30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL SPRING MEETING
APRIL 15 - 18, 2021

As of April 5, 2021, and Subject to Change

Francis Marion Hotel
Charleston, South Carolina

NCOIL SPRING MEETING
Charleston, South Carolina
April 15 - 18, 2021
TENTATIVE SCHEDULE

THURSDAY, APRIL 15th

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	9:00 a.m.	-	5:00 p.m.
Special Committee on Race in Insurance Underwriting	2:30 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		
Welcome Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, APRIL 16th

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:30 a.m.	-	10:00 a.m.
Networking Break	10:00 a.m.	-	10:15 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	10:15 a.m.	-	11:30 a.m.
Keynote Address The Honorable Pamela Evette Lieutenant Governor of South Carolina	11:30 a.m.	-	12:00 p.m.

General Session The Future of the Long Term Care Industry in Light of COVID-19	12:00 p.m.	-	1:15 p.m.
Legislator Luncheon COVID-19: One Year Later	1:15 p.m.	-	2:15 p.m.
NCOIL – NAIC Dialogue	2:15 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.
Life Insurance & Financial Planning Committee	3:45 p.m.	-	5:00 p.m.
Workers' Compensation Insurance Committee	5:00 p.m.	-	6:15 p.m.
Adjournment	6:15 p.m.		
CIP Member & Sponsor Reception	6:30 p.m.	-	7:30 p.m.

SATURDAY, APRIL 17TH

Registration *Exhibits Open: 8:00 a.m. – 3:00 p.m.*	8:00 a.m.	-	3:00 p.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
General Session Mandatory Police Liability Insurance and its Impact on Safety	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 p.m.

Note: In light of the positive feedback from recent Meetings, there will be no Legislative Micro Meetings. However, there will be a room available throughout the duration of the conference for informal meetings.

Health Insurance & Long Term Care Issues Committee	1:30 p.m.	-	3:00 p.m.
Adjournment	3:00 p.m.		

SUNDAY, APRIL 18TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	10:00 a.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:30 a.m.
Business Planning Committee and Executive Committee	10:30 a.m.	-	11:30 a.m.

******Please note all speakers listed are scheduled to speak as of April 5, 2021. There will be modifications between now and the start of the Meeting.******

******Note: In light of the positive feedback from recent meetings, there will be no Legislative Micro Meetings. However, there will be a room available throughout the duration of the conference for informal meetings.******

THURSDAY, APRIL 15, 2021

Special Committee on Race in Insurance Underwriting
Thursday, April 15, 2021
2:30 p.m. – 5:30 p.m.

Chair: Sen. Neil Breslin (NY)

1.) Call to Order/Roll Call/Approval of December 9, 2020 and March 5, 2021 Committee Meeting Minutes
2.) Rating Factor/Disparate Impact Discussion
-David Eckles, PhD, Risk Management and Insurance Program Professor - Terry College of Business, University of Georgia
-Peter Kochenburger, Executive Director, Insurance Law LL.M. Program; Deputy Director, Insurance Law Center, Associate Clinical Professor of Law – University of Connecticut Law School
-Julia Angwin, Editor-in-Chief – The Markup
-Jim Lynch, Chief Actuary and Senior VP of Research and Education – Insurance Information Institute (III)
-American Council of Life Insurers (ACLI) Representative

-Mallika Bender, FCAS, MAAA, Co-Chair of Casualty Actuarial Society (CAS)/Society of Actuaries (SOA) Joint Committee on Inclusion, Equity and Diversity (JCIED)
-Tom Karol, General Counsel – Federal – National Association of Mutual Insurance Companies (NAMIC)
-Rick Swedloff, Vice Dean and Professor of Law, Co-Director, Rutgers Center for Risk and Responsibility - Rutgers Law School
-Daniel Strigberger – Strigberger, Brown, Armstrong, LLP

3.) Any Other Business
4.) Adjournment

Welcome Reception
Thursday, April 15, 2021
6:00 p.m. – 7:00 p.m.

FRIDAY, APRIL 16, 2021

Welcome Breakfast
Friday, April 16, 2021
8:30 a.m. – 10:00 a.m.

1.) Introductory Comments from NCOIL CEO
Hon. Tom Considine
2.) ***Rep. Matt Lehman (IN)***
a.) President's Welcome
b.) New Member Welcome and Introduction
3.) Welcome to Charleston
The Hon. Ray Farmer – Director, South Carolina Dep't of Insurance – NAIC Immediate Past President
4.) Any Other Business
5.) Adjournment

Networking Break
Friday, April 16, 2021
10:00 a.m. – 10:15 a.m.

Joint State-Federal Relations & International Insurance Issues Committee
Friday, April 16, 2021
10:15 a.m. – 11:30 a.m.

Chair: Sen. Bob Hackett (OH)
Vice Chair: Sen. Roger Picard (RI)

1.) Call to Order/Roll Call/Approval of December 10, 2020 Committee Meeting Minutes
2.) Discussion on New Federal Balance Billing Law – The "No Surprises Act"
Chris Garmon, PhD – Senior Consultant, Compass Lexecon; Assistant Professor of Health Administration - University of Missouri
3.) Discussion on U.K. Supreme Court's Decision on Business Interruption Coverage Test Case
Matt Brewis – Director of General Insurance and Conduct Specialists – Financial Conduct Authority (FCA)
4.) Discussion on ERISA-Preemption in Light of SCOTUS Decision in Rutledge v. PCMA
Professor Elizabeth McCuskey - University of Massachusetts School of Law
5.) Any Other Business
6.) Adjournment

Keynote Address
Friday, April 16, 2021
11:30 a.m. – 12:00 p.m.

The Honorable Pamela Evette
South Carolina Lieutenant Governor

General Session
The Future of the Long Term Care Industry in Light of COVID-19
Friday, April 16, 2021
12:00 p.m. – 1:15 p.m.

Susan Ryan	*Allison Hoffman*	*James Balda*
Senior Director	*Professor of Law*	*President & CEO*
The Greenhouse Project	*UPenn Law School*	*Argentum*

Legislator Luncheon
COVID-19: One Year Later
Friday, April 16, 2021
1:15 p.m. – 2:15 p.m.

