA so it will be interesting to see what happens with the litigation and other state actions.

ANY OTHER BUSINESS

Rep. Lehman stated that he looks forward to working with the NAIC and developing some sort of standard regarding rebate reform especially as agents become licensed in multiple states and they need to know multiple state rebate laws. Rep. Lehman noted he has heard debates over whether a frozen turkey would be considered a rebate, in addition to whether an agent could send flowers to a client's funeral without violating rebate laws. Supt. Cioppa noted that when passing Maine's rebate reform law he told legislators that for egregious actions there are always unfair practices laws that can be used to address those actions and therefore rebate laws are not needed for that purpose. Rep. Lehman noted that rebating laws are really protecting agents from each other because you never hear a consumer complain that they got a better deal.

Dir. Cameron stated that there was a situation in Idaho several years ago during the "universal life craze" when a couple of agents went to prison because they were rebating the entire first year premium. They had a carrier that was paying them more in commission than the entire first year premium and of course they were not paying taxes on anything either. Dir. Cameron stated that he thinks rebate statutes are way out of date and need to be reviewed but it is important to be careful when getting into actually paying for part of the premium of the product that they are selling.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 12, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Marriott Newport Beach Hotel on Friday, July 12, 2019 at 4:30 p.m.

Representative Edmond Jordan of Louisiana, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Austin McCollum (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Sen. Dan "Blade" Morrish (LA)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Asw. Maggie Carlton (NV)
Asm. Andrew Garbarino (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Lewis Moore (OK)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Jack Tate (CO)
Asw. Ellen Spiegel (NV)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. Tom Oliverson, M.D. (TX) and seconded by Sen. Jason Rapert (AR), NCOIL Immediate Past President, to waive the quorum requirement, the Committee unanimously approved the minutes of its March 17, 2019 meeting in Nashville, TN upon a Motion made by Rep. Richard Smith (GA), Vice Chair of the Committee, and seconded by Asm. Ken Cooley (CA), NCOIL Treasurer.

CONSIDERATION OF MODEL LEGISLATION IN RESPONSE TO THE AMERICAN LAW INSTITUTE'S RESTATEMENT OF THE LAW, LIABILITY INSURANCE

Rep. Joe Fischer (KY), stated that before presenting the Model Act Concerning Interpretation of State Insurance Laws (Model) for adoption, he would like to say a few words. Rep. Fischer stated that he has the greatest respect for the American Law Institute (ALI) and their scholars and he does not believe he would have graduated law

school or passed the bar without reference to their many restatements and treatises. NCOIL respects the work that the ALI does but in earlier conversations with Sean Kellum, ALI Law Fellow, Rep. Fischer told him that the Model is more about how to interpret insurance laws. The Model really goes to the heart of what NCOIL does as an organization as well as to legislators' constitutional duty to make the law in each respective jurisdiction. Legislators are the ones that state or re-state what the law is every time they meet in session. The Model simply magnifies that duty of legislators. The scholars of ALI have every right to state what they think the law is or what they even want the law to be but it is the duty of legislators to make the law and that is really the basis of the Model. Rep. Fischer stated that he appreciates the opportunity to sponsor the Model and looks forward to hearing form the panel.

Mr. Kellum first thanked the Committee for allowing him to speak today, and then thanked NCOIL for its dialogue with the ALI over the past two years regarding the ALI's Liability Insurance Restatement (Restatement). Mr. Kellum noted that as ALI's Law Fellow he provides research and editorial assistance to the ALI's Director and Deputy Director on ongoing ALI projects. During the final stages of this project he had the opportunity to dig in and read very carefully many of the Restatement's sections and as of today, the final official text is available on Westlaw. The Restatement attracted an enormous amount of attention, including NCOIL's, and the ALI would like NCOIL to know that its comments were very carefully considered and posted on the ALI's website for its members to read. The ALI believes that NCOIL's comments as well as comments from other interested parties really improved the project. The ALI took an additional year of review and many significant changes were made and ultimately the ALI believes the final project is much clearer and will be much more useful to litigants, lawyers, and judges.

Mr. Kellum stated that the ALI has also been observing with interest the reactions of state legislatures to the Restatement and the ALI hopes that state legislators will view the Restatement as working in tandem with the important lawmaking that legislators do. That is how the ALI views the process – a Restatement is a roadmap to caselaw to fill in the gaps where a statute does not control and a court nevertheless has to make a decision on an issue presented in a litigated case. The ALI expects that lawyers and judges always will look first to state statutory law to find the applicable rule or answer to an issue in a case before them and only look to common law if there is no statute on point to provide an answer in the case. The ALI acknowledges that Restatements, by their nature, are works of scholarship and commentary and are not controlling like sources of law. Mr. Kellum stated that the ALI hopes that this Restatement will be useful to litigants, lawyers, judges and legislators and even where a user of a Restatement disagrees with where the ALI came down on a particular issue the ALI is hopeful that the analysis of the issues and the case law will nevertheless be helpful and will improve the quality of litigation in this area of the law.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) thanked NCOIL for its engagement with this issue. Without NCOIL's attention and engagement on this issue, APCIA does not believe that the process that the ALI engaged in and the product that it ultimately developed would be in the place that it is in today. APCIA believes that the Model is warranted and that it is time for it to be adopted. APCIA congratulates NCOIL for its attention and diligence on this particular issue.

Erin Collins, Asst. VP of State Affairs at the National Association of Mutual Insurance

Companies (NAMIC) echoed Mr. O'Brien's comments and noted that NAMIC and APCIA have worked together on this project for quite some time. NAMIC believes that the Model is the result of a lot of great work by this Committee and concurs that it is warranted and time for adoption.

Laura Foggan, Esq., Partner at Crowell & Moring, LLP stated that she has worked with NAMIC and APCIA throughout this process as a liaison to the ALI on its development of the Restatement. Ms. Foggan stated that she is here today to serve as a resource to answer any questions.

Rep. George Keiser (ND) stated that as he reads the Model he does not see a provision that accounts for when a state takes action by not taking action. In other words, many issues may have been debated in the legislature and bills may have been turned in and defeated. As a result, that translates into the legislature taking action but it is not in the form of the Constitution or statute. Rep. Keiser stated that he is concerned that the Model does not account for that situation.

Ms. Foggan stated that to some extent the Model does allow for that as it addresses not only statutory law but common law as well. Rep. Keiser stated that is not common law by definition and that is a problem. Ms. Foggan stated that she believes there is an argument that where the legislature has made a determination not to enact a statute, it is reflecting the public policy of the state and ultimately the common law of the state and that would be the way in which, indirectly, the Model speaks to Rep. Keiser's concern. Rep. Keiser stated that if the legislature took action and defeated a bill four sessions ago, nobody remembers it – but that is nonetheless action. Rep. Keiser stated that he is concerned that adoption will occur even though a state has taken a position by not taking a position.

Rep. Fischer stated that courts have looked at inaction of the legislature as creating an avenue for them to suggest that the law should not be applied. It is a difficult issue but it is an issue that the courts have come down on and stated that if the legislature has not acted then it is ok for courts to proceed. Rep. Fischer also stated that he does not know how to address the situation described by Rep. Keiser in a statute, such as saying "the law of the state includes inaction by the state legislature." Rep. Fischer stated that he does not believe he has seen any statutes that have expressed that and it would be difficult to include that in a Model law. Rep. Keiser suggested that Rep. Fischer and the Committee look at the law passed in North Dakota on this issue. Rep. Fischer stated that he thought the Model was modeled off of what was passed in North Dakota and Arkansas on this issue.

Upon a Motion made by Rep. Fischer and seconded by Sen. Jason Rapert (AR), NCOIL Immediate Past President, the Committee voted to adopt the Model by way of a voice vote. Rep. Keiser was the only vote in opposition.

DISCUSSION ON INSURANCE ISSUES RELATED TO THE P2P CAR SHARING INDUSTRY

Ethan Wilson, Gov't Relations Manager and Sr. Legislative Counsel at Turo, stated that Turo is a peer to peer (p2P) car sharing company marketplace facilitator that is based in San Francisco. Turo operates in 49 states as well as Canada, the U.K. and Germany. Simply put, Turo's mission is to put the world's 1.2 billion cars to better use. There are

roughly 320 million people in the U.S. and there are about 4 times that amount of cars on the planet which is a crazy number but a way to contextualize Turo's motto, part of which is to put depreciating assets to better use. Turo is a p2p car sharing marketplace and it owns no cars – that is the beauty of it. It is a decentralized platform. What makes Turo and p2p car sharing great are the men and women that share vehicles on Turo's platform. It is a vibrant community consisting of men and women, parents, students, seniors, active and retired military members (some of which are currently deployed), first responders, teachers, and many more across the U.S., Canada, the U.K., and Germany.

Mr. Wilson stated that there is a unique value proposition to both hosts who are the vehicle owners and guests who are the vehicle drivers that participate in p2p car sharing. From a guest perspective, guests can choose from an incredibly unique and vibrant selection of nearby and locally sourced vehicles – from fully electric vehicles, to minivans, pickup trucks, convertibles, and rare and exotic cars. From a host perspective, they can earn extra money off of assets that are otherwise sitting idle sometimes 90% of the time. By and large, vehicles are a person's largest depreciating asset he or she will ever buy. Mr. Wilson stated that in 2017, the average monthly Turo host earnings was $625 and it took 11 sharing days to get to that amount of money. Importantly, comparing that to what the average car payment was in 2017, it was $504.

Mr. Wilson stated that 75% of Turo hosts use the money they make from sharing their vehicle to pay down their car loan, pay rent, pay a mortgage, or add to savings. Turo is certainly not a panacea for the retirement crisis in America but it is another method that people can use to save money. Mr. Wilson stated that 17% of Turo's community identifies as either veterans or active duty military, some of which are deployed in the U.S. or overseas. 13% identify as a teacher/educator which is very important because since teachers have summers off, that is a great opportunity to use a depreciating asset to help pay for any expenses during that time. 13% identify as either AARP or retired, 8% identify as working in the trades or being in the labor union, and 6% identify as being in law enforcement/firefighter/emergency responder.

Mr. Wilson noted that Turo has several different types of cars on its platform from BMWs, Corvettes, Audis, to fully electric vehicles like Teslas and the Nissan Leaf, to Jeep Wranglers. This goes to show that there is no barrier to entry to anyone on the Turo platform no matter what type of car they have. Mr. Wilson stated that in 2017 the most popular car on the Turo platform was the Jeep Wrangler, but interestingly the second most popular car was the Toyota Prius which shows that many people are looking for more economical choices when sharing or driving a car on the Turo platform.

Mr. Wilson stated that Turo prides itself on having a very robust trust and safety team as that team is available 24 hours to any host or guest currently in a car sharing transaction on the platform. Also, the person driving the vehicle will have access to 24 hour roadside assistance, and there is a very robust p2p anonymous host/guest review process that does a great job to help explore and vet who the good and bad actors are. With regard to insurance, dating back to 2009, Turo worked with a licensed producer for over a year to secure the country's first p2p car sharing insurance policy and it was available for Turo's first reservation in 2010. Currently, Turo partners with Liberty Mutual. Turo is the named insurer on the blanket policy and has the full premium obligation to pay Liberty Mutual. However, it is under that blanket policy that the host and driver are covered.

Mr. Wilson stated that it is important to note that the car owners and drivers are automatically covered from the start of the reservation until the end of it, including car delivery which means that even if the vehicle's owner is driving the car to meet the person who will be driving the car, that would fall under Turo coverage. Mr. Wilson stated that when you look at insurance on a p2p platform you need to look at it through two lenses - the host lens and the guest lens. For the host lens, the Turo protection provides $1,000,000 in liability insurance from Liberty Mutual included in every p2p car sharing reservation from until the moment the reservation (or delivery) starts until the end of the reservation (and any approved extensions). For the guest lens, it is a little different. At a no-cost added basis in the transaction, the state mandated minimum liability insurance are added. However, a driver can upgrade that liability insurance to up to $1,000,000 which allows flexibility for a driver as many times a driver will not need redundant insurance coverage when they are driving because they have insurance that will cover them. However, even if they did not have insurance they would still get the minimums and if they knew they did not have insurance they would probably purchase the extra added $1,000,000 coverage.

Mr. Wilson stated that this year Turo worked with Allstate's Drift, Getaround, Liberty Mutual, APCIA, and a number of other stakeholders to get legislation passed in Colorado, Indiana, Iowa and last year in Maryland. Mr. Wilson noted that Sen. Jack Tate of Colorado co-sponsored the Colorado legislation, and Rep. Matt Lehman of Indiana, NCOIL Vice President, was a co-sponsor of the Indiana legislation. Mr. Wilson stated that the negotiations in those states were great and that in those states there are now very robust consumers protections for individuals operating on a p2p car-sharing marketplace.

Mr. Wilson stated that the legislation passed in those states, which is based on model legislation mainly developed by Turo and APCIA, can be divided into three components – the first being a definitions section, the second being an insurance section, and the third being a consumer protection section. For the definitions section, it defines things like when the car sharing start time happens and what that means and looks like, what the car sharing termination time looks like, as well as coverage during the delivery period. Taking all of those things together you have the sum of the parts of what a car sharing period would look like. Other definitions include "shared vehicle owner," "shared vehicle driver," "p2p car sharing program," and "car sharing program agreement."

The insurance section of the model legislation establishes robust insurance requirements such as coverage during the entire car sharing period even beginning with a car sharing delivery period if applicable. The model does not restrict an insurer's ability to exclude or limit coverage for a p2p car sharing activity – that was negotiated with the insurers and Turo is confident that the insurance market is very competitive and dynamic and there will be a growth in availability of products for people to purchase that would cover p2p car sharing activity. However, for the time being, Turo and other market participants provide insurance for the car sharing transaction.

Mr. Wilson stated that the model legislation also establishes a number of consumer protections including recordkeeping requirements and transparency. The model also requires disclosures of indemnification, daily rates, fees and if applicable, any other insurance or protection package cost that would be charged to the shared vehicle owner or driver. The model legislation also has a provision that addresses automobile safety recalls which means that a program such as Turo operating in a state in which the model

legislation has passed must verify that every shared vehicle is free of any safety recalls prior to being shared on a p2p platform. Once a vehicle is on that platform and clears that safety threshold, the legislation requires that a shared vehicle owner report to the p2p car sharing program if at any point in time in the future a safety recall is issued on that vehicle – that vehicle will then be pulled from the platform and then that individual will provide that platform with proof that the safety recall has been properly addressed and then the vehicle can go back on the platform. Mr. Wilson stated that he is happy to serve as a resource to the Committee on these issues going forward.

Brian Rothery, VP of Gov't and Public Affairs at Enterprise Holdings stated that Enterprise has a network of car rental locations throughout the country, employs about 100,000 people, and operates a fleet of about 2,000,000 cars to operate its rental car business. In addition to its rental car business, Enterprise also is involved in van pooling, ridesharing, and just offered a new product that relates to subscription services. Enterprise is excited about the evolving transportation industry and looks forward to helping people figure out new ways in getting from point A to point B. Mr. Rothery noted that the debate is not whether or not to embrace innovation, Enterprise believes that there is a certain way to responsibly embrace it.

The issue of how to handle p2p car sharing companies has been a very active discussion in roughly 25 states besides those states that have enacted legislation. Enterprise expects that number to increase and is hopeful that by having discussions like the one being had today consensus on certain issues can be reached. Other sharing economy issues have made their way through legislatures such as Uber, Lyft, and Air BnB. And p2p car sharing is just the next version of that. There are multiple ways of thinking about these types of transactions and Enterprise appreciates the opportunity to voice their thoughts.

Mr. Rothery stated that Enterprise's perspective on these issues is not just one of a marketplace competitor but also one of a company that is thinking about getting involved in this business model as well. Enterprise very much sees an opportunity for a company like itself to create a marketplace to either leave their car when they are about to go on a flight or pick up a car when they get off a flight. Accordingly, in addition to being a competitor, Enterprise would like to see clarity on certain issues so it knows the rules of the road if it decides to participate.