Robert P. Hartwig, PhD, CPCU
Clinical Associate Professor, Finance Department and
Director, Center for Risk and Uncertainty Management
Darla Moore School of Business
University of South Carolina

NCOIL – NAIC Dialogue
Friday, April 16, 2021
2:15 p.m. – 3:30 p.m.

Chair: Asm. Ken Cooley (CA) – NCOIL Vice President
Vice Chair: Rep. Martin Carbaugh (IN)

1.) Call to Order/Roll Call/Approval of December 11, 2020 Committee Meeting Minutes
2.) Discussion and Update on State Adoption of Amended Credit for Reinsurance Models
3.) Discussion and Update on NAIC Special Committee on Race in Insurance
4.) Discussion on NY DFS Circular Letter No. 5 (2021 Re: Diversity and Corporate Governance
5.) Update on Proposed Changes to SSAP No. 71
6.) Overview of NAIC Closed Meeting Process
7.) Update on State Regulatory Responses to COVID-19 and Vaccine Distribution
8.) Any Other Business
9.) Adjournment

Networking Break
Friday, April 16, 2021
3:30 p.m. – 3:45 p.m.

Life Insurance & Financial Planning Committee
Friday, April 16, 2021
3:45 p.m. – 5:00 p.m.

Chair: Asw. Maggie Carlton (NV)
Vice Chair: Rep. Wendi Thomas (PA)

1.) Call to Order/Roll Call/Approval of December 11, 2020 Committee Meeting Minutes
2.) Discussion on Retirement Security Initiatives in the Biden Administration
Monique Morrisey – Economist – Economic Policy Institute

3.) Six Megatrends Defining the Next Wave of Life Insurance and Retirement
Martin Spit – Insurance Strategy & Transactions Leader – Ernst & Young
4.) Consideration of Resolution in Support of The Living Donor Protection Act (S.377/H.R. 1255)
Asw. Maggie Carlton (NV); Rep. Wendi Thomas (PA) – Sponsors
Deborah Darcy, Director of Gov't Relations – American Kidney Fund
Karen Melchert, Regional VP, State Relations – American Council of Life Insurers (ACLI)
5.) Re-adoption of Model Laws
a.) Beneficiaries' Bill of Rights (regarding retained asset accounts) Originally adopted 11/21/10, readopted 2/28/16
b.) Life Insurance Consumer Disclosure Model Act - Originally adopted 11/21/10, readopted 2/28/16
c.) Long Term Care Tax Credit Model Act - Originally adopted 7/10/98, readopted 3/2/01, 7/11/03, 3/4/05, 2/28/16
6.) Any Other Business
7.) Adjournment

Workers' Compensation Insurance Committee
Friday, April 16, 2021
5:00 p.m. – 6:15 p.m.

Chair: Rep. Tom Oliverson, M.D. (TX)
Vice Chair: Sen. Paul Utke (MN)

1.) Call to Order/Roll Call/Approval of December 11, 2020 Committee Meeting Minutes
2.) Discussion on South Carolina Workers' Compensation Marketplace and Responses to COVID-19
Gary Cannon – Executive Director – South Carolina Workers' Compensation Commission
3.) Discussion on California Staffing Agency Reform Association (CAL-SARA)
Mark Bertler – Executive Director – CAL-SARA
Pollie Pent - Cal-SARA Membership Chair and former California Department of Insurance Detective.
4.) The Early Impact of COVID-19 on Workers' Compensation Claim Composition
John Ruser – President & CEO – Workers' Compensation Research Institute (WCRI)
5.) Any Other Business
6.) Adjournment

CIP Member & Sponsor Reception
Friday, April 16, 2021
6:30 p.m. – 7:30 p.m.

SATURDAY, APRIL 17, 2021

Financial Services & Multi-Lines Issues Committee
Saturday, April 17, 2021
9:00 a.m. – 10:30 a.m.

Chair: Rep. Edmond Jordan (LA)
Vice Chair: Rep. Jim Dunnigan (UT)

1.) Call to Order/Roll Call/Approval of December 11, 2020 Committee Meeting Minutes
2.) Discussion/Consideration of NCOIL Insurer Division Model Act
   Sen. Matt Lesser (CT) – Sponsor
   Asm. Ken Cooley (CA), NCOIL Vice President – Sponsor of Committee Substitute
   Paul Martin, VP, State Relations – Reinsurance Ass'n of America (RAA)
3.) Discussion on Development of NCOIL Remote Notarization Model
   Bill Anderson, VP -Gov't Affairs – National Notary Association
   Frank O'Brien, VP, State Gov't Relations – American Property Casualty Insurance Association (APCIA)
4.) Discussion on Captive Insurance Legislative Landscape and Potential Model Act
   Ann Marie Towle - Global Captive Solutions Leader – Hylant
   Jeff Silver, General Counsel – Applied Underwriters
   Gary Osborne, Chair – South Carolina Captive Insurance Association (SCCIA)
5.) Any Other Business
6.) Adjournment

Networking Break
Saturday, April 17, 2021
10:30 a.m. – 10:45 a.m.

General Session
Mandatory Police Liability Insurance and its Impact on Safety
Saturday, April 17, 2021
10:45 a.m. – 12:00 p.m.

Moderator: Rep. Edmond Jordan (LA)

Deborah Ramirez
Professor of Law
Northeastern University

Jeff Harrison
CEO
Prymus Insurance

Ann Marie Towle
Global Captive Solutions Leader
Hylant

The Honorable Justin Bamberg
South Carolina House of Representatives

Luncheon with Keynote Address
Saturday, April 17, 2021
12:00 p.m. – 1:30 p.m.

Note: In light of the compressed schedule, there will be no Legislative Micro Meetings. However, there will be a room available throughout the duration of the conference for informal meetings.

Health Insurance & Long Term Care Issues Committee
Saturday, April 17, 2021
1:30 p.m. – 3:00 p.m.