Mr. Rothery stated that Enterprise wholeheartedly supports the concept of the model legislation discussed by Mr. Wilson since when you are trying to conduct a rental transaction that involves three parties it is probably best to write some rules of the road that apply to them as the business model does not fit into the current insurance codes relating to traditional car rentals. However, one aspect of the model that is problematic for Enterprise is the definitions of "peer-to-peer car sharing" and "peer-to-peer car sharing program" as there is language in there stating that the definitions do not mean rental car or rental activity as defined in the relevant section of existing law. Enterprise objects to that language because the model legislation largely deals with insurance issues and as many probably already know who have dealt with this, there is a significant issue relating to taxation. Enterprise has great concern that if something is considered a model law and does not address taxation and includes the aforementioned language, then it could have an unintended, or intended, policy implication outside the realm of insurance and therefore the model needs to either include taxation or the aforementioned language needs to be stricken.

Mr. Rothery stated that he is not here today to debate the proper way to tax these types of transactions, rather, it is important to acknowledge that the tax conversation is important and deserves its own light of day and should not be back ended through a definitional structure in the insurance code as a justification for why taxation should be different. Mr. Rothery stated that one of the things that Enterprise applauds in the bill is that the minimum financial responsibility limits are set to be equal with the car rental companies. That is something that Enterprise supports and is something that in various versions of legislation across the country has gotten conflated sometimes. Enterprise supports equal treatment as it believes that p2p car sharing vehicles are rentals and they deserve the same protections, obligations, responsibilities, and rights that Enterprise's transactions have. Enterprise is not only looking for equality and parity with respect to taxation rates but also with back of business rules such as financial responsibility limits.

Mr. Rothery stated that on page 7 of the model in the Disclosure section, it is a great effort to encapsulate some of the good and honest consumer protection laws that are out there in various states. However, some states do have an existing scheme such as California that sets forth very specific requirements on the way in which prices are disclosed to customers, specifically the prices that they cannot avoid. Within two clicks of a webpage, you need to show a customer in California the total charge that the customer will pay when renting a car from Enterprise. That is important because customers make the decision to rent a car at their desk or at their home expecting that the price they see will be the final price they pay when getting the car, and Enterprise supports such requirements being included in the model or language saying that, in states where there is a more stringent standard such as California, the p2p law needs to reflect that. That is important because, make no mistake, Enterprise and companies like Turo are competitors as they are after the same customer.

Asw. Pam Hunter (NY) stated that she understands the realities of the sharing economy and that it is here to stay but she is concerned that the businesses in her district (Syracuse) are going out of business because of companies like Uber and Air BnB. Accordingly, it is hard to gauge what is right for progressive, leading edge businesses and also making sure that there is a level playing field. Asw. Hunter urged the Committee to take that into consideration when considering model legislation on this issue as every state is different. Asw. Hunter then asked who is paying the taxes on p2p car sharing platforms. Asw. Hunter also asked if the lienholders of the vehicles are ok with the vehicle being rented out to third parties.

Mr. Wilson stated that in the model legislation there is a disclosure that requires a p2p car sharing program to disclose to hosts on the platform that it could violate terms of a lease agreement or some type of lienholder or financing agreement if that individual does not hold title to that vehicle. It is designed to somewhat be hands-off as Turo does not want it to be a barrier to entry but at the same time it understands the importance of it and does not want individuals breaking any contractual obligations that they are already under. Mr. Wilson noted that such language may look different in different states, however.

Asw. Hunter then asked if someone owns ten cars and is renting them, can that person be an individual host on the platform? Mr. Wilson replied yes – if you have registered all of the cars and pay registration every year, and paid the sales tax on all of the cars since you are not a rental car company then you could do that. But you would also have to pay insurance on all of those cars to register them every year so if it makes sense from a

dollars and cents perspective it could certainly happen but there is a tipping point from a volume of vehicles perspective where it would no longer make sense.
Rep. Jordan then clarified to the committee that the model legislation being referenced is not a proposed NCOIL model law but only model legislation that was negotiated between Turo, APCIA, and others.

Asm. Andrew Garbarino (NY) asked Mr. Wilson out of the 49 states Turo operates in, how many of them have the specific p2p legislation that was referenced earlier. Mr. Wilson stated that legislation has recently passed in CO, IN, IA, MD, and dating back to 2010 there was "western states language" in CA OR and WA that took the form of car sharing language but the industry looked a lot different then and it will probably need to be re-visited. Asm. Garbarino asked if the legislation passed in CO, IN, IA and MD addressed the issues referenced by Mr. Rothery. Mr. Wilson stated that there was a taxation structure passed in MD and IN.

Rep. Tom Oliverson, M.D. (TX) asked if there was any other reason besides taxes as to why rental cars were excluded in the definitions referenced by Mr. Rothery. Mr. Wilson stated that excluding rental cars from those definitions was not done for tax purposes but rather because in certain states there are a myriad of regulatory components that would flow from being categorized as a rental car transaction which would be impossible or very unlikely for an individual car owner to comply with. Rep. Oliverson asked for specific examples of those regulatory components. Mr. Wilson stated that some examples include having a 1-800 number, particular signage at brick and mortar locations, and having contracts or content be in certain point font.

Rep. Oliverson then asked Mr. Wilson to state again how the insurance coverage works when a "renter" is driving a car sharing vehicle. Mr. Wilson stated that the individual's personal policy would be primary if that person has a policy that would cover p2p car sharing activity but in the absence of that, the minimums of that state are still in place and provided by Turo through Liberty Mutual and then that individual has the opportunity to increase coverage.

Rep. Oliverson then noted that the Committee has discussed other sharing economy issues and the limits of liability insurance of when someone uses something that they own personally and then they start performing a business activity. For example, someone may take a Lime scooter home and charge it in their home and burn the house down - technically that is commercial activity since you are being paid to charge it.

Accordingly, Rep. Oliverson asked if there are any limitations in this marketplace being discussed with regard to the individual owning the vehicle and any insurance coverage they might have not applying because the vehicle is engaged in commerce as opposed to being a personal vehicle. Mr. Wilson replied yes and Turo knows that the individual car owner's policy would not cover that type of transaction and to be safe, that is why in the model act the delivery period is included as being covered. So for the vehicle owner, it is designed to be primary and if something were to happen and there was liability on that driver or there are attorneys fees just to defend a claim, that would be primary for that individual because we know normal, personal polices would not cover that type of activity.

Asw. Maggie Carlton (NV) asked how Turo makes money. Mr. Wilson stated that there is no subscription fee and as a startup, Turo is still not a profitable company but aims to

be. There is a take-rate from the transaction as a whole and it averages at 25%. Mr. Wilson also noted that he failed to mention earlier that the vehicle owners on the platform have 100% pricing power over their car. Asw. Carlton then asked how the $1,000,000 coverage referenced earlier would work in the scenario of leaving your car at the airport, someone picking it up and taking it out to the desert and it does not survive – what is the owner's responsibility in getting the car replaced. Mr. Wilson stated that the owner's vehicle, at no extra cost, is covered up to the actual cash value (ACV) established through normal means. In terms of out of pocket costs for the driver of the vehicle, they can select difference coverage options regarding damage to the vehicle. For the owner, the car would probably be retrieved from a tow, and damage would be covered and if totaled, up to the ACV. Asw. Carlton asked if that would be a claim against the owner's personal insurance. Mr. Wilson replied no.

Asw. Ellen Spiegel (NV) stated that in NV, Air BnB's have to be licensed as businesses and asked if something like that has come up with Turo where hosts have to be licensed as businesses. Mr. Wilson stated that he is not aware of that issue arising yet. 97% of vehicle owners on the platform share one to two vehicles so licensing on that is probably not prudent from a compliance perspective and probably would not be worth the state's effort in enforcing it, but Mr. Wilson stated that maybe there is a threshold on how many vehicles or there may be a licensing structure but it is not clear what that would be.

Asw. Spiegel stated that she did not see anything in the model legislation requiring the host to warrant the condition of the vehicle or have periodic maintenance. From a consumer protection standpoint, how is that fulfilled? Mr. Wilson stated that in order to register a car in a state there is a certain protocol and some states require vehicle inspections. Mr. Wilson further stated that because every state is unique and because the cars are personal to the owners and they drive them, there is not a lot of issues with having to keep them safe, and there is also safety recall language in the model.

Rep. Bart Rowland (KY) asked Mr. Wilson to clarify that when the host puts his or her car on the platform, physical damage is primary under the Liberty Mutual policy for the host. Mr. Wilson replied it would be primary but it is provided through the Turo platform, not through Liberty Mutual. Rep. Rowland then asked Mr. Wilson to clarify that Turo has its own primary policy and then there is a Liberty Mutual coverage in addition to that if the buyer chooses to buy it. Mr. Wilson stated that the contractual agreement with Turo would only cover the ACV of the vehicle for physical damage – third party liability would always be through the Liberty Mutual policy. Rep. Rowland then asked if that applied regardless of value of the car such as with a Lamborghini. Mr. Wilson replied yes and there are limits on what a particular value of a vehicle would be on a platform for that reason alone. There are exotic cars on the platform but that would be a very expensive car to have on the platform because of the potential loss involved.

Rep. Keiser asked if at the end of the year Turo sends a 1099 to hosts. Mr. Wilson replied yes, for the federal limits – so to comply with states that are tethered to the 1099k, Turo does. And for MA and VT that have de-tethered, Turo will send whatever the state limit is for their equivalent of a 1099k.

Rep. Jordan then asked the Committee if is interested in working on a broad NCOIL p2p car sharing model law that includes taxation and other issues besides just insurance issues. Rep. Matt Lehman (IN), NCOIL Vice President, stated that when discussing this issue in Indiana, insurance started out as the biggest issue and taxation ended up being

the biggest issue. In the end, the bill punted on the tax issue and is very heavily focused on insurance. Rep. Lehman stated that if the Committee decides to go down the road of developing a p2p car sharing model law, it should include all of the issues discussed today. Rep. Jordan stated that he wanted to note that he appreciates Enterprises' concerns about not wanting to stifle innovation but wanting to ensure a level playing field. Rep. Lehman stated that Enterprise was heavily involved in discussions in Indiana and noted that one provision that was included in the Indiana bill was that local governments cannot enact ordinances to effect p2p car sharing transactions, but airport authorities can. Part of that was that Indiana did not want communities to simply ban the use of p2p car sharing but at the same time some airports are very protective of the rental car business.

Asm. Garbarino stated that there was big push at the end of session in NY for a p2p car sharing bill and it fell apart not because of the insurance issues but because of all of the other issues. Accordingly, Asm. Garbarino agreed with Rep. Lehman that if the Committee develops a model law it should encompass all issues discussed today although it would be very difficult of course to set any sort of tax rates or anything that specific.

DISCUSSION ON AUTOMOBILE INSURANCE REFORM EFFORTS

Cameron Mazaherian, EVP of Carrier Development at Gabi, stated that Gabi is an insurance agency and is a licensed personal lines independent agent in 50 states plus Washington D.C. Gabi is one of the flavors of online direct-to-consumer insurance agents. Gabi never actually sees the client or consumers but provides a platform for consumers to go online, get a quote, and complete the entire transaction without actually seeing an agent. However, Gabi has licensed agents who get involved in the process should the customer have any questions or need any points of clarification.

Mr. Mazaherian stated that one unique aspect of Gabi's business model is that it starts with the current insureds "dec" page rather than arbitrarily coming up with coverage recommendations – Gabi actually links the insureds current policy from their current carrier and does an apples to apples match. That is a way to mitigate any confusion in the process and also a way to ensure that all consumers are protected equally in terms of having adequate coverage. From thereon, consumers have the option of increasing coverage should they need to in the process. Another unique aspect of Gabi's business model is that it feels that its value proposition with the consumer is that they are engaged in a digital environment in the shopping process which has become very popular with shopping overall, and each side to the transaction is engaged in the journey. So even if a customer does not buy from Gabi initially, Gabi keeps that information should the consumer want to come back and buy at another point.

Mr. Mazaherian stated that some things make it difficult for Gabi to provide consumers with a quick, accurate rate in an online experience and it deals with the data that is required to truly underwrite an insurance policy. Credit is a big factor, as is driving history and vehicles in the household. All of those types of reports are costly and are required in the process so Gabi cannot just provide a quote based on consumer-admitted information – all the data has to be verified. Accordingly, third party data sources are involved such as Transunion, motor vehicles through LexisNexis and that all adds a cost to consumers which are not transparent and they don't really understand it. As a result, many platforms will provide estimated rates that are based on admitted

information which is then verified. So if you think about it from the consumer point of view – they get an estimated rate and don't understand what it is but later on in the process and a couple of clicks down the line they get a refined rate that has gone up because the information has been verified.

Accordingly, the challenge for Gabi in this space is that the reports are costly and there is not currently a process in which the data can be shared on a cost basis – in other words, order the report once and share it among all carriers rather than having each carrier incur costs in the process.

Richard Gibson, MAAA, FCAS, Sr. Fellow at the American Academy of Actuaries, first discussed the fundamentals of auto insurance ratemaking. At a high level they are very simple. First, the overall rate level is a function of expected cost within the insurance system. Second, expected costs are measured from the data and information gathered by insurance companies that come from premiums collected and claims paid on the policies. Third, just as important to the overall rate need, measuring the relative risk across a structured classification plan is very important to a well-functioning insurance system.

Mr. Gibson stated that as we look at the insurance system costs, two data elements are very important to actuaries: claim frequency, i.e. how often claims occur, and claim severity, i.e. what the claims really cost. Those two elements really drive the insurance ratemaking process. Industry data from 2014 to 2018, which is broken down by bodily injury, property damage, and collision, shows that the movement in claim frequency averaged in the range of a 3% decline to a 3% increase annually. Claim severity was in the range of a 3% increase up to a 7% increase on an annual basis. Claim severity is commonly an upwardly trending data element. When you combine those two, the range comes in at around a 1% increase to an 8% increase on an annual basis. In short, costs are moving up in the insurance system. At the low end of that range, the rate increase would not be substantive and at the high end, the rate increases would be larger than general inflation. The numbers cited are based on national, industry data and would vary by state and company.

Mr. Gibson then touched on the classification structure that reflects the relative risk of loss being important to a well-functioning insurance system. Basically, not everyone should have the same rate or the same rate change over time. By way of example, it would not be wise to charge the same rate for a 20 year old inexperienced driver as you would a 50 year old experienced driver. Likewise, you would not want to ignore the existence of multiple driving violations and charge the same for someone with violations as you would for someone without. These are simple examples and the classification structures have been in place for auto insurance for decades. They are evolving as big data and analytics are pushing the classification structures to the point where they are much more sophisticated using much more data than we saw perhaps ten years ago.

It is important to understand that the overall rate need that an actuary may calculate is an economic measurement of how much the average rate should change. The average rate is just a number and no insurance company customer is going to get the average rate. What then happens is that the classification system through the relative risk of loss determines how the overall rate change is spread across the entire insurance population. So even if there is a small rate increase on average or even a rate decrease there will be some customers who may well get large rate changes because of that

classification structure. Mr. Gibson stated that you are most likely to hear about the folks who got the largest increases which should not be ignored, but it does create a skewed perception of rates if all you ever hear about are the rate increases and not rate decreases.

With regard to what some of the drivers are to the costs in the insurance system, Mr. Gibson stated that insurance obviously pays for personal injuries, medical costs, lost wages, car damage repair, vehicle theft, weather related vehicle damage, and legal costs. As those underlying costs change they get reflected in the insurance rates and data via the frequency and severity of claims and they lead to the rate changes. Clearly the long term effects of inflation in medical costs, car prices, car repair prices, and weather play a role in the price of insurance in the long term.

Mr. Gibson stated that cars are getting safer and there are a lot of new safety devices and that comes with an expectation that claim frequency might go down as a result. However, just because new cars have all of these new devices, data shows that it does not make it into the registered vehicle population that quickly. The adoption rate has muted what we had hoped the benefits would be and it is simply not known how much the claim frequency will go down in the future. You also have to keep in mind that newer cars with newer technology are more expensive to repair and as those get adopted the claim severity is going to go up over time.

Mr. Gibson stated that distracted driving is something that has clearly received a lot of attention and attention diverters are not just cell phones. The National Highway Traffic Safety Administration (NHTSA) identified 3,166 deaths in 2017 attributed to distracted driving. The National Safety Council says that 25% of crashes involve cell phone use and drivers using cell phones are 4 times more likely to crash. Mr. Gibson noted that fraud has been in the news for a long time and a recent quote from North Dakota Insurance Commissioner Jon Godfread stated that fraud costs North Dakotans $950 per year in extra premiums. The North Carolina Department of Insurance has said recently that 20% of what you pay for insurance is going to fraudulent claims. The Coalition Against Insurance Fraud has stated that fraud costs $80 billion per year across all lines of insurance. Property & casualty fraud is $34 billion per year according to the Insurance Information Institute. The Insurance Research Council estimates that excess payments due to fraud represents 13% to 17% of auto insurance claims paid. Mr. Gibson stated that insurance fraud is a very difficult thing to estimate and you question whether some of those numbers are consistent with one another but it is certainly a real issue. Mr. Gibson closed by stating that there is one simple theme: insurance rates must be reflective of expected costs on an average level and across the classification structure.

Douglas Heller stated that in addition to being a Consumer Advocate and Insurance Expert at the Consumer Federation of America (CFA) he works with state consumer groups across the country and is an appointee of the CA Insurance Commissioner on the board that oversees CA's assigned risk plan. Mr. Heller stated that CFA has looked at the ways different regulatory systems impact outcomes for consumers such as a prior approval system which many states have that requires insurance companies to justify their rates and get approval from the state department of insurance before they can go into the market with those rates and plans. Then there are the most common systems – file & use and use & file which have less regulatory oversight. And then there are flex rating and deregulated markets. CFA found that those states that have a prior approval

system that require accountability before a rate or plan can go into the market have shown the best outcomes in terms of taming rate increases over time. Looking at data from 1989 – 2015, states with prior approval systems have experienced a 45% increase in auto insurance expenditures and it is about double that for the use & file and file & use systems, and worse when you get to flex rating and deregulation.

Mr. Heller stated that the same data showed that the median in the country was Virginia at about 75% and the state that has provided the best outcomes for consumers has been California at 12.5% - that is unadjusted for inflation. Mr. Heller then discussed key elements of California's system for other states to consider. First, California has a prior approval system where rates, rule and forms all have to get approval before they can go into market. Additionally, California has a strong and standardized system and formula for rate making which does not mean that California sets the rates of insurance companies or requires them to use certain kinds of classification plans but it does require that everybody abide by the same transparent formula in demonstrating that their rates are not excessive.

California also has the strongest transparency rules in the country. There are no trade secrets in the auto insurance or broader insurance market in California. If you want to do business in this state and you want to charge a rate, you have to open up your books as there are no black boxes and no hidden tiering systems that the public cannot see. That requires full disclosure and allows for accountability from other players. California also has very strong consumer participation standards which means organizations like the ones Mr. Heller represents can hire actuaries and go to the regulator and say that we looked at a certain company's rate plan and it doesn't make sense or that it costs too much money.

Mr. Heller stated that some people, including the insurance industry, have argued that all of the provisions of California's Proposition 103, which set all of this in motion in 1988 would be a hinderance to a competitive marketplace, but if you use the DOJ's standard for measuring market concentration, California has managed to become the second most competitive auto insurance market in the nation. The point is that these rigorous regulations do not inhibit competition but rather bolsters it.

Mr. Heller further stated that California's rules prioritize driving related factors in the individual premium setting, things like your driving safety record, how many miles you drive each year and how many years of driving experience you have; and that either deprioritizes or simply eliminates non-driving related factors. So in California you cannot use credit score which does not have to do with your driving safety, and by doing that it has afforded consumers a much fairer playing field in terms of the pricing of insurance. Mr. Heller then discussed fairness in the marketplace because the folks that CFA spends its time worrying about are low to moderate income folks who are required to buy auto insurance but cannot afford it in the private marketplace because of certain problems. One of they key problems that CFA sees is that premiums are often tied to personal characteristics and socioeconomic factors that have nothing to do with driving safety.

Mr. Heller then provided an example of quotes he got for a 35 year old driver who had a perfect driving record. The driver was a male lawyer with a graduate degree who owns his home, is currently insured and buys the insurance policy paid in full. He received a premium quote for a basic policy of $810. Going back to that company and saying that

such person was a female, the quote went up to $972. Going back to that company and saying that such person was a female factory worker, the quote went up to $1,014. Going back to that company and saying that such person had a high school diploma, the quote went up to $1,082. Going back to that company and saying that such person rented her home, the quote went up to $1,114. Going back to that company and saying that such person was unemployed, the quote went up to $1,188. Going back to that company and saying that such person had to pay in installments, the quote went up to $1,394. Finally, going back to that company and saying that the person took a break from driving and was uninsured, the quote went up to $1,712. Mr. Heller stated that the first example of the male lawyer could have bought two policies with money to spare compared to the last example, and in fact, when he told the company that the male lawyer had moving violations on his record he still paid more but much less than the last example of the uninsured woman. Mr. Heller stated that in many states these types of ratings are still allowed.

Mr. Heller then touched upon the role of credit score in rating and stated that the reason that, in his opinion, it has been a problem in many states is because many states adopted the NCOIL Model Act Regarding Use of Credit Information in Personal Insurance (Model) and that has been an absolute disaster for financially stressed Americans. That policy has served as the cover for insurance companies to conduct practices that result in a good driver with excellent credit in New York paying $1,400 for insurance and that same policy goes up by $250 if that good driver only has a good credit. If the credit score were to go to poor, the premium jumps by almost $1,800 per year. That is outrageous because that is a good driver who is trying to comply with the state law to buy insurance and they need that car to get to work. Mr. Heller stated that if that driver with excellent credit had been convicted of driving under the influence he will still pay less than the good driver with a perfect record but poor credit. Mr. Heller stated that is unacceptable and it is not just occurring in New York but in Texas, Indiana and pretty much every state except California, Hawaii, and Massachusetts which have outlawed the use of credit history in auto insurance pricing. Mr. Heller stated that there are other factors that are problematic which can be discussed by contacting him after the Committee's meeting.

Mr. Heller stated that another issue often discussed at CFA is that even when you have good prior approval regulations and a fair system of rating there are still going to be low income people who need cars and car insurance but cannot afford it. California therefore created a low-limits plan which is below the financial responsibility limits of the state but it qualifies you as allowing to drive legally. To be eligible for that plan you must have a good driving record and an income of 250% poverty or below. In Los Angeles, which is a very expensive insurance market, you can have an annual policy anywhere in the county for $490 and that is a supreme benefit and it costs nothing to other policyholders and the insurance industry breaks even and there are no taxpayer costs. Mr. Heller stated that in putting all of this together, state legislators should consider strong oversight of the insurance industry, fairer practices when it comes to premium setting, and recognizing that for the lowest income people in states you may need to look at dropping limits or finding an alternative product that will at least let them have some policy and some coverage when they get behind the wheel.

Sen. Bob Hackett (OH) stated that Ohio has some of the best rates and competition but noted that California has a strange rule that allows people to share driving lanes and noted that it seems very dangerous.

Asw. Hunter stated that she has a very high concentration of poverty for people of color in her district and it can be said that there is no red-lining and disproportionate rating by zip codes but that is not true. For districts like Asw. Hunter's that do not have adequate public transportation it is shameful that auto insurance rates are so high so that they essentially cannot work because it is too expensive to get to work. Asw. Hunter stated that it seems like we are getting this issue wrong and is not sure if there are adequate steps being taken to fix it.

Mr. Mazaherian stated that Gabi is an insurance agency and a distribution partner for carriers and agreed with Asw. Hunter that access to products in certain communities is limited. Gabi feels that regardless of where you are, everyone has a phone so there is no type of red-lining being conducted. Any consumer can go on-line on a phone and provide the information required to get a quote for a policy whereas some insurance companies may limit their distribution in certain areas but Gabi exposes all of its rates to anyone without any restrictions or guidelines.

Mr. Heller stated that with regard to red-lining, some people seem to think that red-lining is dissipating but CFA just conducted a study that looked at numerous cities, including Buffalo, and there was a situation that on the border of two zip codes, if you lived on one side of the street you would be in a different zip code and pay anywhere from 15% to 100% more than your neighbor right across the street in a different zip code. CFA correlated race and income and in the communities that had higher levels of minorities and lower incomes, that is where the rates were consistently higher. Redlining is not dead and that means that in addition to legislators, regulators need to be looking at these issues as there is no actuarial way that people who live right next to each other can have different risks based on their zip code alone.

ANY OTHER BUSINESS

Ms. Collins noted that at the NCOIL 2018 Annual Meeting this past December, this Committee heard introductory testimony about the issue of last-mile electronic scooters. There has been a strong surge in the activity of those scooters in the U.S. in 2018 and 2019 and NAMIC is hearing both in the news and anecdotally in the insurance industry that there is a necessity to try and address liability in the context of electronic scooters. Therefore, Ms. Collins requested that the Committee further advance its initial conversations towards addressing liability concerns with electronic scooters.

NAMIC believes that liability issues need to be addressed for not only the uses of the scooters but also the secondary piece of the business where individuals contract with the companies to take the scooters to a different location such as their home or somewhere else to charge the scooters in exchange for payment. NAMIC believes that there needs to be a commercial liability coverage to address those concerns both in the act of actually charging the scooter and in the collection and distribution of them. There has been evidence thus far where that has been a problem such as incidents of people burning down their homes while charging the scooters or people getting into accidents with the vehicles that are in the midst of collecting the scooters.

NAMIC encouraged the Committee to take this issue up as soon as possible as legislation addressing the insurance issues and the establishment of where the scooters should be regulated is moving throughout the states.

Rep. Jordan then stated that due to the decision of the Special Committee on Natural Disaster Recovery to move forward with a separate private flood insurance model law rather than continuing with amendments to the NCOIL State Flood Disaster Mitigation and Relief Model Act, said Model needs to be re-adopted or it will sunset per NCOIL bylaws.

Upon a Motion made by Rep. Keiser and seconded by Rep. Fischer, the Committee voted without opposition to readopt the Model by way of a voice vote.

ADJOURNMENT

There being no further business, the Committee adjourned at 6:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON NATURAL DISASTER RECOVERY
NEWPORT BEACH, CALIFORNIA
JULY 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Natural Disaster Recovery met at The Marriott Newport Beach Hotel on Thursday, July 11, 2019 at 1:45 p.m.

Senator Vickie Sawyer of North Carolina, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)
Rep. David Santiago (FL)
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)
Sen. Dan "Blade" Morrish (LA)
Rep. George Keiser (ND)

Other legislators present were:

Rep. Austin McCollum (AR)
Rep. Collen Burton (FL)
Rep. Richard Smith (GA)
Rep. Tammy Nichols (ID)
Rep. Martin Carbaugh (IN)
Rep. Joe Fischer (KY)
Del. Kriselda Valderrama (MD)
Sen. Paul Utke (MN)
Asw. Maggie Carlton (NV)
Sen. Bob Hackett (OH)
Rep. Lewis Moore (OK)
Rep. Ryan Mackenzie (PA)
Del. Steve Westfall (WV)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Rep. David Santiago (FL) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 15, 2019 meeting in Nashville, TN and its June 3, 2019 interim conference all minutes upon a Motion made by Rep. Edmond Jordan (LA) and seconded by Sen. Dan "Blade" Morrish (LA), NCOIL President.

CONTINUED DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL STATE FLOOD DISASTER MITIGATION AND RELIEF MODEL ACT

Senator Vickie Sawyer (NC), Chair of the Committee, thanked Senator Morrish for appointing her as Chair of this Committee and stated that she is looking forward to leading this Committee's work as it deals with such important and timely issues. Sen. Sawyer stated that she thought that last month's interim conference call meeting of this Committee was very productive and important in defining the Committee's road ahead. Sen. Sawyer further stated that after the conference call she spoke with NCOIL staff and

Representative Santiago about his private flood insurance model legislation and it was decided that going forward, the proposal will take the form of a separate NCOIL model law proposal for the Committee to consider rather than the form of amendments to the existing NCOIL State Flood Disaster and Mitigation Relief Model Act. Sen. Sawyer stated that she believes that is a better approach for two reasons. First, an issue as important and timely such as the private flood insurance market should be given the focus it deserves as a separate NCOIL Model Law as opposed to being viewed as amendments to an existing NCOIL Model Law. Second, having a separate model law is much easier and streamlined from a procedural perspective because the Committee can now avoid having to make a motion to re-adopt the existing Model every meeting and can now instead, consistent with NCOIL bylaws, move to re-adopt the model for five years. Accordingly, the existing Model will be considered by the Property & Casualty Insurance Committee for a five-year re-adoption during its meeting tomorrow, and the Executive Committee will consider that action during its meeting on Saturday.

Sen. Sawyer noted that in the next couple of weeks or so, a separate NCOIL Model Law proposal regarding the private flood insurance market will be prepared and distributed. Rep. David Santiago (FL) agreed with Sen. Sawyer's statement regarding last month's conference call being very productive and stated that the language being considered by the Committee was brought forward as a model law proposal partly because private flood insurance is getting a lot of attention nationwide. Rep. Santiago noted that the version of the proposal before the Committee is different than the original proposal and it continues to evolve. Rep. Santiago stated that he has had several conversations with industry members and other Committee members and his commitment is to figure out how to best tweak the language so that the best possible model legislation is distributed to the states with the understanding that there are always going to be different nuances among the states.

Rep. Santiago stated that as he entertains potential changes to the model language, he is looking at it from the perspective of whether the language has the best chance of being adopted by as many states as possible. The Florida private flood insurance market continues to expand and it is a good thing for everyone. Rep. Santiago noted that he has talked to consumers and seen policies where some were paying a $600-$700 annual premium in the National Flood Insurance Program (NFIP) and there are now some private companies that have been putting it on as an endorsement for as low as $100 with better coverage and with one deductible. Rep. Santiago closed by reiterating his commitment to making the model law proposal the best it can be so that as many states as possible can adopt it.

Paul Martin, Regional VP – Southwestern Region at the National Association of Mutual Insurance Companies (NAMIC), referenced the comment letter recently submitted to the Committee by the National Association of Realtors (NAR) and noted that it outlines a number of the concerns that NAMIC has. Mr. Martin noted that the decision to move forward with a stand-alone private flood insurance model law is a good one and will provide much needed flexibility. Mr. Martin stated that if a state does not currently have a model law dealing with private flood insurance that should not be discouraging as a recent report from the National Association of Insurance Commissioners (NAIC) to its Property & Casualty Insurance (C) Committee noted that from 2016 to 2018 there has been a 140% growth in the number of companies writing private flood in America which is phenomenal.

With regard to NAMIC's opposition to the proposed model law language, Mr. Martin noted that NAMIC has member companies that write private flood and is not opposed to a robust private flood market. The question is what the best path is to get there. Mr. Martin then cited some private flood premium increases from 2017 to 2018: Arkansas – 3%; Louisiana – 15%; North Carolina – 12%; North Dakota – 19%; South Carolina - 8%; Texas – 18%; Virginia – 11%. Surprisingly, there was a 6% decrease in Florida so the point is that there are a lot of states looking at private flood without a model law but that is not to say that things cannot improve.

The Honorable Jennifer Hammer, Founder/Principal of JWHammer, LLC and former Director of the Illinois Department of Insurance, stated that the flood insurance market has seen a dramatic increase in severity and frequency of events. Such events are no longer single billion but tens of billions of dollar events. Accordingly, the question is how to create a marketplace that is going to compete with the federal government rates that are subsidized and not making a profit like the private flood insurance marketplace would need. Dir. Hammer stated that we know there is capital out there whether it is sitting in reinsurance companies or in admitted carriers or surplus lines. Upon look at the draft model law language, Dir. Hammer stated that it was clear that there are some freedoms that should be included such as underwriting freedom since we know that data has changed and flood maps are outdated and inaccurate. There are things happening that insurance carriers in the private market would have access to in order to have better data to underwrite products that consumers could want. We all strive as regulators to have a consumer purchase a product at the right place and time and when you put restrictions on underwriting products you do not have the ability to have a product that is variable. When you put the minimum standard at the NFIP-level, you don't have the ability for consumers that may want a product that is not exactly like that to purchase a product like that.

Dir. Hammer stated that having the ability for insurance companies to have additional underwriting freedoms would be helpful. With regard to form freedom, regulators have current standards such as use and file and file and use, and the current draft of the model law is not addressing whether those standards apply. For instance, in Louisiana there are current standards in place where you would not have the ability to cancel or non-renew for three years and it is not clear whether that applies to the private flood market. Giving more clarity and providing more freedom for the state in those areas would be helpful.