Chair: Asw. Pam Hunter (NY)
Vice Chair: Rep. Deborah Ferguson (AR)

1.) Call to Order/Roll Call/Approval of December 11, 2020 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Telemedicine Authorization and Reimbursement Model Act
Asw. Pam Hunter (NY) – Sponsor
Brendan Peppard, Regional Director of State Affairs – America's Health Insurance Plans (AHIP)

3.) Continued Discussion on NCOIL Model Act Regarding Air Ambulance Patient Protections

Rep. Tom Oliverson, M.D. (TX); Del. Steve Westfall (WV) – Sponsors
Chris Myers, Executive Vice President, Reimbursement and Strategic Initiatives – Air Methods Corporation (AMC)
The Hon. Eleanor Kitzman, Former South Carolina and Texas Insurance Commissioner – Global Medical Response (GMR)

4.) Discussion on All Copays Count Coalition Accumulator Adjustment Program State Model Language

Steven Schultz, Director of State Legislative Affairs – The Arthritis Foundation
Brendan Peppard, Regional Director of State Affairs – America's Health Insurance Plans (AHIP)

5.) Re-adoption of Model Law

-Employer Sponsored Group Disability Income Protection Model Act
Originally adopted November 2016

6.) Any Other Business
7.) Adjournment

SUNDAY, APRIL 18, 2021

Property & Casualty Insurance Committee
Sunday, April 18, 2021
9:00 a.m. – 10:30 a.m.

Chair: Rep. Bart Rowland (KY)
Vice Chair: Sen. Vickie Sawyer (NC)

1.) Call to Order/Roll Call/Approval of December 12, 2020 and February 19, 2021 Committee Meeting Minutes
2.) Consideration of NCOIL Distracted Driving Model Act

Asm. Ken Cooley (CA), NCOIL Vice President; Sen. Bob Hackett (OH) – Sponsors
Andrew Kirkner, Regional VP, Ohio/Mid-Atlantic Region – National Association of Mutual Insurance Companies (NAMIC)

3.) Consideration of Amendments to NCOIL Post Assessment Property and Liability Insurance Guaranty Association Model Act

Asm. Ken Cooley (CA), NCOIL Vice President – Sponsor

4.) Introduction of NCOIL Fairness for Responsible Drivers Model Act

Sen. Shawn Vedaa (ND) – Sponsor
Kenneth S. Klein - Professor of Law - California Western School of Law
Andrew Kirkner, Regional VP, Ohio/Mid-Atlantic Region – National Association of Mutual Insurance Companies (NAMIC)

5.) Consideration of Amendments to NCOIL Peer-to-Peer Car Sharing Program Model Act
Rep. Bart Rowland (KY) – Sponsor
Andrew Kirkner, Regional VP, Ohio/Mid-Atlantic Region – National Association of Mutual Insurance Companies (NAMIC)
6.) Presentation on Community-Based Catastrophe Insurance: A Model for Closing the Disaster Protection Gap
Daniel Kaniewski, PhD, Managing Director – Marsh & McLennan
Andy Read, Vice President, Public Sector Practice – Guy Carpenter/Marsh & McLennan
7.) Any Other Business
8.) Adjournment

Business Planning Committee and Executive Committee
Sunday, April 18, 2021
10:30 a.m. – 11:30 a.m.

Chair: Rep. Matt Lehman (IN) – NCOIL President
Vice Chair: Asm. Ken Cooley (CA) – NCOIL Vice President

1.) Call/to Order/Roll Call/Approval of December 12, 2020 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
a.) Meeting Report
b.) Receipt of Financials
4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Readopted Therein
5.) Other Sessions
a.) Legislator Luncheon
b.) Featured Speakers
6.) Any Other Business
7.) Adjournment

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY/CASUALTY INSURANCE MODERNIZATION ACT

Adopted by the NCOIL Executive Committee on July 13, 2001.
Amended by the NCOIL Executive Committee on November 16, 2001, and March 1, 2002.
Reviewed and amended by the NCOIL Executive Committee on November 21, 2003.
Readopted by the NCOIL Executive Committee on July 22, 2006.
Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018.
Amendments sponsored by Sen. Neil Breslin (NY) and Rep. Matt Lehman (IN), NCOIL President, adopted by the Special Committee on Race in Insurance Underwriting on March 5, 2021. To be considered by the Executive Committee on April 18, 2021.

Amendments are indicated by bold, italics, and underline.

Summary
This model bill establishes a use-and-file rate regulatory system for personal lines of insurance, a no-file system for commercial lines, and allows policies sold to large, sophisticated commercial insurance providers to be exempt from rate and regulatory requirements. This creates a more competitive and less onerous regulatory industry. This model is intended for consideration in insurance regulatory jurisdictions with a more restrictive rate filing and review system than outlined in the bill. ***Additionally, this model defines proxy discrimination and makes clear that proxy discrimination is unfairly discriminatory in all kinds of insurance.***

Section 1. {Short Title}

This act shall be known as the Property/Casualty Insurance Modernization Act.

Section 2. {Legislative Declaration}

This legislature finds and declares that a modernized and competitive procedure be employed

A. To recognize and enhance the role well-informed consumers play in the competitive marketplace

B. To promote price competition among insurers

C. To protect policyholders and the public against adverse effects of excessive, inadequate, or unfairly discriminatory rates

D. To prohibit unlawful price fixing agreements by or among insurers

E. To authorize essential cooperative activities among insurers in the ratemaking process and to regulate such activities to prohibit practices that tend to substantially lessen competition or create monopolies

F. To provide necessary regulatory authority in the absence of a competitive Marketplace

G. To prevent unfair discrimination, including proxy discrimination.

Drafting Note: This model is intended for consideration in insurance regulatory jurisdictions with a more restrictive rate filing and review system than outlined in this bill. States may also wish to consider implementing a competitive rating law that eliminates the regulatory rate filing process for all lines of insurance that are competitive.

Section 3. {Definitions}

A. For the purpose of this Act, “Advisory organization” means any person or organization, which has five (5) unrelated members and which assists insurers as authorized by Section 11. It does not include joint underwriting organizations, actuarial or legal consultants, single insurers, any employees of an insurer, or insurers under common control or management of their employees or managers.

B. For the purpose of this Act, “Classification system” or “classification” means the process of grouping risks with similar risk characteristics so that differences in costs may be recognized.

C. For the purpose of this Act, “Commercial risk” means any kind of risk, which is not a personal risk.

D. For the purpose of this Act, “Commissioner” means the Commissioner or Director or Superintendent of Insurance of this state.

E. For the purpose of this Act, “Competitive market” means any market except those which have been found to be non-competitive pursuant to Section 5.