Dir. Hammer stated that it would also be helpful to give policyholders the chance to mitigate possible damage as that would provide another opportunity for it to be more affordable in the private space. Most importantly, we know that in order to have a vital and robust insurance marketplace you have to leave ability for the Commissioners to provide the industry the ability to have a variable amount of products that have rates that are across the board and some provisions in the proposed model language to not provide for that. With regard to filing forms, Dir. Hammer stated that putting more of a burden on insurance departments that are already under-staffed and don't have the ability to get to the products they have right now and requiring them to certify that a company is meeting the NFIP standard is something that, as a former regulator, she would not be interested in and would want to see that as part of a different approval process whether its self-certification from the company or none at all.

In response to Mr. Martin's remark about the 6% decrease in premium in Florida, Rep.

Santiago stated that he believes it is a good thing because that means Florida is having more private sector market involvement and premiums are going down.

Jeff Hinesly, NFIP Program Director at Farmers Insurance Group stated that Farmers is one of the top 10 companies participating in the NFIP's Write Your Own (WYO) program, and about a year and a half ago, Farmers began allowing its agents to write private flood insurance on a brokered surplus lines basis. Farmers started with eight states on a pilot basis and as of June, expanded to all 50 states. Mr. Hinesly stated that personally, he would love to see Farmers offering a product on an admitted basis and would love to see Farmers offering flood insurance as an endorsement to a homeowners insurance policy. However, when he goes to his personal lines product team and presents his vision, they do not think it is realistic.

With regard to growing the private flood insurance market, Mr. Hinesly stated that if all that is done is moving from the public to private marketplace, that is not a bad thing. We have failed America because they biggest challenge right now is that there are not enough people insured. 80% of the homes and businesses in Houston suffering damage from Hurricane Harvey were not insured. Innovation and more product choices are needed. Mr. Hinesly stated that he does not view the proposed model law language as encouraging the private flood insurance market because what is needed for this market in its infancy is more form and underwriting freedom. Mr. Hinesly also noted that on the federal level, recognition of private flood by the FHA and VA is needed.

Mr. Hinesly noted that some might say that the surplus lines market is where experiments and growth can take place, but stated that he believes there is a chance for both of those things in the admitted market as well. We all need regulation at some point in time but as of now it is too soon, albeit well intentioned, as time is needed for the product to develop.

Dennis Burke, VP of State Relations at the Reinsurance Association of America (RAA), stated that reinsurers have the capacity and willingness to write private flood insurance for adequately priced risks. For that reason, RAA supports efforts by NCOIL and the NAIC to facilitate the development of the private flood insurance market. It is not just a matter of taking risks from the NFIP but rather about broadening the pie of risks that are transferred to the private market and spread around the world. Mr. Burke stated that RAA appreciates those opportunities and when there is a disaster, reinsurers will pay to insurers and insurers will pay to consumers and recovery will happen that much faster. There are mitigation steps to protect property so it is resilient, and there is also financial resiliency of which RAA is a part of. RAA welcomes the opportunity to see growth in this market. Mr. Burke stated that one of the things to be aware of when looking towards developing a model law is that this will not be the last time we have to visit this issue. The market is changing and we need to have opportunities for insurance to change as states are laboratories of democracy.

Mr. Burke noted that in order to write, reinsurers must have insurance clients who are willing to write, and insurers need agents who are willing to place business with them. Mr. Burke encouraged the Committee to listen to the concerns that the insurers and agents are raising as it is important that a model law passed out of the Committee be one that does in fact facilitate the private flood insurance market.

Lisa Miller, President & CEO of Lisa Miller & Associates stated that with regard to the

comments made surrounding form freedom, Ms. Miller noted that while attending the National Flood Insurance Conference in Washington D.C. she heard from bankers the angst they have with private flood insurance. If banks ultimately do not accept the product, it does no one any good and that is the reason behind the form approach in the draft model legislation. Ms. Miller also noted that the draft model legislation uses the word “may” when discussing prior form approval so it will be up to the state adopting the model whether or not to make that a requirement. Similarly, the Insurance Commissioner certification language is permissive and Ms. Miller noted that she has had insurers say to her that they want the Commissioner to certify their product so that they can use it in their marketing materials.

Nick Lamparelli, co-founder and Chief Underwriting Officer at reThought Insurance, stated that he spends most of his time trying to place coverage for catastrophic risks, specifically flood. As an MGA he has direct experience with how the process is working and not working. In other industries, the creation of novel and innovative products requires the ability of the manufacturer to quickly deliver some minimal version of that hypothetical solution to the market and then be able to assess feedback as to whether the solution begins to satisfy the customer demand. This product-market fit often takes multiple rounds of product delivery and feedback just to evaluate the viability of whether it is going to work. In the insurance space there is only one tool in the toolbox to provide this flexible approach which is the excess and surplus (E&S) lines offerings. In order to have a health admitted market where carriers are able to offer novel and innovative risk transfer solutions for catastrophic and non-catastrophic exposures a healthy E&S market is vital as a sandbox to test risky solutions without the additional risk and burden of the admitted regulations.

Mr. Lamparelli stated that legislators and regulators would be doing the market a service by thinking of the E&S space as a laboratory for both market solutions and potential reregulation in terms of looking at the admitted space and seeing what can be changed to make it function better and have the novel approaches that are occurring in the E&S space more adaptable in the admitted space. If it is the goal of this group in this space to increase take-up coverage to reduce the protection gap and raise resiliency of property owners, the model legislation being debated will go a long way towards making that happen. Mr. Lamparelli stated that in both football and flood insurance, inches matter, which means the traditional admitted rate filing process would be equivalent to fitting a square peg into a round hole. It is not the proper mechanism to assure proper pricing in flooding. Mr. Lamparelli stated that the threshold and the standard should be raised for how agents and policyholders are communicating with one another. It is by no means a burden to have agents communicating the flood risk or any potential risk to potential property owners – it is the right thing to do.

John Ashenfelter, Associate General Counsel at State Farm Insurance Company, stated that he appreciated the fact that this issue will now take the form of a stand alone model law given the magnitude that it presents for the public and legislatures. Mr. Ashenfelter stated that the federal government faced a $20 billion dollar deficit from two catastrophic flooding events. That amount of money is not something that an insurance company could step in and cover with ease. It is for that reason that NAMIC and others have testified to the importance of rating, form, and underwriting freedom and the incredible responsibility for mitigation because over $20 billion dollars for two separate storms is too much if you cannot price it, underwrite it, and provide the form with the right amount of coverage to ensure there are not insolvencies.

Mr. Ashenfelter stated that the big difference between the surplus lines and admitted lines is that the surplus lines do not enter into the guaranty fund. If this type of business is placed in the admitted market and the aforementioned catastrophic events occur, that will put several homeowners insurers “under water” through a guaranty fund situation and you are going to have the fallout on the guaranty fund assessments. That is why it is important to take caution and be smart about this and be sure that underwriting, rating, and form freedom along with mitigation are enabled. Mr. Ashenfelter stated that when Biggert-Waters passed there was a great uproar about increases in flood rates and Congress ended up reversing field as it did not mean to cause the increase as it could not afford to do that in the state sandbox.

Wes Bissett, Senior Counsel – Gov’t Affairs, at the Independent Insurance Agents & Brokers of America (IIABA), stated that IIABA shares the Committee’s excitement about private flood insurance but would oppose the model legislation in its current form. IIABA is one of the strongest proponents of expanding the private flood insurance market as agents enjoy having more insurance products and options to sell. IIABA was also the only industry group that was invited to testify at a hearing before the House Financial Services Committee several months ago on private flood insurance. Accordingly, it would be ironic and unfortunate for IIABA to oppose a proposal designed to foster private flood insurance.

Mr. Bissett stated that the source of IIABA’s concern is current Section 4 of Part V which would impose a series of subjective and vague requirements on agents which are undoubtedly well-intentioned but really have nothing to do with fostering and promoting private flood insurance. That section would require agents to explain how the NFIP and private flood markets work, and even explain the rate-making process which is something that is not easily done in a quick conversation with a client. The section also requires agents to produce evidence that they accomplished that explanation. Mr. Bissett stated that those type of requirements are notably not in the Florida private flood insurance statute which the model language is based off of. IIABA is also not aware of any sort of analogous provision elsewhere in state law. IIABA believes that the requirements raise some practical concerns such as how to subjectively explain the NFIP and how it can be accomplished in an on-line innovative insurance marketplace.

Further, what if there are no viable alternatives besides the NFIP, of if there are bad alternatives – is the agent in a position where they must force those on a client when they might not be appropriate? Mr. Bissett urged the Committee to remove Section 4 of Part V and not dampen the enthusiasm of the agent community for supporting private flood insurance as the agent community wants to be in a position where it can support any effort, legislative or otherwise, to foster the private flood insurance market.

Rep. Matt Lehman (IN), NCOIL Vice President, questioned whether the biggest hurdle in developing private flood insurance model legislation is the federal government because it sounds like they need to either get out of the way as they have done with other things or be a partner with the states but on a different level than how they are currently. Rep. Lehman stated that flood insurance has the perfect model for government intervention – the Terrorism Risk Insurance Act (TRIA). If you look at the largest claims in U.S. history, it is not weather but rather 9/11 which was a $2 trillion dollar loss and the industry said it could never cover that type of exposure again. Accordingly, the federal government stepped in and said it will put a cap on what the industry has to cover and then cover the rest. Now, every carrier offers terrorism insurance because of that backstop and the risk

can be calculated. Rep. Lehman questioned why flood insurance does not follow a similar model and stated that the NFIP wouldn't be in so much debt if it was not the primary carrier. The insurance industry is great and will adapt given the opportunity but thus far said opportunity has not been given to it.

With regards to the model legislation, Rep. Lehman stated that he agreed with Mr. Bissett's concerns regarding the agent requirements, and asked if the states are doing anything to actively communicate to the federal government that it should either help the states solve the problem or let the states handle it because at the end of the day the industry will figure it out.

Ms. Miller stated that the concept presented to the NFIP is that it become a residual market just like how Citizens Property Insurance functions in Florida. For the past 10 years, the residual market has shrunk and the private market has grown. Ms. Miller suggested staring to "plant the seed" on this issue when talking with federal officials.

Mr. Burke noted that the NFIP is not just an insurance program – it is partly a social and risk management program. Accordingly, under the model legislation it would be difficult for an agent to explain the NFIP. The thing that would facilitate the private flood insurance market the most would be to remove impediments to said market, the primary impediment being the ability to go in and out of the NFIP without losing discounts. Some of the carriers currently writing private flood insurance are smaller carriers such as in Florida. If they lose their reinsurance they could change their underwriting standards and if that happens and someone has to go back to the NFIP without their discounts they might have to go back at full risk rate and that is a problem for agents, carriers, reinsurers and consumers.

Mr. Burke further noted that the TRIA analogy made by Rep. Lehman is not a good analogy because in addition to creating the government behind the industry, TRIA also caps the actual liability of the insurance industry. The maximum loss that can be covered under a terrorist event that is subject to TRIA is $100 billion dollars so if there is a $200 billion dollar event, the industry covers $100 billion dollars and the people that bought insurance are out of luck for the other $100 billion. The private insurance market has an obligation to pay the amount it said it would pay and it has a good track record in doing that.

Sen. Dan "Blade" Morrish (LA), NCOIL President, stated that it sounds like the panel is saying that the private flood insurance industry has the ability to figure this out and can do so as long as there is no consumer protection. Sen. Morrish stated that he believes Rep. Santiago's draft model contains consumer protections along with the ability to write the insurance. Sen. Morrish asked where the middle ground was for the industry to offer coverage at a rate that is better than an NFIP rate while also offering consumer protections.

Mr. Ashenfelter stated that the NFIP will always be more than a residual market because it has subsidized inadequate rates. That may be hard for NFIP policyholders to accept but it is the reality. The federal government has offered to the private market all sorts of claims loss experience over 30 years which is helpful and may help create models that will not have to go through a rigorous approval process as long as it is using credible data. It is imperative to match the price to the risk and if you cannot do so and have a profit margin then private insurers will not enter into the market. And if you tell those

insurers that if they are on a certain risk for three years then they are on it forever, and an event like Hurricane Katrina or Sandy occurs and you expect them to stay on that risk, that will not encourage them to come into the market. That is the harsh reality, in addition to the reality that perhaps some people should move off the coast away from the risk but they cannot do so because their livelihood is on the coast.

Dir. Hammer stated that the entire job of an Insurance Commissioner is to balance consumer education and protection with creating a vital and robust insurance marketplace. You provide consumer education and protection by providing rates that consumers can afford. When you encourage a competitive marketplace and getting consumers the right product at the right place and right time you are simultaneously providing education and protection. Dir. Hammer stated that the products are also becoming more complex which is why it is important to have agents discuss and explain the products with consumers but it is also important to not stifle innovation before it has a chance to get off the ground, especially for consumers who are not required to purchase flood insurance. You want to embrace and encourage a marketplace whereby if an insurer wants to offer parametric flood insurance then they should be able to do so. Innovation should not be stifled before it has the chance to develop. Some of the consumer education and protection should be left to the insurance departments whose entire mission is to protect and educate consumers.

Rep. Santiago stated that he believes Mr. Ashenfelter actually made the case for why the model legislation is needed because when talking about credible data, the proposed model doesn't require the rating methodologies to be approved but does require insurers to retain it for two years after the effective date of a rate change and the Insurance Commissioner can review if she or he chooses. The goal of the model is to create an admitted market so a message can be sent to consumers that some form of government has looked at the product to ensure that it has met the minimum standard of the NFIP coverage. That is strong for the consumer and strong for mortgages.

Rep. Santiago stated that the concerns from the agent community are valid as he does not want to create some sort of pitfall for agents as they already have a fiduciary responsibility due to the fact that they are licensed. Rep. Santiago committed to working with the agent community on the model legislation. Rep. Santiago also noted that the proposed model does not require the Insurance Commissioner to approve rate filings. Rather, the model allows the free marketplace to move wherever it wants. It is also important to note that in Florida, the majority of the expanded private flood insurance market is being backed by reinsurance. The consumer expects that if state legislators are going to endorse something by having it admitted then it meets some minimum standard. The E&S market is where innovation and experiments can take place and depending on how they develop, can be adopted in the admitted market. Rep. Santiago closed by stating that the minimum standard requirement is important for consumers, and that he is open to suggested changes to the model before the Committee meets again in December.

DISCUSSION ON THE FALLOUT FROM THE CALIFORNIA WILDFIRES

Karen Reimus, Outreach Coordinator in the Roadmap to Recovery Program at United Policyholders stated that in 2003 she and her husband lost their home in the Cedar Fire. They purchased the house four months before the fire and had bought a brand new insurance policy and extended replacement cost policy, in addition to an earthquake

rider because they wanted to make sure they were extra-covered. However, after the fire it soon became clear that they and many of their friends and neighbors were facing significant insurance recovery issues. Six months later, then CA Insurance Commissioner John Garamendi came to their community and in a townhall asked, among other things, how many people were underinsured.

Ms. Reimus stated that she could never imagine that with a brand new policy from one of the nation's leading insurers that she would be underinsured. One of the biggest problems that disaster survivors face that causes economic problems are the painstaking and re-traumatizing insurance recovery processes. As an example, Ms. Reimus referenced the personal inventory document she had to complete for her children's bathroom. Disaster survivors should not be spending hours upon hours creating lists like that, especially when in the case of a disaster people often flee their homes with no time to spare. That time could be better served navigating the dwelling portion of their claim so that they can re-build in a timely fashion and get back into the community.

Ms. Reimus stated that some of the most common problems associated with disaster survivors are underinsurance, low-balling, and non-responsive adjusters. Ms. Reimus noted that after working 15 natural disaster recovery efforts for United Policyholders these types of problems occur again and again. It is also important to note that communities and economies suffer when disaster recoveries are slow. Local tax revenue also decreases because disaster survivors commonly have their property reassessed and the reassessed value is lower without the home on the land. The longer it takes to re-build, the longer people are forced to live in another community and spend their money there, thereby hurting local businesses. There is also a risk of job loss for disaster survivors as going through the recovery process was like having another fulltime job. Families also lose during disaster recovery efforts as many marriages often dissolve due to the stress from trying to obtain the insurance money needed to re-build.

Ms. Reimus noted that there has been progress made and cited some legislation that has been passed in California for other states to consider. "Re-build or buy" allows disaster survivors to use their dwelling benefits to rebuild or purchase a replacement home at a different location. That is great for everyone, particularly for seniors who may not want to spend several years navigating the disaster recovery process. Another option is to extend time to collect additional living expense (ALE) and full replacement cost when loss occurs in a natural disaster. It is best if losses are paid for by insurance funds but sometimes when there is a demand surge for building supplies and labor it takes more than a year and that is not the fault of the disaster survivor and they need to be able to access their benefits for as long as possible to ensure that they can use those benefits that they paid for.

Another option is to require insurers to provide a complete copy of the insurance policy to the insured within 30 calendar days of receipt of request from the insured. Furthermore, states can allow one insurance policy renewal after a declared disaster which recognizes the challenges disaster survivors face in obtaining new coverage for a property that is in the middle of an existing claim. States can also consider requiring insurers to provide a list of items covered by ALE upon request which lessens the need for publicly funded assistance. Ms. Reimus stated that certain legislative fixes are still needed: underinsurance is still a huge problem; the earlier mentioned personal property

inventory form use is burdensome and not an appropriate use of resources; and lowballing needs to be addressed.

Brad Roeber, Executive Director of the California Insurance Guarantee Association (CIGA) stated that he took over as Executive Director of CIGA in September and on November 8 the campfire began to burn. Shortly thereafter CIGA began to receive coordination phone calls from the CA conservation and liquidation officer (CLO) which is CIGA's receiver. It became clear that there would be a problem with some carriers and it ended up being Merced Property & Casualty Insurance Co (Merced), which is a small central CA company that had been in business since 1906. The company had less than 200 homes insured in Butte County. The camp fire was focused on two small communities – Paradise and Magalia – totaling about 40,000 people. Virtually 75-80% of the homes were totally destroyed as a result of the fire.

Mr. Roeber stated that on December 3 Merced was declared insolvent. Through good pre-planning and work with the CLO, CIGA was prepared. After data exchanges, CIGA started issuing checks on December 7. It was a tremendous example of transfer of responsibility and really is what the guaranty funds exist to do and why admitted carriers and members of the funds get assessed – so that the funds can be there to provide something for the people that have nowhere else to go. Mr. Roeber noted that CIGA partnered with then CA Insurance Cmsr. Dave Jones to eliminate the inventory requirement and make upfront offers of 80% of the dwelling limits without inventory. If people stated that they don't want to rebuild and could not face going back, they were cashed out. CIGA took on about 200 claims in Paradise and as of today about ¾ are completely closed.

Mr. Roeber stated that he knows many carriers have done similar things. Mr. Roeber stressed the importance and capability of guaranty funds. To put in context, Paradise has a population of about 40,000 people and the insured losses totaled around $20 billion dollars. Mr. Roeber stated that he is proud as the leader of CIGA to highlight the great work it did in helping people throughout this difficult process.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NEWPORT BEACH, CALIFORNIA
JULY 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Marriott Newport Beach Hotel on Thursday, July 11, 2019 at 10:15 a.m.

Assemblywoman Maggie Carlton of Nevada, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)
Sen. Jerry Klein (ND)
Rep. Lewis Moore (OK)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Colleen Burton (FL)
Rep. Tammy Nichols (ID)
Rep. Deanna Frazier (KY)
Sen. Dan "Blade" Morrish (LA)
Sen. Brian Feldman (MD)
Del. Kriselda Valderrama (MD)
Rep. Michael Webber (MI)
Sen. Shaen Vedaa (ND)
Asw. Ellen Spiegel (NV)
Sen. Bob Hackett (OH)
Rep. Chris Sneed (OK)
Rep. Ryan Mackenzie (PA)
Rep. Wendi Thomas (PA)
Del. Lamont Bagby (VA)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Rep. Lewis Moore (OK) to waive the quorum requirement, the Committee unanimously approved the minutes of its March 16, 2019 meeting in Nashville, TN upon a Motion made by Sen. Jerry Klein (ND) and seconded by Rep. David Santiago (FL).

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL ACT

Rep. Matt Lehman (IN), NCOIL Vice President and sponsor of the NCOIL Workers' Compensation Drug Formulary Model Act (Model), stated that the Model was first introduced at the NCOIL Spring Meeting in Nashville a few months ago and is based off

of Indiana SB 369 which Rep. Lehman sponsored and was signed into law last year. During that process in Indiana, Rep. Lehman stated that they were looking for a way within the workers' compensation system to address the opioid crisis and lower prescription drug costs. Rep. Lehman stated that in the new draft of the Model he took some language from the legislation that had passed in California and was introduced in Pennsylvania and incorporated it into the Model. There will be some additional changes before adoption and it may be best to have an interim conference call meeting of the Committee before it meets at the NCOIL Annual Meeting in December so that the Committee could adopt the Model on the conference call and have the Executive Committee adopt it in December. Rep. Lehman noted that part of the problem with having the national meeting in December is that some states have deadlines around that time in which legislation must be filed. Accordingly, it is important to have something for states to see before that.

Stacy Jones, Senior Research Associate at the California Workers' Compensation Institute (CWCI), stated that the legislative intent for the California workers' compensation drug formulary was to improve the quality of care, limit over-prescribing of highly-addictive opioids, and control prescription drug costs. Some basic provisions of the legislation require prescribed drugs to be in accordance with the medical treatment utilization schedule (MTUS) which is the American College of Occupational and Environmental Medicine (ACOEM) guidelines which is basically the foundation of the formulary and how drugs are treated in the formulary.

The legislation applies to all dispensed drugs with the exception of non-exempt or unlisted drugs which means that if there is a chronic use of a drug for an injured worker they are not cutoff automatically pursuant to formulary rules. The legislation provides for special fill and perioperative fill which means that during the immediate days after an acute injury fills can occur. The legislation requires medical necessity for brand name drugs so a physician wanting a brand name drug must provide medical necessity on why that branded drug is needed as opposed to a generic. The legislation limits physician dispensing which is primarily where the medical cost comes into more control as there are very specific limitations on when a physician can dispense drugs out of their office. The legislation requires prior authorization for all compounded drugs which is another cost control mechanism. The legislation also requires the establishment of a pharmacy & therapeutics (P&T) committee that will advise the division of workers' compensation on formulary changes. The formulary went live in January 2018.

Ms. Jones stated that CWCI conducted a study in March 2019 measuring the trends of prescriptions and associated payments. The study identified the leading drugs in the formulary, and measured the utilization review (UR) and independent medical review (IMR) volumes and decisions which is basically the dispute resolution process in CA. With regard to the percent of prescriptions by formulary category, there are exempt drugs, non-exempt drugs - which require prior authorization - and drugs not specifically listed - which also require prior authorization. The CWCI study looked at data from 2016, 2017 and 2018 which is based on paid prescriptions during that time period and the data shows an increase in the percentage of exempt drugs, a decrease in nonexempt drugs – which is what the formulary intended to do – and an increase in not-listed drugs which consists largely of legacy claims.

Ms. Jones stated that with regard to the percent of payments by formulary category, the study showed similar trends: a decrease in exempt drugs; a decrease in non-exempt

drugs; and a large increase in not-listed drugs. If you look at the list of the top ten exempt drugs you can see the reason why there has been a decrease in the payments associated with an increase in utilization as the list consists of basic, generic drugs such as Ibuprofen, Naproxen and Omerprazole. Most of the list consists of nonsteroidal anti-inflammatory drugs (NSAIDs) so there has been a replacement of opioids with NSAIDs primarily. Unfortunately, omeprazole is on the list which is used to treat the side effects of NSAIDs, but it was also used to treat the side effects of opioids so the usage is not expected to decrease much going forward.

Ms. Jones stated that when looking at the list of the top ten non-exempt drugs you see generic Vicodin leading the pack but it is being decreased. You also see an increase in anticonvulsants which are used to treat neuropathic pain so those are increasing as we see the use of opioids decreasing. When looking at the list of the top ten not-listed drugs, the leader is zolpidem which is basically a sleep-aid. Also listed are drugs that are drugs that in a lot of jurisdictions are not probably seen in workers' compensation data but they are compensable for things such as heart disease so that is why they are listed.

With regard to special fills and perioperative fills, special fills are drugs that are primarily opioids that a physician can provide even though it is a non-exempt drug during the initial stage of an acute injury. There is a limitation on both the number of days that they can fill and when they can fill it. The CWCI study shows that special fills represent a very small portion of the overall pharmaceutical utilization. For perioperative fills, those are fills within a certain number of days after a surgery without prior authorization – mostly opioids. Those fills also represent a very small number of the overall medications prescribed and dispensed.

Ms. Jones stated that when looking at the dispute resolution process, the CWCI study looked at how pharmaceuticals are approved, modified, or denied during the UR and IMR process. The study looked at the incremental decisions by formulary category following both UR and IMR. For the UR process – the initial process after a physician requests a certain drug for the treatment of the individual – the study shows that there is a pretty high approval rate and there is not a huge change from 2017 to 2018. There is a small decrease in the approval rate for the non-exempt drugs and there is stability in the not-listed drugs. Looking at the denials and modifications after UR, a modification could be a change in the number of refills from what was requested or a change in the quantity of the drug requested. The study shows that for exempt drugs there is a very low modify rate, a slight increase for non-exempt drugs, and non-listed drugs essentially stayed the same.

Ms. Jones stated that the referral of UR denials and modifications go to IMR so if a physician or the applicant's injured worker's attorney requests that the modification or denial in UR be appealed it goes to IMR. Ms. Jones stated that the study doesn't show a huge change but there is a decrease in those going from UR to IMR which is a good sign if that continues because it will help mitigate some of the conflict resolution costs that are out there in CA. Ms. Jones stated that when looking at the percentage of UR denials and modifications referred to IMR as a proportion of all pharmaceuticals, it is a very small number. It looks like a large number when you look at the raw numbers that go to IMR but overall, it is a very small proportion.

Ms. Jones stated that when the denials and modifications go to IMR, the study shows

that there is a pretty high uphold rate which means that the IMR physician agrees with what the UR physician said with regard to whether or not the drug was medically necessary for the individual. The study does not show a huge change from 2016 to 2018, the biggest drop being a small decrease in the percentage of non-exempt drugs being upheld. Ms. Jones stated that when looking at how often pharmacy is approved, modified, and denied, the study shows that the approves after UR are roughly 95% for exempt drugs before and after the formulary; a decrease in the non-exempt drugs; and a slightly smaller decrease in the not-listed drugs. Looking at the approvals after IMR, the study shows a pretty high approval rate for the medication for non-exempt drugs which are the drugs with ingredients that are specified in the formulary as not exempt under the ACOEM guidelines that are underlying the formulary.

In summary, Ms. Jones stated that the study shows a greater utilization of NSAIDs; lower utilization of opioids; an increased utilization of exempt and not-listed drugs; a high degree of volume of agreement across the dispute resolution chain; and the P&T committee is working to develop other aspects of the formulary that hopefully will contain some of the costs and utilization patterns.

Christine Baker & Len Welsh of Baker & Welsh, LLC delivered a joint presentation. Ms. Baker noted that under the leadership of former CA Governor Jerry Brown, she spearheaded CA workers' compensation reforms. A series of bills took effect in CA to improve medical care delivery, remove waste, friction and fraud, and use the savings to increase benefits for employees and reduce workers' compensation rates for employees. It was a win-win. The formulary was part of the reform legislation enacted which occurred from 2012 to 2016. Ms. Baker stated that the reforms were accomplished by way of labor and management getting together which was a beautiful integration of interests aiming towards improving healthcare quality and delivery; using evidence-based guidelines for presumptive first-level treatment decisions; establishing protocol – a hierarchy of decision making – for escalating to other treatment regimens based on individual circumstances; reducing over-care, i.e. by calling for less invasive, evidence-based care first before surgery is decided upon; and eliminating litigation over issues that belong to the healthcare experts, not lawyers and judges.

Ms. Baker stated that the foundation for the reforms was standardized reference material for first level, evidence-based treatment; a drug formulary fully integrated with treatment parameters; and most importantly, securing trust in the efficacy and integrity of guidelines for medical treatment, which fundamentally depends on addressing the use of drugs as part of treatment. Mr. Welsh stated that formulary issues should be considered in light of how much they can benefit from being integrated into medical treatment guidelines. That is the lesson that CA teaches. Some principles that guided the development of the guidelines and the formulary concepts were: a.) evidence-based; b.) peer-reviewed and nationally recognized; c.) address the full range of tests and therapies commonly utilized particularly for injuries of spine, arm and leg; d.) reviewed or updated at least every three years; e.) developed by a multidisciplinary clinical team; and f.) cost less than $500 per individual user to subscribe. Those were the principles that were used in the study to select what would be the best model to use.

In conducting the study, Rand Corporation pretty much landed on ACOEM guidelines which far and away seemed to model more of the characteristics that CA wanted to see in an evidence based model. There were some statements made about the need for improvements and ACOEM pretty much jumped on those so then CA basically selected

ACOEM. First, it was a slow process as they had to build it from scratch so they went through the process of selecting the best guideline model out there for medical treatment and the next step was to come up with a formulary and integrate that into the guideline model. Mr. Welsh stated that looking at the ACOEM guidelines and what they do for the practitioner, they provide the clinician with a completely analytical framework for what the practitioner is dealing with both in selecting and rejecting a treatment. They provide a first-level default to what you would want to use to treat the patient with a certain condition. They speed up the process and in fact there is now a digital interface that allows you to essentially instantaneously search for the treatments that match up with the condition. The point is that you want to do this rapidly, efficiently, and easily and you want the worker to be getting what is believed to be the best state of the art treatment as indicated by medical evidence. Last but not least, there has to be a drug treatment model as part of it so you cant really leave treatment decisions out of consideration of the drugs that may accompany those decisions.

With regard to how CA selected the formulary, Ms. Baker stated that they were very evidence based in making policy in CA. The RAND study evaluated five distinct formularies: data from Washington state Department of Labor and industries; the Reed Group ACOEM; the work loss data from ODG; the Ohio Bureau of Workers' Compensation; and the Department of Health Services. Ms. Baker stated that they were open to determining what would work best in CA and a key item in that formulary was integrating the formulary to the guidelines. Ms. Baker stated that they established by evidence based criteria as rigorous as those criteria underpinning the MTUS. They facilitated the provision of appropriate medical care to the injured worker by providing a list of the most effective medications, which not only benefits the patient but also minimizes unnecessary disputes and associated medical costs. They really wanted a flow of drugs to move through that were safe and as long as they were linked to the treatment guidelines, they knew that that care could be provided with a presumption of care and could flow easily without delays or interruption of care. They fully integrated with MTUS so that drug prescription, too often a separate consideration, is fully a part of the overall medical treatment plan for the patient – that sped up the delivery of care.

Mr. Welsh stated that the point is integration and evidence based. Regular state of the art updates are critical and in CA there is a special committee created by statute to do that. The formulary also needs to be easily understood and used by the treating physician and select the drugs that are most effective when treating a condition or trying to address an injured worker. Mr. Welsh stated that it is great to have a model that works and CA has gone well down the pathway of making the model work but there are some cultural problems, among others, in that the idea of adhering to guidelines whether in medical treatment or drug treatment decisions is not a concept that all practitioners subscribe to. Some feel that when you adopt a guideline model that it is limiting their discretion and there is perhaps a perception that practitioners are going to be limited in their choices or the guidelines are actually going to get in their way.

Mr. Welsh stated that he and others believe that once they understand what the guidelines do and how easy it is to access the information they provide then they are going to see that they will actually help their practice, not hinder it. But people have their way of doing things and you have to address where they are and take the time to help them understand how they can improve their own practices. It is also not just a matter of the medical practitioner but also claims adjusters. In CA, claims adjusters don't have access to the guidelines and formulary by law – the physicians and most nurses do.

Granting claims adjusters access to the guidelines and formulary is something that is being considered in CA. Mr. Welsh stated that he and others believe that the more broad range of access there is to the treatment model, the more people are going to adopt it and utilize it. You do need to have the claims adjuster understanding what the physician is doing as the physician makes his or her choice. The guidelines help smooth that process. Mr. Welsh stated that there has been a lot of work done in CA to plow this new ground and there has been a lot of success so far. The figure is almost $2 billion dollars per year in frictional costs that has been chopped out of the system since these reforms began in 2012 and that has been documented by the CA Bureau of Workers' Compensation. It is believed that medical care is improving and that anybody that is considering a national model should be looking as much as they can at what has worked and has not around the nation.