F. For the purpose of this Act, “Developed losses” means losses (including loss adjustment expenses) adjusted, using standard actuarial techniques, to eliminate the effect of differences between current payment or reserve estimates and those which are anticipated to provide actual ultimate loss (including loss adjustment expense) payments.

G. For the purpose of this Act, “Expenses” means that portion of a rate attributable to acquisition, field supervision, collection expenses, general expenses, taxes, licenses, and fees.

H. For the purpose of this Act, “Experience rating” means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder’s loss experience against the loss experience of policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

I. For the purpose of this Act, “Joint underwriting” means an arrangement established to provide insurance coverage for a risk, pursuant to which two or more insurers contract with the insured for a price and policy terms agreed upon between or among the insurers.

J. For the purpose of this Act, “Large Commercial Policyholder” is a commercial policyholder with the size, sophistication, and insurance-buying expertise to negotiate with insurers in a largely unregulated environment and which meets at least two of the following criteria: (1) aggregate premium on commercial policies held by the insured, including workers’ compensation, (2) number of employees, (3) annual net revenues or sales, (4) net worth, (5) annual budgeted expenditures for not-for profit organizations or a public body or agencies, or (6) population for municipalities.

Drafting Note: Specific criteria may require a large commercial policyholder to generate annual net revenues or sales in excess of $50,000,000; employ more than 50 employees; procure insurance through a full-time risk manager or retained qualified insurance consultant; possess net worth in excess of $25,000,000; or, if a nonprofit organization or public body/agency, generate annual budgeted expenditures of at least $25,000,000.

K. For the purpose of this Act, “Loss adjustment expense” means the expenses incurred by the insurer in the course of settling claims.

L. For the purpose of this Act, “Market” is the statewide interaction between buyers and sellers in the procurement of a line of insurance coverage pursuant to the provisions of this Act.

Drafting Note: A state may wish to consider a geographic area smaller than the statewide market to be tested, keeping in mind the state’s particular insurance market environment.

M. For the purpose of this Act, “Non-competitive market” means a market, which is subject to a ruling pursuant to Section 5 that a reasonable degree of

competition does not exist, and, for the purposes of this Act, residual markets, and pools are non-competitive markets.

N. For the purpose of this Act, “Personal risk” means homeowners, tenants, nonfleet private passenger automobiles, mobile homes, and other property and casualty insurance for person, family, or household needs. This includes any property and casualty insurance that is otherwise intended for non-commercial coverage.

O. For the purpose of this Act, “Pool” means an arrangement pursuant to which two or more insurers participate in the sharing of risks on a predetermined basis. A pool may operate as an association, syndicate, or in any other generally recognized manner.

P. For the purpose of this Act, “Prospective loss cost” means that portion of a rate that does not include provisions for expenses (other than loss adjustment expenses) or profit, and are based on historical aggregate losses and loss adjustment expenses adjusted through development to their ultimate value and projected through trending to a future point in time.

Q. For purposes of this Act, as well as for the purpose of any regulatory material adopted by this State, or incorporated by reference into the laws or regulations of this State, or regulatory guidance documents used by any official in or of this State, “Proxy Discrimination” means the intentional substitution of a neutral factor for a factor based on race, color, creed, national origin, or sexual orientation for the purpose of discriminating against a consumer to prevent that consumer from obtaining insurance or obtaining a preferred or more advantageous rate due to that consumer’s race, color, creed, national origin, or sexual orientation.

~~Q~~R. For the purpose of this Act, “Rate” means that cost of insurance per exposure unit whether expressed as a single number or as a prospective loss cost with an adjustment to account for the treatment of expenses, profit, and individual insurer variation in loss experience, prior to any application of individual risk variations based on loss or expense considerations, and does not include minimum premiums.

~~R~~S. For the purpose of this Act, “Residual market mechanism” means an arrangement, either voluntary or mandated by law, involving participation by insurers in the equitable apportionment of risks among insurers for insurance which may be afforded applicants who are unable to obtain insurance through ordinary methods.

~~S~~T. For the purpose of this Act, “Special assessments” means guaranty fund assessments, Special Indemnity Fund assessments, Vocational Rehabilitation Fund assessments, and other similar assessments. Special assessments shall not be considered as either expenses or losses.

~~T~~U. For the purpose of this Act, “Supplementary rate information” means any manual or plan of rates, classification, rating schedule, minimum premium, policy

fee, rating rule, and any other similar information needed to determine an applicable rate in effect or to be in effect.

~~U~~V. For the purpose of this Act, "Supporting information" means (1) the experience and judgment of the filer and the experience or data of other insurers or organizations relied upon by the filer, (2) the interpretation of any statistical data relied upon by the filer, (3) a description of methods used in making the rates, and (4) other similar information relied upon by the filer.

~~V~~W. For the purpose of this Act, "Trending" means any procedure for projecting losses to the average date of loss, or premiums or exposures to the average date of writing, for the period during which the policies are to be effective.

Section 4. {Scope}

A. ***Section 6(A)(3)(a) of this*** Act applies to all kinds of insurance written on risks in this state by any insurer authorized to do business in this state.

B. ***All remaining sections of this Act apply to all such kinds of insurance written on risks in this state by any insurer authorized to do business in this state*** except:

1. Life insurance
2. Annuities
3. Accident and health insurance
4. Ocean marine insurance
5. Aircraft liability and aircraft hull insurance
6. Reinsurance
7. Surplus Lines
8. Workers Compensation Insurance

Section 5. {Competitive Market}

A. A competitive market for a line of insurance is presumed to exist unless the commissioner, after notice and hearing, determines that a reasonable degree of competition does not exist within a market and issues a ruling to that effect. The burden of proof in any hearing shall be placed on the party or parties advocating the position that competition does not exist. Any ruling that a market is not competitive shall identify the factors causing the market not to be competitive. Such ruling shall expire one year after issue unless rescinded earlier by the commissioner or unless the commissioner renews the ruling after a hearing and a finding as to the continued lack of a reasonable degree of competition. Any ruling that renews the finding that competition does not exist shall also identify the factors that cause the market to continue not to be competitive.

B. The following factors shall be considered by the commissioner for purposes of determining if a reasonable degree of competition does not exist in a particular line of insurance:

1. The number of insurers or groups of affiliated insurers providing coverage in the market

2. Measures of market concentration and changes of market concentration over time
3. Ease of entry and the existence of financial or economic barriers that could prevent new firms from entering the market
4. The extent to which any insurer or group of affiliated insurers controls all or a portion of the market
5. Whether the total number of companies writing the line of insurance in this state is sufficient to provide multiple options
6. The availability of insurance coverage to consumers in the markets
7. The opportunities available to consumers in the market to acquire pricing and other consumer information

C. The commissioner shall monitor the degree and continued existence of competition in this State on an on-going basis. In doing so, the commissioner may utilize existing relevant information, analytical systems, and other sources; or rely on some combination thereof. Such activities may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, and/or in any other appropriate manner.

Section 6. {Rating Standards and Methods}

A. Rates shall not be excessive, inadequate, or unfairly discriminatory.

1. For the purpose of this Act, “Excessive” means a rate that is likely to produce a long-term profit that is unreasonably high for the insurance provided. No rate in a competitive market shall be considered excessive.

Drafting Note: Reflecting the well-accepted economic principle that costs and prices are driven downward by competition, insurance laws in seventeen (17) states do not allow a finding of excessiveness in a competitive market. Those seventeen (17) states are: Arkansas, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Michigan, Missouri, Montana, Nevada, Oklahoma, Oregon, Vermont, Virginia, and Wyoming. Insurance laws in five (5) other states say that rates are “presumed” not to be excessive if there is a reasonable degree of competition. Those five (5) states are: Arizona, Kansas, Minnesota, New Mexico, and Wisconsin.

2. For the purpose of this Act, “Inadequate” means a rate which is unreasonably low for the insurance provided and

a. the continued use of which endangers the solvency of the insurers using it, or

b. will have the effect of substantially lessening competition or creating a monopoly in any market

3. a. For the purpose of this Act, “Unfairly discriminatory” refers ***either*** to rates that cannot be actuarially justified***, or to rates that can be actuarially justified but are based on proxy discrimination.*** It does not refer to rates that produce differences in premiums for policyholders with like loss exposures, so long as the rate reflects such differences with reasonable accuracy. A rate is not unfairly discriminatory if it averages

broadly among persons insured under a group, franchise or blanket policy, or a mass marketing plan.

b. No rate in a competitive market shall be considered unfairly discriminatory unless it violates the provisions of section 6(B) in that it classifies risk, on the basis of race, color creed, or national origin. Risks may be classified in any way except that no risk may be classified on the basis of race, color, creed, or national origin.

B. In determining whether rates in a non-competitive market are excessive, inadequate, or unfairly discriminatory, consideration may be given to the following elements:

1. Basic Rate Factors. Due consideration shall be given to past and prospective loss and expense experience within and outside of this state; to catastrophe hazards and contingencies; to events or trends within and outside of this state; to dividends or savings to policyholders, members, or subscribers; and to all other factors and judgments deemed relevant by the insurer.

2. Classification. Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified for individual risks in accordance with rating plans or schedules which establish standards for measuring probable variations in hazards or expenses, or both.

3. Expenses. The expense provision shall reflect the operating methods of the insurer and its own past expense experience and anticipated future expenses.

4. Contingencies and Profits. The rates shall contain a provision for contingencies and a provision for a reasonable underwriting profit, and reflect investment income directly attributable to unearned premium and loss reserves.

5. Other relevant factors. Any other factors available at the time of hearing.

Section 7. {Rate Regulation in a Market Determined to be Non-Competitive}

A. If the commissioner determines that competition does not exist in a market and issues a ruling to that effect pursuant to Section 5, the rates applicable to insurance sold in that market shall be regulated in accordance with the provisions of Section 6 through 9 applicable to non-competitive markets.

B. Any rate filing in effect at the time the commissioner determines that competition does not exist pursuant to Section 5 shall be deemed to be in compliance with the laws of this state unless disapproved pursuant to the procedures and rating standards contained in Section 6 through 9 applicable to non-competitive markets.

C. Any insurer having a rate filing in effect at the time the commissioner determines that competition does not exist pursuant to Section 5 may be required to furnish supporting information within 30 days of a written request by the commissioner.

Section 8. {Filing of Rates, Supplementary Rate Information, and Supporting Information}

A. Filings in Competitive Markets. For personal lines, every insurer shall file with the commissioner all rates and supplementary rate information to be used in this state no later than 30 days after the effective date; provided, that such rates and supplementary rate information need not be filed for inland marine risks, which by general custom are not written according to manual rules or rating plans. Rates in a competitive market for commercial insurance need not be filed.

B. Filings in Non-Competitive Markets.

1. Every insurer shall file with the commissioner all rates, supplementary rate information, and supporting information for non-competitive markets at least 30 days before the proposed effective date. The commissioner may give written notice, within 30 days of the receipt of the filing, that the commissioner needs additional time, not to exceed 30 days from the date of such notice to consider the filing. Upon written application of the insurer, the commissioner may authorize rates to be effective before the expiration of the waiting period or an extension thereof. A filing shall be deemed to meet the requirements of this Act and to become effective unless disapproved pursuant to Section 9 by the commissioner before the expiration of the waiting period or an extension thereof. Residual market mechanisms or advisory organizations may file residual market rates.

2. The filing shall be deemed in compliance with the filing provisions of this section unless the commissioner informs the insurer within 10 days after receipt of the filing as to what supplementary rate information or supporting information is required to complete the filing.

C. Reference Filings. An insurer may file its rates by either filing its final rates or by filing a multiplier and, if applicable, an expense constant adjustment to be applied to prospective loss costs that have been filed by an advisory organization on behalf of the insurer as permitted by Section 11.

D. Filings Open to Inspection. All rates, supplementary rate information, and any supporting information filed under this Act shall be open to public inspection once they have been filed, except information marked confidential, Trade Secret, or proprietary by the insurer or filer. Copies may be obtained from the commissioner upon request and upon payment of a reasonable fee.

E. Consent to Rate. Notwithstanding any other provisions of this section, upon written application of the insured, stating the reason therefore, a rate in excess of or below that otherwise applicable may be used on any specific risk.