Daniel Blaney-Koen, Senior Legislative Attorney at the American Medical Association Advocacy Center (AMA), stated that controlling costs and ensuring the right treatment at the right time are two of the primary issues he will address during his remarks. The AMA wants to ensure that overall, the formulary provides sufficient information to the physician and other healthcare professionals at the point of care, and also ensure sufficient choices in the treatment decision. A decision on whether or not to prescribe a medication is integral to the overall treatment plan. Also, if a medication is not exempt then there should be a clear, transparent and efficient appeals process to be able to adjudicate whether or not the patient ultimately receives that treatment.

Mr. Blaney-Koen stated that the claims review process should also be between healthcare professionals and ideally, the AMA supports that it be between physicians of the same specialty in the same practice to be able to have conversation with equal expertise. For example, if a physician's judgment is to prescribe a medication for a muscular skeletal pain, the person on the other end of the phone call should also understand the treatment for muscular skeletal pain – two orthopedic surgeons for example. With regard to the Model, Mr. Blaney-Koen stated that there is a need for state flexibility and physician and other healthcare professional input. While a national formulary might be a starting point for some, the AMA believes that a formulary really needs to take into account state-specific needs. Moreover, it should be developed with input from physicians and other healthcare professionals, pharmacists, and others who are treating patients in that state. The workers' compensation agency developing the formulary should have the benefit of the expertise and deliberative process from a P&T committee that is well established. That P&T committee should also be free of conflict – free of conflict, for example, from the pharmaceutical, PBM and health insurer industry as it is important to make sure P&C committee decisions for the formulary have the benefit of ensuring not just the direct potential conflicts of interest but even the perception of conflicts of interest to make sure that those decisions of what medications are in a formulary are truly decided on the benefits of medical treatment.

Mr. Blaney-Koen stated that the formulary should be transparent. In many states it is probably the exception rather than the rule that the physician and other healthcare professionals have information about what is the exempt and non-exempt information in a formulary at the point of care. If they have that information then the appeals process would probably be greatly reduced, so to the extent that efforts – whether regulatory or statutory – can further that information being available at the point of care, that would benefit everybody and reduce the cost of the appeals process and the IMR process. If 80% to 90% of those decisions are upheld in CA then if the physician knows at the point

of care perhaps that is an opportunity for the physician to provide the exempt medication at the beginning.

Regarding cost, Mr. Blaney-Koen stated that we know that much has been made in the news and elsewhere about the opioid epidemic and the workers' compensation industry has particular interest in ensuring increased access to non-opioid and nonpharmacologic pain care. Nationally, there has been a 33% reduction in opioid prescriptions from between 2013 and 2018, and there was a 12.5% decrease just between 2017 and 2018. It is heartening to see that in CA there are many non-opioid options on the formulary. It is known that the use of restrictions and arbitrary thresholds is something that a lot of workers' compensation agencies and states have adopted but the AMA would ask a different question – whether or not those restrictions have led to increases in access to non-opioid pain care and other types of benefits. If the formulary does not have those then the formulary needs further revision to make sure that those options are available.

Mr. Blaney-Koen stated that the AMA understands that formularies are a tool to reduce cost but the pharmaceutical benefit needs to be integrated into the overall treatment plan. The use of guidelines such as ACOEM or other guidelines that are put forward by the medical industry is encouraged by the AMA. Mr. Blaney-Koen stated that his remarks are general principles and reform ideas for the Model and the AMA thinks that there are several revisions that could help the Model take advantage of programs that appear to be working not only in CA but elsewhere. The AMA would be happy to provide specific revisions to the Model in the interim period between now and the Committee's next meeting.

Mitch Steiger, Legislative Advocate at the California Labor Federation (CLF), first thanked the Committee for its work in fully discussing and analyzing proposals such as the Model as it is important to do so before it is sent to states for consideration. Having been in the labor movement for 20 years, Mr. Steiger stated that he has seen its thoughts on healthcare in general and prescription drugs specifically really shift. Before the Affordable Care Act (ACA), the focus was on employers not spending enough on healthcare and treatment and over time after the ACA took effect and the opioid crisis started the labor movement did a 180 and you will now not find many labor advocates stating that we don't spend enough on healthcare whether its group health or workers' compensation.

Mr. Steiger stated that when the issue of a formulary in CA showed up around 2014 the labor movement was generally open to it as the opioid crisis had been ravaging its membership for a long time and the labor movement saw it up close and personal when the CA workers' compensation reforms started in 2012 by speaking personally to a lot of the workers who stated that opioids ruined their lives and presented a lot of problems that a formulary seemed to provide a lot of solutions to. Accordingly, the labor movement was definitely open to the idea but at the same time it was not exactly something that its members were clamoring for as phone calls were not being received with requests to limit treatment options. The labor movement, therefore, went into it optimistically but cautiously with the goal of ensuring that some broad concepts were in the legislation that would guide the specific regulatory process.

Mr. Steiger then reviewed the four big concepts. The first was to not eliminate access to medically necessary pain management. Realizing a big goal of the formulary was to deal with opioid over-prescription it was important to make sure that it not be too abrupt

in cutting workers off or making it too hard for them to get treatment. That is really where most of the labor movement's problems with the workers' compensation system happened was when workers could not get the medically necessary treatment that they need so it was important to ensure that the formulary did not make that problem worse. By the same token, it was important to make sure that workers who were on a drug that was allowed under the old system and may not be allowed under the formulary that there was a gradual tapering and not a shift to a new drug.

Third was to protect off label use that a lot of the workers spoken to, especially those with complex claims such as back pain that didn't respond to the guidelines and MTUS, stated that a lot of the time the only thing that worked was something "weird" such as Botox injections in their back which at the time was unheard of but a lot of workers found benefit from that. Therefore, it was important to make sure the formulary did not cut off access to that type of treatment when it was the only thing that worked for an injured worker. Fourth, it was important to make sure that the formulary was updated in a timely fashion so that as new drugs came on the market, especially those that offer a lot of benefit to a lot of workers, that that would still be something that would be on the formulary as soon as reasonably possible so that workers could benefit from that.

Mr. Steiger stated that when the regulatory process started one of the goals that the labor movement wanted to focus on was to learn from the experience of workers in other states. A lot of research was conducted by talking to workers in Washington state, Texas, and some of the other states with formularies to see what their experience was. No one really had a negative experience to relay which was encouraging and helped ease some concerns about what it would be like to live in a world with a formulary.

Mr. Steiger stated that one issue that he would highlight for anyone considering moving in this direction is to take a hard look at the dispute resolution process and make sure it works as well as it can. The big workers' compensation reform done in 2012 centered around that. Prior to that reform, if there was a dispute over treatment it went through the CA workers' compensation appeals board courts where there were judges who were not doctors making these decisions and it led to an absurd, terrible spectacle of workers spending a year and a half in court to get a prescription for opioids approved. One worker spent 18 months trying to get aspirin approved. No sane person would think that makes sense so if there are issues like that in the dispute resolution process it is really important to make sure they are taken care of before you build a formulary on top of something with that many flaws. The system works much better now and that is part of the reason why the formulary seems to be having the success that it does. The UR and IMR process now is far more preferable than the former process and it is almost impossible to imagine building a formulary on top of the old system.

Mr. Steiger stated that another big issue to highlight is how the process of getting out of the formulary works. The system in place now has not been in place for that long so there are a lot of specific questions left to be answered but it is clearly something that happens a lot as there are a lot of cases where the non-exempt drugs are not what the worker needs or that even the exempt drugs are not what the worker needs to get the maximum benefit. The process needs to be something that physicians can understand, and workers and their attorneys can understand so that the worker doesn't find themselves without access to those drugs. That is an important guiding principle to have in the back of your mind when talking about a formulary. Probably all of us at some point in our lives have been in a place where we were in excruciating physical pain and

we needed some sort of pain management to get through that and it is difficult to imagine going through that without access to the drugs you need, or being told that you have to wait 14 days for it. It is not a theoretical exercise as it is something that happens to a lot of the labor movement's members every day. Right now in CA thousands of workers are probably going through that so it is important to ensure that the formulary does not just allow them to get the treatment they need but that it happens as quickly as it possibly can.

Mr. Steiger stated that the final point is to be very careful with the research both pre and post formulary where numbers show that certain drugs are not being prescribed as much as they were so there is an unspoken implication that that is a victory – spending less on prescription drugs or prescribing fewer opioids. In some sense it is but hidden in those numbers are a lot of individual workers who may or may not be getting the care that they need and therefore while such broad data is extremely helpful, to the extent possible the research should involve talking to actual workers. Mr. Steiger stated that a lot of his job is answering calls from injured workers whose life is falling apart because they cant get the treatment that they need. No workers' compensation system completely prohibits that but there is always room for improvement to make even the best system work better. By talking to injured workers and listening to their stories you can then figure out what is causing the problem such as doctors struggling with the formulary and perhaps benefiting from a more electronic system, or the electronic system may be causing the problem. As encouraging as the data is, there is still a lot to learn to make sure the formularies work as well as they can for workers.

Thomas Naughton, President of MAXIMUS Federal Citizen Services, stated that MAXIMUS is an IMR organization that has worked with CA since it implemented its IMR program in workers' compensation and has also worked with Arizona and Montana, and soon New York. In one of its programs MAXIMUS also manages all appeals for the Medicare Part D program nationwide. Therefore, MAXIMUS has a lot of experience with workers' compensation dispute resolution as well as pharmacy and prescription dispute resolution. MAXIMUS is supportive of the implementation of a formulary as well as formulary guidelines. Medicare has a formulary and states should take the time to look at the way Medicare does things as it could be very helpful to states.

Mr. Naughton stated that when setting up the program, it is important to make sure it is most effective and New York is in the process of setting up an entirely electronic prior authorization process for their prescription formulary. That process not only makes it more efficient but also more transparent meaning that the systems can be set up where a physician submits a prescription and the system will then tell the physician "if you want this prescription this is the information you have to submit." So if the physician does not have that information to submit at that time she cannot submit the prescription or else she will be told by the system that the request is denied until the information requested has been provided. Therefore, it works not only as preventing unnecessary prescriptions that are going to be automatically denied, it educates the physicians as to what they need to do to ensure they are doing everything they need to do to ensure the injured worker gets the prescription that they need.

With regard to the prior authorization process, Mr. Naughton stated that many states will have initial denial, allow the claims administrator to engage in a UR, and then have an IMR. Although those timeframes are faster than regular medical disputes, it still takes a lot of time and folks generally want to know whether they are going to get their

prescription as quickly as possible. MAXIMUS does not believe it is necessary to have an initial denial, a UR, and then an IMR. Rather, MAXIMUS believes that: a.) the IMR program is in agreement with UR a lot of the time so you do not need both (the CA data shows this); and b.) it should not work for any of the claims administrators or employers but is rather an independent organization that provides independent physicians that are specialty matched information to make the decisions and that will provide cost savings and time savings to the program.

Mr. Naughton stated that if states are considering IMR it is important to not allow the employers or claims administrators to contract with an IMR of their choosing, rather the states should contract with the IRO and if states want to have the impact that CA and other states are having they should contract with one IRO, not multiple IRO's. Contracting with one IRO allows the IRO to develop a relationship with the state where the data is shared. MAXIMUS shares a lot of its data with CA and CA has used it for a number of fraud takedowns the past few years and also used it to educate. Mr. Naughton further stated that guidelines are good but they are only guidelines so it is important to have formulary exception processes for injured workers and to allow independent physicians to look at those formulary exceptions to see if the injured worker falls into them.

On behalf of the American Association of Payors, Administrators and Networks (AAPAN), Robert Holden stated that AAPAN believes that the Model should contain more language regarding a state agency-developed formulary. AAPAN also believes there should be some additional discussion and language regarding stakeholder outreach of a formulary, in particular the transition period to the formulary. Lastly, AAPAN believes that the formulary needs to complement medical treatment guidelines. Mr. Holden stated that AAPAN submitted written comments on the aforementioned concepts and looks forward to working with the Committee as it further develops the Model.

Ken Eichler, Vice President of Government Affairs at ODG by MCG Health, first thanked the Committee for working on the Model, particularly Rep. Lehman and Rep. Ryan Mackenzie (PA) who were champions of this issue in their own respective states and stood up to opposition. Mr. Eichler stated that the question is not whether or not to adopt a formulary in a state but rather whether or not to legislate and regulate it. Whether or not you realize it, formularies are used in every state. In many states where formularies are not formally adopted, legislated or regulated, they are done behind the curtains so to speak. This is an opportunity to bring it in front of the curtain to create transparency, protect injured workers and to protect state commerce.

Mr. Eichler stated that he was at a meeting of the National Institute for Occupational Safety and Health (NIOSH) yesterday that focused on the opioid and prescription drug crisis - formularies were a popular topic. Interestingly, there were very few objections to formularies and the labor movement did not oppose. In Indiana, the labor movement testified about the importance of formularies getting injured workers back to work and the fact that the prescriptions that are being given preclude injured workers from going back to work. It is proven that formularies expedite and facilitate the delivery of care.

Mr. Eichler stated that formulary bills are do no harm bills as they protect everyone by creating transparency. Regarding many drugs not being listed on a formulary, in most states most of the drugs that are not listed in CA are actually listed. Recent state

adoptions including Kentucky have identified that eight to ten of the top prescribed drugs are preferred drugs and on the drug lists, so formularies are not going to slow down the process at all. It has been mentioned that drug formularies are used in other forms of insurance and it makes it easier for the doctors if they have a list as there is no mystique about it. There is a printed list that can be shared with an injured worker so at the time of the patient encounter it does not become a hostile situation – the doctor can "just say no."

Regarding P&T committees, one of the features in CA vs. IN is that IN does not have the resources of a huge department and budget that CA does – most states don't. Therefore, the Model allows states to specifically either work how CA did or do a more slimmed-down program like IN and other states. Regarding peer to peer and UR, Mr. Eichler stated that states implementing formularies are coming up with innovative peer to peer options, one of which just came out of Kentucky where physicians currently are in a like-to-like/same-specialty system but going forward they will now have the option of deferring to a second-tier provider such as a physician's assistant in their office or a nurse practitioner or if it is a question of physical therapy on the guidelines, a physical therapist – with the approval of the treating physician – can engage in the peer to peer. The regulations further create situations where the treating physician names the time and date of the peer to peer review for the phone conversation to cut out the problem of missing each other. Overall, the Model is a tool to create transparency and better the outcomes for injured workers.

Asw. Maggie Carlton (NV), Chair of the Committee, asked what CA has seen for what the timeframe is for an appeal to get an injured worker a drug not on the formulary. Ms. Baker stated that if the drug is not on the formulary it can get approved by UR if there is sufficient documentation by the doctor. If the claims adjustor continues to refuse it goes on to IMR and there are timelines of 14 days for a decision. Mr. Naughton stated that he believes it is 14 calendar days and it may be ten, and noted that it will soon be reduced to five to seven days.

Rep. David Santiago (FL), Vice Chair of the Committee, asked Mr. Blaney-Koen to follow up his earlier comment regarding a formulary needing to be flexible to adapt to state specific needs with examples of what such needs might be. Rep. Santiago also asked Mr. Blaney-Koen to follow up on his earlier comment regarding the P&T committee needing to be free of conflicts, and noted that he believes that there may be conflicts in the medical field as well – not just the pharmaceutical and insurance industries.

Mr. Blaney-Koen stated that yes, there are conflicts in the medical field and as a first step all conflicts should be disclosed as not all conflicts would require someone to preclude themselves. But all conflicts should nevertheless be disclosed so that the state, P&T committee, or ethics board would be able to evaluate whether or not that conflict would require that individual to recuse him or herself from a decision of whether a medication should be included. It is possible that that individual would have to recuse him or herself for a specific drug class but necessarily all of the medical decisions on a formulary. That goes for the healthcare professionals on a P&T committee, and for a representative or an employee of a PBM for example that is on a P&T committee – that is a conflict that could potentially require recusal from many more decisions. Conflict does not necessarily automatically require recusal or removal from a decision but it should absolutely be disclosed and transparent.

In terms of the state-specific question, Mr. Eichler made a great point that not all states have the same resources. So a state may want to use the ODG guidelines as a starting point but for a variety of reasons a state may want to make certain changes to that in concert with working with labor and management. Not all of the medications or other decisions that would go into creating a formulary would be the same for IN as they would for CA or Illinois. One national guideline might be a starting point but should not be the endpoint.

Rep. Lehman noted that in the current draft of the Model, references to a specific formulary were removed. States need to be very specific on what fits them the best. Rep. Lehman believes the Model is in a good position to answer the question of what formulary to use in that it is up to the states to decide. Rep. Lehman noted that there was also a concern raised regarding the number of days within which a decision must be reached regarding a UR decision. The current draft requires five days and Rep. Lehman stated he has interest in moving it up to three days. Ms. Jones stated that in CA there is the opportunity to request an expedited review which requires a decision to be made within 72 hours.

Rep. Mackenzie stated that while working on this issue in PA one thing they looked at was using a hybrid model – adopting a national guideline and formulary and then doing state specific actions just as contemplated in the Model. Rep. Mackenzie asked Ms. Baker and Mr. Welsh how the RAND study was used in the CA process – did it become the definitive statement on which model was going to be adopted or did a CA department or agency or the legislature weigh in on that recommendation. Ms. Baker stated that the department weighed in as the RAND study was advisory only and its purpose was to evaluate, with certain criteria, the options for CA. Ms. Baker stated that most of the formularies were good and CA wanted to integrate theirs with their guidelines – that was the ultimate decision and it was done by the agency. Rep. Mackenzie asked if that was initiated by legislation or regulation. Ms. Baker stated that it was initiated by legislation – the legislature directed the agency to conduct a study to evaluate which was the best formulary product and then the agency could make that decision.

Rep. Wendi Thomas (PA) asked if research was conducted as to how quickly injured workers got back to work. That would help the argument for formularies if injured workers are getting back to work faster and the conversation is not just about cost savings. Ms. Baker stated that since multiple workers compensation reforms were enacted during the timeframe mentioned earlier it was very difficult to isolate that statistic. Overall, wage losses are improving for workers and there are ongoing wage loss studies and we know that if there is less wage loss they are returning back to work.

Rep. Lehman thanked everyone for their participation and stated he looks forward to making some changes to the Model, having an interim committee conference call, and adopting the Model in December.

“STATE OF THE LINE” – AN UPDATE ON THE STATUS OF AND TRENDS IN THE WORKERS’ COMPENSATION INSURANCE MARKETPLACE

Jeff Eddinger, Senior Division Executive – Regulatory Business Management at the National Council on Compensation Insurance (NCCI), stated that his presentation today is an abbreviated version of what is given at NCCI’s annual symposium and anyone who

wants to see that can view it on NCCI's website. Mr. Eddinger stated that for workers' compensation net written premium for private carriers and state funds, it is up 8% for the latest year to $48.6 billion dollars. That large increase is actually due to reinsurance so when looking at direct written premium it is flat. Net written premium has increased more than 40% since 2010 and this is the first time it has exceeded the peak of 2005 prior to the great recession where it hit $47.8 billion dollars.

Direct written premium decreased by only 0.6% and there is a little bit of variation by state. Kentucky had the biggest increase where a self insured fund converted to a private carrier so that is what caused that. There are some offsetting factors that are keeping the premium flat in workers' compensation. Payroll is up about 5% but loss costs are down almost 9%. Carrier pricing is up less than 1% and other factors are up about 3% so the overall change is almost nothing.

Mr. Eddinger stated that when looking at payroll you can see the separate impacts of wages and employment. Most of the increase is due to wages as they are up 3.3% and they increased across all sectors of employment. Employment is up about 2% and for the last few years or so construction is up more than other sectors. The loss costs for NCCI states are down 10% in 2019 which is the largest single year decrease followinga 9.7% decrease the year before. The loss costs impacts have been relatively stable for the past 15 years basically keeping within plus or minus 5% but the cumulative decrease during this period is almost 40%. Mr. Eddinger stated that for the most recent rate-filing cycle showing approved changes by state as of March, only one state (Hawaii) had an increase in loss costs. Fourteen states experienced double digit decreases. That pattern was similar last year as well.

Mr. Eddinger stated that NCCI files loss costs but the carriers file final rates so when we talk about carrier discounting that is the pricing they attach to the loss costs. The impact of that has continued to be very small and flat for the past six or seven years. However, there is a cyclical nature of carrier pricing. The discounting exceeded 20% below NCCI loss costs back in 1998 and 1999 and in the next cycle it was much more moderate with discounting off of loss costs being about 8% in 2000 and 2010. Now it is very close.

Regarding the components of carrier pricing, Mr. Eddinger stated that in recent years the components have pretty much offset each other so it has been a mix of very small, downward dividends, moderate downward scheduled rating credits, and upward loss costs departures. The combined ratio which is losses and expenses added together divided by the premium – a combined ratio of 100% would mean that you are breaking even as you are taking in exactly enough money to pay claims – for 2018 is projected to be 83%, the lowest it has been in many years dating back to the 1930s. This is the fourth straight year of combined ratios under 100% and in 2014 the combined ratio was exactly 100%. These results are really unprecedented in the workers' compensation system and we are in uncharted territory when it comes to these results.

Mr. Eddinger stated that when looking at the components of the combined ratio what is really driving it is the loss ratio so we are seeing good experience. The loss ratio dropped from 49% to 43% and all the other components remained exactly the same. Regarding investment gain in workers' compensation insurance transactions, the 2018 estimate is 9%, down from 12.6% the previous year – still below the long term average of about 13%. Investment gains are not as cyclical as the underwriting results looked at before. They are pretty good considering the low interest rate environment we have

been in now for a while. When looking at the operating results we are basically combining the underwriting results with the investment results so an 83% combined ratio gives you a 17% underwriting gain and adding that to a 9% investment gain arrives at a 26% operating gain for the latest year, almost four times the long term average. In fact, the last six years have been above the long-term average of about 7%. However, it is very cyclical, so you really need to look at a long term average to get the full picture of the results.

Mr. Eddinger then discussed what is driving the losses. Workers' compensation lost-time claim frequency is down another 1% for the latest year and decreases the previous three years have exceeded the long term average by about 4%. Over the last 20 years, claim frequency is down more than 50%. The moderate decrease in frequency for the latest year is likely caused by a strong economy, job growth, inexperienced workers entering the workforce. Also, a severe winter resulted in more slip and fall injuries than had previously been seen. Be that as it may, claims frequency is down again.

Looking at the claims severity – or the average cost per claim – for indemnity/wage replacement, it is up 3% in 2018 to $24,600 for lost time claims which is pretty much in line with wage inflation. It was more than 4% the prior year. NCCI has seen increases in both severity and medical moderate in recent years. Since indemnity is wage replacement you would expect it to move in line with wage inflation and from 2008 onwards that is true because the gap has remained pretty much the same but prior to that that was not true. Indemnity severity grew faster than wages from 1998 to 2008 (2% per year). However, since then it is only growing 1% faster. Over the past five years, most states also show an increase in indemnity claim severity. The decreases in certain states were caused by certain reforms enacted.

Mr. Eddinger stated that for medical lost-time claim severity, the latest year shows an increase of 1% and the prior year showed an increase of 4%. It is a similar story as it was for indemnity in that in the latest ten year period, medical severity is moving in line with the medical price index. Prior to that they had been going up much faster than the medical price index – more than 4% per year. The story you want to take away for indemnity and medical severity is that they have moderated in recent years and claim frequency continued to go down.

Regarding the residual market – where business get coverage when they cannot find coverage in the voluntary market – the story is that it has remained extremely stable with about $1 billion dollars of premium over the past seven years. When you turn that into a residual market share – in other words a percentage of total premium – it has been about 7-8% over the last six years which has proven to be a very manageable level. The combined ratio in the residual market – which is where the worst of the worst risks are, although most states require that the residual market be self-funded – even though the current year shows 107%, over the past four to five years it is close to breaking even. Overall, the results are the best they have been in many years and the residual market is stable so it shows the system is working very well.

Rep. Lehman asked if NCCI is seeing any impact on costs in states that have adopted fee schedules. Rep. Lehman stated that IN is seeing from the carrier side very aggressive back to work programs and ramped up loss control but they are also seeing a fee schedule on hospitals and that reduced their rates in IN by about 8%. IN is now looking to possibly adopt a fee schedule for other providers. Mr. Eddinger stated that

most states do have fee schedules and have had them for years and the activity surrounding them has been no more than it has been in prior years. Mr. Eddinger stated that he believes Virginia just implemented a fee schedule, but little tweaks here and there can result in costs savings which is something that NCCI frequently sees.

Asw. Ellen Spiegel (NV) stated that with regard to the information about the direct written premium change, Nevada was the second highest increase and accordingly asked what the increase was attributed to and whether it was overall premium that is written or on a per-employee basis. Mr. Eddinger stated that the information showed the overall premium in the state and he does not have any specific notes on the Nevada increase. Mr. Eddinger stated that he would follow-up with Asw. Spiegel after the Committee's meeting.

Rep. Santiago asked if NCCI is seeing states experience significant cost savings from adopting and/or implementing formularies. Mr. Eddinger stated that NCCI recently published information on formularies and offered to share it with Rep. Santiago after the Committee's meeting.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL
OCTOBER 10, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee held an interim meeting via conference call on Thursday, October 10, 2019 at 1:30 p.m.

Assemblywoman Maggie Carlton of Nevada, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Ryan Mackenzie (PA)
Rep. Wendi Thomas (PA)

Also in attendance were:

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

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL Vice President, and seconded by Rep. Wendi Thomas (PA) the Committee waived the quorum requirement without objection.

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL ACT

Rep. Lehman began by stating that the Model started out as essentially the bill that he sponsored in Indiana as something to work off of. The Committee has had two extensive hearings on this topic at the recent NCOIL Spring and Summer Meetings and changes have been made to the Model to address certain concerns. Rep. Lehman then reviewed the latest version of the Model and noted some of the changes made from the prior version. First, in Section 3, language was included to provide states the option of developing their own formulary. Accordingly, states can either choose to adopt and implement one of the nationally recognized, evidence-based formularies, or develop their own to meet the unique needs of that state. Next, in Section 3, language was added to add evidence-based guidelines among the factors that a state must consider when developing or selecting a formulary.

Rep. Lehman then noted that a comment letter on the Model was submitted by MedChi – the Maryland State Medical Society – and PRI – the Physicians Research Institute. In their letter they noted that the Model requires states to choose a "nationally recognized, evidence-based drug formulary", and only two formularies would qualify under that definition. However, Rep. Lehman noted that since the new version of the Model contains language that provides states the option of developing their own formulary, the issue raised in the comment letter is addressed.

Next, throughout Section 4 of the Model, the wording of "included but not recommended in the formulary" was changed to "listed but not approved in the formulary" in an effort to better describe the categories of drugs on the formulary. Next, in Section 4, the timeframe within which to notify the prescribing physician and the injured employee of the third party's determination of a request to use a drug that is listed but not approved in the formulary was shortened from five business days to three business days. Next, a new Section – now Section 5 – was added titled "Third Party Conflict of Interest" in order to ensure that the third parties resolving formulary disputes are conflict-free.

Rep. Lehman stated that he believes the current version of the Model is a strong work product for states to consider adopting and noted that his philosophy when developing model laws at NCOIL has always acknowledged that it is impossible to develop a perfect Model since states are almost always going to change certain provisions as they deem appropriate. Accordingly, Rep. Lehman stated that he hopes that by the end of this interim conference call meeting the Committee can agree upon the version of the Model that will be voted on at the NCOIL Annual Meeting in December. Rep. Lehman stated that he is not opposed to making certain changes to the Model between now and then that do not represent a major shift in policy, and hoped that the Committee can adopt the Model in December to send out to states for adoption.

Rep. Lehman stated that one of the issues to keep in mind is the calendar the Committee is working off of in that the timing of the Annual Meeting may conflict with state bill-filing deadlines. Therefore, Rep. Lehman stressed the importance of at least having the Committee, by the end of this interim conference call meeting, agree to the direction in which the Model is headed so a solid framework could be filed in states.

Asw. Carlton thanked Rep. Lehman for his comments and noted that conflict of interest provisions seem to be appearing in a lot of legislation across the country. Asw. Carlton then opened up the discussion to legislators present on the call.

Rep. Thomas asked who the new Section 5 – Third Party Conflict of Interest – is meant to apply to. Rep. Lehman stated that said Section is meant to apply to essentially everyone involved in a formulary dispute, such as the employer, insurer, claims administrator, and third party organization that handle the drug request. Rep. Lehman stated that he believes this Section is important as there appear to be more and more intersections of ownership when analyzing these types of dealings.

Rep. Thomas asked if that means that the parties mentioned in Section 5 cannot be involved in the development of the formulary. Commissioner Tom Considine, NCOIL CEO, stated that Section 5 is meant to deal with the appeals process. As an example, if insurance company "x" owns TPA "y", then TPA "y" cannot be used as the third party reviewer on any appeals that insurance company "x" is the insurer for.

Rep. Ryan Mackenzie (PA) stated that he thinks what Cmsr. Considine said makes a lot of sense but that is not necessarily what Section 5 is saying as said Section seems to only apply to third parties certified by the Utilization Review Accreditation Commission (URAC). Rep. Mackenzie said he agrees with the intent of Section 5 but noted that he believes the language might not incorporate everything that was stated by Rep. Lehman and Cmsr. Considine. Rep. Lehman stated that he reads the Section to apply to everyone involved in the appeal process but noted that if something needs to be changed in the Section, he is open to discussing that. Rep. Mackenzie stated that he

agrees with Rep. Lehman's interpretation of the Section but noted that if the intent is to expand the Section to exclude conflicts of interest between somebody actually involved with the formulary, such as a formulary board member, then language would need to be added to the Section.

Cmsr. Considine stated that the concern that was raised, and which Rep. Lehman directed NCOIL staff to address, related solely to conflicts of interest within the appeal process. Rep. Lehman stated that this is an issue that reflects why drafting Model laws as a framework for states to work with is the best approach as, in his experience, it is easier to expand a Model and retract one. It is important the conflict of interest provisions be in the Model and then states can expand it as they deem appropriate.

Rep. Mackenzie stated that he is not opposed to the new language that provides states the option of developing their own formulary, but noted that Pennsylvania avoided such language in its legislation because they heard from other states that developing the formulary became a very long and arduous process and implementation of the formulary was ultimately delayed in many instances. Accordingly, Pennsylvania opted to start with a nationally-recognized formulary and then make changes to it if necessary. Rep. Mackenzie then stated that the new language that provides a process to obtain a drug that is omitted from the formulary seems to be cumbersome and a challenge for the injured worker.

Rep. Lehman stated that in Indiana they decided to adopt the ODG Workers' Compensation Formulary, but for purposes of a Model law, it is important to provide states options so that they can determine what is best for their state. Regarding Rep. Mackenzie's second point, Rep. Lehman stated that he believes that comes down to how each state's workers' compensation system is set up as Indiana is an employer-driven system. Rep. Lehman further stated that it is important to remember that an emergency situation, as noted in Section 4(F) of the Model, trumps all of the other provisions of the Model related to appeals. Rep. Lehman noted that the American Medical Association (AMA) submitted comments that seek to fundamentally change the Model such that the employer should not come between the patient and physician relationship. Rep. Lehman noted that he does not want to alter the Model in that fashion as he believes the current version of the Model still affords the injured worker an opportunity to obtain the drug prescribed by the physician.

Rep. Mackenzie stated that the approach tried in Pennsylvania was that if the drug was on the formulary it was essentially deemed approved and it the drug was not on the formulary then a medical provider could provide justification for going outside of the formulary and then if that was challenged by the employer it would then go to the URAC review process. Rep. Mackenzie closed by thanking Rep. Lehman for the work thus far on the Model.

Asw. Carlton then opened the discussion up to any interested parties on the call who wished to comment on the Model.

Daniel Blaney-Koen, Senior Legislative Attorney at the AMA, stated that the AMA appreciates the increased emphasis on ensuring the absence of conflicts of interest but concerns do remain: for example, the interpretation of Section 5 and whether it would exclude certain people from the review process such as medical professionals who might have, for example, privileges at hospitals or who are contracted by a payor where

there is not necessarily direct financial conflict but there may be an affiliation that is mercurial. Accordingly, while the conflict of interest section represents a step in the right direction for the Model some of the language needs to be worked on in order to avoid unintended consequences. Mr. Blaney-Koen further stated that not all conflicts may require someone to be excluded from the review process and perhaps could be cured by disclosure combined with some sort of process to determine whether the conflict would require recusal.