Section 9. (Disapproval of Rates)

A. Bases for Disapproval

1. The commissioner shall disapprove a rate in a competitive market only if the commissioner finds pursuant to subsection (B) of this section that the rate is inadequate under Section (6)(A)(2) or unfairly discriminatory under Section 6(A)(3)(b).

2. The commissioner may disapprove a rate for use in a non-competitive market only if the commissioner finds pursuant to subsection (B) of this section that the rate is excessive, inadequate, or unfairly discriminatory under Section 6A.

B. Procedures for Disapproval

1. Prior to the expiration of the waiting period or an extension thereof of a filing made pursuant to Section 8, subsection (B), the commissioner may disapprove by written order rates filed pursuant to Section 8, subsection (B), without a hearing. The order shall specify in what respects such filing fails to meet the requirements of this Act. Any insurer whose rates are disapproved under this section shall be given a hearing upon written request made within 30 days of disapproval.

2. If, at any time, the commissioner finds that a rate applicable to insurance sold in a non-competitive market does not comply with the standards set forth in Section 6, the commissioner may, after a hearing held upon not less than 20 days written notice, issue an order pursuant to subsection 9I disapproving such rate. The Hearing notice shall be sent to every insurer and advisory organization that adopted the rate and shall specify the matters to be considered at the hearing. The disapproval order shall not affect any contract or policy made or issued prior to the effective date set forth in said order.

3. If, at any time, the commissioner finds that a rate applicable to insurance sold in a competitive market is inadequate under Section 6(A)(3)(a) or unfairly discriminatory under Section 6(A)(3)(b), the commissioner may issue an order pursuant to subsection 9(C) disapproving the rate. Said order shall not affect any contract or policy made or issued prior to the effective date set forth in said order.

C. Order of Disapproval. If the commissioner disapproves a rate pursuant to subsection (B) of this section, the commissioner shall issue an order within 30 days of the close of the hearing specifying in what respects such rate fails to meet the requirements of this Act. The order shall state an effective date no sooner than 30 business days after the date of the order when the use of such rate shall be discontinued. This order shall not affect any policy made before the effective date of the order.

D. Appeal of Orders; Establishment of Reserves. If an order of disapproval is appealed pursuant to Section 20 the insurer may implement the disapproved rate upon notification to the court, in which case any excess of the disapproved rate over a rate previously in effect shall be placed in a reserve established by the insurer. The court shall have control over the disbursement of funds from such reserve. Such funds shall be distributed as determined by the court in its final order except that de minimus refunds to policyholders shall not be required.

Section 10. {Large Commercial Policyholder}

A. A policy of insurance sold to a “Large Commercial Policyholder,” as defined in Section 3(J), shall not be subject to the requirements of this chapter, including but not limited to, Sections 5, 6, 7, 8, and 9. The forms and endorsements for any policy sold to a “Large

Commercial Policyholder" shall not be subject to filing and approval requirements of (reference form filing and approval provisions plus other applicable provisions).

B. All policies issued pursuant to the provisions of this section shall contain a conspicuous disclaimer printed in at least ten-point, bold-faced type that states that the policy applied for (including the rates, rating plans, resulting premiums, and the policy forms) is not subject to the rate and form requirements of this state and other provisions of the insurance law that apply to other commercial products and may contain significant differences from a policy that is subject to all provisions of the insurance law. Such notice shall set forth possible differences in policy conditions, forms, and endorsements, as compared to a policy that is subject to all of the provisions of the insurance law. The format and provisions of such notice shall be prescribed by the commissioner. The disclosure notice will also include a policyholder's acknowledgment statement, to be signed and dated prior to the effective date of the coverage, and shall remain on file with the insurer.

C. In procuring insurance, a "Large Commercial Policyholder" shall certify on a form approved by the department of insurance that it meets the eligibility requirements set out in Section 10(A) and specify the requirements that the policyholder has met. This certification is to be completed annually and remain on file with the insurer.

D. A surplus lines broker seeking to obtain or provide insurance for a "Large Commercial Policyholder" is authorized to purchase insurance from any eligible unauthorized insurer without making a diligent search of authorized insurers as required by (applicable surplus lines law).

Section 11. {Records and Reports: Exchange of Information}

A. In only those markets found to be non-competitive pursuant to Section 5, insurers and advisory organizations shall file with the commissioner, and the commissioner shall review, reasonable rules and plans for recording and reporting of loss and expense experience. The commissioner may designate one or more advisory organizations to assist in gathering such experience and making compilations thereof. No insurer shall be required to record or report its experience in a manner inconsistent with its own rating system.

B. The commissioner and every insurer and advisory organization may exchange rates and rate information and experience data with insurance regulatory officials, insurers, and advisory organizations in this and other states and may consult with them with respect to the collection of statistical data and the application of rating systems.

Section 12. {Joint Underwriting, Pools, and Residual Market Activities}

A. Acting in Concert. Notwithstanding the provisions of Section 13, insurers participating in joint underwriting, pools, or residual market mechanisms may act in cooperation with each other in the making of rates, rating systems, supplementary rate information, policy or bond forms, underwriting rules, surveys, inspections and investigations; in the furnishing of loss and expense statistics or other information; and in conducting research. Joint underwriting, pools, and residual market mechanisms shall not be deemed advisory organizations.

B. Regulation

1. If, after notice and hearing, the commissioner finds that any activity or practice of an insurer participating in a joint underwriting or pooling mechanism is unfair, unreasonable, will tend to substantially lessen competition in any market, or is otherwise inconsistent with the provisions or purposes of this Act and all other applicable statutes, the commissioner may issue a written order specifying in what respects such activity or practice is unfair, unreasonable, anti-competitive, or otherwise inconsistent with the provisions of this Act and all other applicable statutes, and require the discontinuance of such activity or practice.

2. Every pool shall file with the commissioner a copy of its constitution, articles of incorporation, agreement, or association bylaws; rules and regulations governing activities; its members; the name and address of a resident of this state upon whom notices, process, and orders of the commissioner may be served; and any changes or modifications thereof.

3. Any residual market mechanism, plan, or agreement to implement such a mechanism, and any changes or amendments thereto, shall be submitted in writing to the commissioner for approval, together with such information as may be reasonably required. The commissioner shall approve such agreements if they foster (i) the use of rates which meet the standards prescribed by this Act and all other applicable statutes and (ii) activities and practices not inconsistent with the provisions of this Act and all other applicable statutes.

4. The commissioner may review the operations of all residual market mechanisms to determine compliance with the provisions of this Act and all other applicable statutes. If after a notice of hearing, the commissioner finds that such mechanisms are violating the provisions of this Act and all other applicable statutes, the commissioner may issue a written order to the parties involved specifying in what respects such operations violate the provisions of this Act and all other applicable statutes. The commissioner may further order the discontinuance or elimination of any such operation.

Section 13. {Assigned Risks}

A. Agreements may be made among insurers with respect to the equitable apportionment among them of insurance that may be afforded applicants who are in good faith entitled to, but who are unable to, procure such insurance through ordinary methods, and such insurers may agree among themselves on the use of reasonable rate modifications for such insurance, such agreements, and rate modifications to be subject to the approval of the commissioner.

Drafting Note: This section is to be included if the current provision authorizing agreements for the assigned risk or other residual market is repealed as part of the current rating law. You may wish to pick up current state provisions.

Section 14. {Examinations}

A. The commissioner may examine any insurer, pool, advisory organization, or residual market mechanism to ascertain compliance with this Act.

B. Every insurer, pool, advisory organization, and residual market mechanism shall maintain adequate records from which commissioner may determine compliance with the provisions of this Act. Such records shall contain the experience, data, statistics, and other information collected or used and shall be available to the commissioner for examination or inspection upon reasonable notice.

C. The reasonable cost of an examination made pursuant to this section shall be paid by the examined party upon presentation to it of a detailed account of such costs.

D. The commissioner may accept the report of an examination made by the insurance supervisory official of another state in lieu of an examination under this section.

Section 15. {Exemptions}

The commissioner may, after public notice and hearing, exempt any line of insurance from any or all of the provisions of this Act for the purpose of relieving such line of insurance from filing or any otherwise applicable provisions of this Act.

Section 16. {Consumer Information}

The Commissioner shall utilize, develop, or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of homeowners, private passenger non-fleet automobile, or property insurance for personal, family, or household needs. The commissioner may utilize, develop, or cause to be developed a consumer information system(s) which will provide and disseminate price and other relevant information on a readily available basis to purchasers of insurance for commercial risks and personal risks not otherwise specified herein. Such activity may be conducted internally within the insurance department, in cooperation with other state insurance departments, through outside contractors, and/or in any other appropriate manner. To the extent deemed necessary and appropriate by the commissioner, insurers, advisory organizations, statistical agents, and other persons or organizations involved in conducting the business of insurance in this State, to which this section applies, shall cooperate in the development and utilization of a consumer information system(s).

> *Drafting Note: For jurisdictions that need a separate and distinct means of funding a consumer information system the following provision may be added to Section 16:*
>
> *The cost of complying with this section shall be assessed against insurers subject to this Act and authorized to write types of business subject to a consumer information system. The assessments shall be made on an equitable and practicable basis established, after hearing, in a rule promulgated by the commissioner. This activity shall be conducted in a reasonably economical manner consistent with the purposes of this Act.*

Section 17. {Dividends}

Nothing in this Act shall be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their

policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers shall not be deemed a rating plan or system.

Section 18. {Penalties}

A. The commissioner may impose after notice and hearing a penalty determined in accordance with (refer to appropriate penalties provision).

B. Technical violations arising from systems or computer errors of the same type shall be treated as a single violation. In the event of an overcharge, if the insurer makes restitution including payment of interest, no penalty shall be imposed.

C. The commissioner may suspend or revoke the license of any insurer, advisory organization, or statistical agent which fails to comply with an order of the commissioner within the time prescribed by such order, or any extension thereof which the commissioner may grant.

D. The commissioner may determine when a suspension of license shall become effective and the period of such suspension, which the commissioner may modify or rescind in any reasonable manner.

E. No penalty shall be imposed and no license shall be suspended or revoked except upon a written order of the commissioner stating his or her findings, made after notice and hearing.

Section 19. {Judicial Review}

A. Any order, ruling, finding, decision, or other act of the commissioner made pursuant to this Act shall be subject to judicial review in accordance with (cite applicable provisions of state civil practice act).

Section 20. {Notice and Hearing}

A. Notice Requirements. All notices rendered pursuant to the provisions of this Act shall be in writing and shall state clearly the nature and purpose of the hearing. All relevant facts, statutes, and rules shall be specified so that respondent(s) are fully informed of the scope of the hearing, including specific allegations, if any. If a hearing is required, all notices shall designate a hearing date at least 14 days from the date of the notice, unless such minimum notice period is waived by respondents.
B. Hearings. All hearings pursuant to the provisions of this Act shall be conducted in accordance with (cite applicable provisions of Administrative Procedures Act) to the extent such provisions are consistent with the procedural requirements contained in this Act.

Section 21. {Severability}

If any provision or item of this Act, or the application thereof, is held invalid, such invalidity shall not affect other provisions, items, or applications of the Act that can be given effect without the invalid provision, item, or application.

Section 22. {Effective Date}

The provisions of this Act become effective _____ months after the enactment.

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

National Council of Insurance Legislators (NCOIL)

Resolution in Support of The Living Donor Protection Act (S. 377/H.R. 1255)

To be discussed and considered by the Life Insurance & Financial Planning Committee on April 16, 2021.

Sponsored by Asw. Maggie Carlton (NV) and Rep. Wendi Thomas (PA)

WHEREAS, deciding to donate an organ to someone else is one of the most selfless, difficult decisions anyone could ever make; and

WHEREAS, every day, 17 patients die on the national organ transplant waiting list which contains 108,000 people[1]; and

WHEREAS, transplants from a living donor not only improve patient quality of life and extend life expectancy, they also save money as each year Medicare alone spends approximately $89,000 per dialysis patient and less than half, $35,000, for a transplant patient; and

WHEREAS, while organ donation saves thousands of lives every year, barriers remain that stop individuals from becoming living-donors; and

WHEREAS, almost a quarter of living donors experience difficulty securing or paying for insurance after their procedures because of unfair practices, and others face job loss after taking required time off to recover from their donation surgery; and

WHEREAS, the bipartisan "Living Donor Protection Act" (S. 377/H.R. 1255) would protect living organ donors and promote organ donation by making it unlawful to:

---

[1] https://www.organdonor.gov/statistics-stories/statistics.html

- decline or limit coverage of a person under any life insurance policy, disability insurance policy, or long-term care insurance policy, solely due to the status of such person as a living organ donor;

- preclude an insured from donating all or part of an organ as a condition of continuing to receive a life insurance policy, disability insurance policy, or long-term care insurance policy; or

- otherwise disadvantage consumers in the offering, issuance, cancellation, amount of such coverage, price, or any other condition of a life insurance policy, disability insurance policy, or long-term care insurance policy for a person, based solely and without any additional actuarial risks upon the status of such person as a living organ donor.