Mr. Blaney-Koen further stated that the Model would benefit from provisions regarding increased transparency in the formulary. Mr. Blaney-Koen stated that he appreciates the effort in the Model to make sure that the medications are listed, but for the physicians involved, knowing what those medications are is certainly one aspect of providing optimal care in addition to knowing what the utilization management requirements may be is important as well. Further, Mr. Blaney-Koen noted that while the original version of the Model may have worked for Indiana as an employer-driven workers' compensation state, at its core, the medical necessity review is a medical process that should be made by medical professionals. That does not in all cases necessarily require a physician but the AMA advocates for that.

The AMA also encourages additional work on the Model to be done in order to reduce the burden on the injured worker. The AMA supports the emergency provision in the Model, Section 4(F), but notes that the three (3) business day timeframe (Section 4(C)(2)) within which to notify the prescribing physician and the injured employee of the third party's determination of a request to use a drug that is listed but not approved in the formulary can be burdensome. In some instances that timeframe can increase to 96 hours if a weekend is involved and for purposes of continuity of care, some injured workers may not be able to wait that long even in non-emergency situations. That is why the AMA supports streamlining the medical review process instead of putting an employer or third party administrator in the middle of the patient-physician relationship.

With regard to the review process, Mr. Blaney-Koen stated that he is not sure if the current Model has sufficient detail in terms of the timeliness and notification of all parties, particularly the treating physician and the patient. Mr. Blaney-Koen stated that while states certainly could add more to the Model as was alluded to earlier, the Model is still too sparse to move forward knowing that if an NCOIL-endorsed Model was introduced in a state, it would be a very difficult process for all states to determine what might need to be added. Accordingly, Mr. Blaney-Koen requested that the Committee conduct more work on the Model and noted that it would be great to have the Model get to the point where the AMA could support it.

Rep. Lehman stated that most workers' compensation systems already have in-place utilization review and other processes, as does health insurance, and therefore questioned whether the review system in the Model needed to be reformed to be conducted by medical professionals. With regard to conflicts of interest, Rep. Lehman stated that the main issue is direction of care and noted that he agreed with Mr. Blaney-Koen that there could be some unintended consequences resulting from that Section of the Model as currently drafted. Rep. Lehman stated that he is open to discussing how to amend that Section to address that issue but noted that he is comfortable with said Section as currently drafted.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that APCIA is mindful of Rep. Lehman's approach that from a model law drafting point of view, oftentimes less is more and lawmakers should be afforded the opportunity to change a Model as appropriate to meet the needs of their state. APCIA provided comments regarding the Model's review process based upon APCIA's experience in Texas and California and noted that those comments would cause significant concern from the AMA. Mr. O'Brien stated that APCIA believes the Model is a very good piece of legislation and is supportive of it moving forward. There may be some issues that require some technical amendments and APCIA would be happy to work with Rep. Lehman and the Committee on that.

On behalf of the American Association of Payors, Administrators and Networks (AAPAN), Robert Holden stated that AAPAN supports the Model but noted the three (3) business day timeframe (Section 4(C)(2)) within which to notify the prescribing physician and the injured employee of the third party's determination of a request to use a drug that is listed but not approved in the formulary. Mr. Holden stated that in polling AAPAN's members there can be some logistical issues in terms of notifying employees as such notification frequently must be done by mail. Mr. Holden stated that he is not objecting to the language but just wanted to ask if consideration had been applied to notifying the injured employee and where the change from five to three business days originated from.

Rep. Lehman stated that Mr. Holden made a valid point regarding notification by mail but noted that in Indiana, several of its notification laws have been changed to where electronic delivery is acceptable. Rep. Lehman stated that he believes everyone can agree that five business days for notification was too long and noted that – as the AMA pointed out – three business days in certain circumstances perhaps could be too long as well. Rep. Lehman further stated that he believes the change from five to three business days makes sense and noted that he would be interested in learning how many states require notification by mail. Mr. Holden stated that he would be glad to get that information to Rep. Lehman.

Nate Myszka, Senior Manager of State Government Affairs at Medtronic, stated that Medtronic is typically not involved with drug formularies but one of Medtronic's therapies is increasingly being used as an alternative to oral opioids and there has been some confusion in some state formulary laws as to whether they apply to medications delivered by the aforementioned therapy which is called a intrathecal pain pump that is implanted into the body and has a catheter that goes right into the spinal fluid where it is able to deliver mediation in very small, fractional doses compared to an oral medication. Accordingly, Medtronic submitted a proposed amendment to Section 3 of the Model which would exempt such intrathecal pumps from the formulary.

Rep. Lehman asked why the delivery method of the medication would matter with regard to whether or not the delivery process would be exempted from the formulary. Mr. Myszka stated that the issue is not so much whether the formulary would allow for the medication but rather the time limits that are set forth. You may have a seven day limit for an oral dose of medication but because of the very small, fractional dose that you have in a pain pump a physician might be able to go several months before refilling the pump and there are some physicians that Medtronic is hearing from who are able to wean patients off of oral opioids and get patients on a much more extended refill schedule.

Rep. Lehman stated that he understands the differences between the intrathecal pump and oral medications but is concerned about simply exempting said pump from the formulary as requested by Medtronic. Rep. Lehman also noted that he believes employers would not deny such a medication delivery method and therefore the timing requirements of the formulary referenced by Mr. Myszka would not apply. Also, exempting certain medications or delivery processes from the formulary leads to a slippery slope of others then asking: "why am I not exempted?" Mr. Myszka stated that he understood Rep. Lehman's point and will try to put some thought as to how Medtronic's goal can be realized without simply asking for an outright exemption from the formulary.

Len Welsh of Baker & Welsh, LLC thanked the Committee for the new language in Section 3 that added evidence-based guidelines among the factors that a state must consider when developing or selecting a formulary. However, Mr. Welsh noted that it might be beneficial to be more explanatory as to what it means regarding the connection between the formulary and treatment guidelines. A good example would be phase-of-care with opioid prescriptions. No one really argues with opioid prescriptions for pain management in response to a traumatic injury such as a broken bone or some other direct injury to the body that causes immediate pain to the body and immediate need for surgery or some sort of medical intervention. The problem arises in most cases with opioids in the chronic pain management phase that comes after the traumatic phase as most abuse occurs there – the prescriptions continue and people become addicted and that is why we have the problem we have.

Accordingly, if may be beneficial to provide an example in that Section of the Model that references evidence-based guidelines relating prescriptions to phase of care with opioids which are usually deemed appropriate for the traumatic injury phase and deemed inappropriate for the chronic pain management phase. Mr. Welsh stated that he would be happy to submit proposed language to include in the Model. Rep. Lehman stated that he understands the point made by Mr. Welsh but noted that in the lawmaking process, examples are not typically given in code. Mr. Welsh acknowledged that his proposal is outside-the-box of legislative drafting but noted that the situation itself is somewhat outside-the-box and stated that in his experience in California, examples in legislation and regulation do often help figure out what intent is. Mr. Welsh stated that he will send Rep. Lehman some proposed language for consideration.

Asw. Carlton then asked Rep. Lehman how he wanted to proceed with the Model, noting that in response to Rep. Lehman's earlier remarks about having the Model ready for states to consider in advance of bill-filing deadlines, changes to a bill can always be made after it is filed. Rep. Lehman stated that he is not seeking a vote on the Model from the Committee today but rather a consensus that the version of the Model discussed today will be the version presented to the Committee at the Annual Meeting in December subject to any changes made between now and then. Rep. Lehman further stated that he does not believe he has heard anything on the call today that would cause him to make any major policy changes to the Model and hoped that the Committee would conduct a formal vote on the Model in December.

Asw. Carlton asked Rep. Lehman if his intended path forward for the Model means that he is open to any technical changes that may come before him between now and December and that any substantive changes would need to be discussed by the Committee in December. Rep. Lehman replied yes and noted that he is open to

changes but noted that his goal is for the Committee to vote on the version of the Model discussed today. Asw. Carlton stated that she is comfortable with that since nothing is set in stone in any legislative process and asked for any thoughts from the legislators present on Rep. Lehman's statements.

Hearing no objection, Asw. Carlton thanked Rep. Lehman for his work thus far on the Model and noted that she has utilized several NCOIL Models in Nevada but changed them as necessary to meet Nevada's needs. A Model law is a nice template to work from knowing that it must adapt to state's needs.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
NCOIL SUMMER MEETING – NEWPORT BEACH, CA
JULY 13, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Newport Beach Marriott Hotel on Saturday, July 13, 2019 at 12:19 p.m.

NCOIL President, Sen. Dan "Blade" Morrish, LA, Chair of the Committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Rep. Matt Lehman, IN, Vice President
Asm. Ken Cooley, CA, Treasury
Asm. Kevin Cahill, NY, Secretary
Rep. Martin Carbaugh, IN
Rep. Edmond Jordan, LA
Asw. Maggie Carlton, NV
Asm. Andrew Garbarino, NY
Asw. Pam Hunter, NY
Sen. Jerry Klein, ND
Sen. Bob Hackett, OH
Rep. Tom Oliverson, M.D., TX

OTHER LEGISLATORS PRESENT:

ID Rep. Tammy Nichols
MN Sen. Paul Utke
NV Asw. Ellen Spiegel

ALSO PRESENT:

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

QUORUM

A motion was made by Asw. Carlton and seconded by Asm. Cooley to waive the quorum that carried on a voice vote.

MINUTES

A motion was made by Asm. Cahill and seconded by Asm. Garbarino to approve the minutes of the March 17th, 2019 Committee Meeting minutes.

FUTURE LOCATIONS

Commissioner Considine discussed options for both Scottsdale and Seattle for the 2021 Annual Meeting from November 17th – 21st. He suggested that no final discussion be made until the Annual Meeting in December. Asw. Carlton said Nevada would love to have us back.

ADMINISTRATION

Commissioner Considine noted that there were 314 registrants for the Summer Meeting, 57 legislators and participants from 27 states. 13 first time legislators, 4 legislators participated via ILF scholarship. 4 Commissioners participated, and 13 insurance departments were present.

There were also 8 different consumer representatives who participated, including organized labor for the first time in recent memory.

Paul Penna gave the 2019 mid-year unaudited financial report through June 30, 2019 showing revenue of $577,671.92 and expenses of $444,532.02 for an excess of $133,139.90.

Rep. Lehman reported that the Audit Committee met with the auditor and both NCOIL and the ILF received a clean bill of health. The auditor noted that the change he suggested last year by including all officers on invoice approval was helpful for control and liked Asm. Cahill's suggestion that the other officers respond to the email as they are currently just copied on them.

Rep. Carbaugh made a motion to accept the administration report that was seconded by Asm. Garbarino. It carried on a voice vote.

CONSENT CALENDAR

Sen. Morrish asked if any member had an item to take off the consent calendar. No member did so and Asm. Cooley made a motion to accept and Asm. Cahill seconded the consent calendar. The motion carried on a voice vote.

OTHER SESSIONS

Sen Morrish discussed the other sessions including the Institutes Griffith Insurance Education Foundation Legislator Luncheon – Subrogation: A Primer for Public Policymakers by Prof. Lori Medders, Appalachian State University

Featured speakers included CA Insurance Commissioner Ricardo Lara, FIO Director Steven Seitz, and Jim Parker, Advisor to the Secretary of Health and Human Services for Health Reform

Two staff training sessions for Essential Education for Legislative Staff: Exploring Risk Management & Insurance Regulation Fundamentals. Asm. Cahil stated that his staff member that was in attendance loved it and thought it was executed very nicely. He also stated that in New York one party has complete control and that we be sure that the minority party have opportunities to participate. Asw. Carlton noted she will include travel for staff in future NV budgets so they can participate and encouraged other states to do the same.

Rep. Jordan thanked the staff for all the work they do to organize the meetings.

OTHER BUSINESS

John Ashenfelter, of State Farm and representing the IEC presented four topics for consideration for a future NCOIL meeting general session:

1. E-Scooters: Regulation, Liabilities and New Policy Coverages?
2. The Gig Gap: Need to Accelerate Development of New Products and Coverages to Address the Needs of Gig Workers and Other Members of the Changing Work Force.
3. Promotion of Enhanced Auto Safety: How to Reduce Distracted Driving by Encouraging Carriers to Devise and Market Rating Programs that Utilize Discounts and the Use of Motivational Tools Such as Gamification, Already in Use for Other Products.
4. What Can States do to Accelerate Natural Disaster Recovery? A Consideration of Public Policy Proposals Relating to:
    a. Creation of Disaster Recovery Zones to Facilitate Shared Purchasing
    b. Temporarily Suspend or Reduce Sales Tax on Key Construction Materials and Lost Goods
    c. Address Specific Regulatory Requirements That Slow Down Insurers' Efforts to Adjust and Pay Claims Quickly and Efficiently

Sen. Morrish thanked Mr. Ashenfelter and told him NCOIL would take their suggestion under advisement.

Sen. Morrish reminded the Executive Committee that the application for officer position would be emailed later this summer by the NCOIL national office and to be on the look for it.

Sen. Morrish thanked Asm. Cooley and Newport Beach for being a wonderful hosts city. Cooley thanked everyone shocked by earthquake and persevered and came to CA. it s a good reminder why we are in the insurance profession or creating policies governing it.

Sen Morrish noted that pursuant to NCOIL bylaws, NV Asw. Ellen Spiegel as chair of the NV Assembly Labor & Commerce Committee has been added to the Executive Committee.

Sen. Morrish made motion to make Sen. Vickie Sawyer an executive committee member as she has been serving as chair of the Special Committee on Natural Disaster Recovery. It was seconded by Asm. Garbarino and carried on a voice vote without objection.

ADJOURNMENT

There being no further business, Sen. Morrish made a motion to adjourn that was seconded by Rep. Jordan. The committee adjourned at 12:39 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
NEWPORT BEACH, CA
JULY 10, 2019

The National Council of Insurance Legislators (NCOIL) Business Planning and Budget Committee met at the Newport Beach Marriott Hotel on Wednesday, July 10 at 6:00 p.m.

In the absence of the Chair, Sen. Morrish served as acting chair and called the meeting to order.

MEMBERS OF THE COMMITTEE PRESENT:

Sen. Jason Rapert (AR)
Sen. Dan "Blade" Morrish (LA)
Sen. Travis Holdman (IN)
Asm. Kevin Cahill (NY)
Rep. Matt Lehman (IN)

ALSO PRESENT:
Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services

Sen. Morrish called the meeting to order and asked Cmsr. Considine to go over the budget highlights in Asm. Cooley's absence. Considine went over the proposed 2020 budget which projects revenue of $1,382,000 and expenses of $1,264,130.87 for an excess of $117,869.13.

Considine noted that the new dues structure goes into effect where dues increase from $10K to $20K and includes a legislative stipend and the budget is cautious and assumes 20% attrition most recent year paid 25 states. He also noted that the CIP increases but is consistent and based on anticipated growth. Summer mtg minor growth.

Sen. Morrish asked if the CIP had grown from 2018 to 2019 and Cmsr. Considine stated that it had.

Considine noted that revenue increased in the proposed budget to $1.38 million from the 2019 adopted budget of $1.15 M.

In reviewing the expenses, Considine noted that the legislator stipend is a new category and part of the new dues structure. For planning purposes, the budget allocates full exhaustion of funds for states to send 2 legislators per meeting. Having stipends will encourage attendance and spike interest among interested parties.

Asm. Cahill noted that if the fund is not fully exhausted that perhaps some of it could be used for legislators from non participating states. Cmsr. Considine noted that the scholarship fund still exists to support those legislators. Sen. Morrish suggested maybe having it roll over into the next year.

Considine reviewed the remaining line items noting that the annual meeting is consistent with the previous year and while the retainer with existing contract looks like a big jump but in reality, it is the same but the reallocation of funds to remain in ILF operating fund. The previous agreement had the management fee split 93% for NCOIL and 7% for ILF and that was too much on draw on ILF. The new agreement is 98% NCOIL and 2% ILF. Sen. Holdman noted that the management fees are up, but incentive payment goes down because of the new allocation will increase expenses.

Considine noted that vast majority of the remaining expenses are consistent with the previous year. Expenses are proposed at $1.26 M, an increase from the 2019 budget at $1.06 M for an excess of $117K.

A motion was made by Sen. Morrish and seconded by Rep. Lehman to approve the minutes of the Oklahoma City on December 6th, 2018. It passed unanimously on a voice vote.

There being no other business, Asm. Cahill made a motion to adjourn that was seconded by Sen. Morrish. The committee adjourned at 6:23.