WHEREAS, the bill would also amend the Family and Medical Leave Act of 1993 to specifically include living organ donation as a serious health condition for private and civil service employees (thereby codifying an August 2018 U.S. Department of Labor opinion letter addressing this issue), and direct the U.S. Department of Health and Human Services to update their materials on live organ donation to reflect these new protections and encourage more individuals to consider donating an organ; and

WHEREAS, while NCOIL will always remain cautious regarding federal involvement in the proven state-based system of insurance regulation, such involvement is sometimes warranted and until federal legislation such as the "Living Donor Protection Act" is enacted that would give baseline protections to organ donors nationwide, states are operating under a patchwork of living organ donor protection laws; and

WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges Members of Congress to take action to pass the "Living Donor Protection Act" in order to remove barriers to organ donation and provide certainty to organ donors and recipients; and

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

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

National Council of Insurance Legislators (NCOIL)

Insurer Division Model Act

Sponsored by Sen. Matt Lesser (CT)

Discussion Draft as of August 25, 2020.

To be ~~introduced and~~ discussed during the Financial Services & Multi-Lines Issues Committee on April 17, 2021.~~September 26, 2020~~

NOTE --- Asm. Ken Cooley (CA), NCOIL Vice President, will be offering an amendment to this Model by way of a Committee substitute. That document appears immediately following this document.

Table of Contents

Section 16 . Effective date.

Section 1. Title

This act shall be known and may be cited as the “Insurer Division Act.”

Section 2. Definitions.

(a) As used in this act, the following words and phrases have the meanings given to them in this section unless the context clearly indicates otherwise:

“Dividing insurer” means a domestic insurer that approves a plan of division pursuant to section 5 or 6.

“Divide” or “division” means a transaction in which an insurer divides into two or more resulting insurers in the manner authorized by this act or a similar law of another jurisdiction.

“Domiciliary jurisdiction” means the jurisdiction in which an insurer is domiciled.

“Liability” includes any liability or obligation of any kind, character, or description, whether known or unknown, absolute or contingent, accrued or unaccrued, disputed or undisputed, liquidated or unliquidated, secured or unsecured, joint or several, due or to become due, determined, determinable, or otherwise.

“New insurer” means an insurer that is created by a division.

“Property” includes all property, whether real, personal or mixed, or tangible or intangible, or any right or interest therein, including rights under contracts and other binding agreements.

“Resulting insurer” means the dividing insurer, if it survives a division, or a new insurer.

“Transfer” includes:

(A) an assignment;

(B) an assumption;

(C) a conveyance;

(D) a sale;

(E) a lease;

(F) an encumbrance, including a mortgage or security interest;

(G) a gift; and

(H) a transfer by operation of law.

(b) As used in this act, the following words and phrases have the meanings given to them in the cited provisions of the law of this state:

"Admitted insurer." [Citation.]

"Capital." [Citation.]

"Commissioner." [Citation.]

"Domestic insurer." [Citation.]

"Person." [Citation.]

"Policy." [Citation.]

"Record." [Citation.]

"Sign" or "signature." [Citation.]

"Surplus." [Citation.]

Section 3. Division authorized.

(a) By complying with this act, a domestic insurer may divide, with the prior approval of the commissioner, into:

(1) the dividing insurer and one or more new insurers; or

(2) two or more new insurers.

(b) A new insurer created by the division of a domestic insurer may be domiciled in a jurisdiction other than this state if:

(1) a division of an insurer is authorized by the law of the domiciliary jurisdiction of the new insurer; and

(2) the division of the domestic insurer is approved in accordance with any applicable provisions of the law of the domiciliary jurisdiction of the new insurer.

(c) A new insurer created by the division of an insurer domiciled under the law of a jurisdiction other than this state may be a domestic insurer if the division is approved in accordance with the applicable provisions of this act.

Section 4. Plan of division.

(a) A domestic insurer may become a dividing insurer under this act by approving a plan of division. The plan must be in a record and include:

(1) The name of the dividing insurer.

(2) A statement as to whether the dividing insurer will survive the division.

(3) The name of each new insurer and its domiciliary jurisdiction.

(4) The manner of:

(A) If the dividing insurer survives the division and it is desired:

(i) Canceling some, but less than all, of the shares in the dividing insurer.

(ii) Converting some, but less than all, of the shares in the dividing insurer into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination of the foregoing.

(B) If the dividing insurer does not survive the division, canceling or converting the shares in the dividing insurer into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination of the foregoing.

(C) Allocating between or among the resulting insurers the capital, surplus, and other property of the dividing insurer that will not be owned by all of the resulting insurers as tenants in common pursuant to section 10 and those policies and other liabilities of the dividing association as to which not all of the resulting insurers will be liable jointly and severally pursuant to section 11.

(D) Distributing the shares in the new insurer or insurers to the dividing insurer or some or all of its shareholders.

(5) The proposed articles of incorporation and bylaws for each new insurer.

(6) If the dividing insurer will survive the division, any proposed amendments to its articles of incorporation or bylaws.

(7) The other terms and conditions of the division.

(8) Any other provision required by:

(A) the laws of this state;

(B) the articles of incorporation or bylaws of the dividing insurer.

(9) If one or more of the resulting insurers will be a party to a merger under section 12, a statement to that effect, including whether

(A) a new insurer that will not be a surviving party to the merger will need to hold a certificate of authority, accreditation, or other authorization under the laws of the state of domicile of the surviving party to the merger; and

(B) the merger under section 12 is required to meet the standard set forth in section 7(b)(2).

(b) It is not necessary for a plan of division to list each individual policy or other liability, and each item of capital, surplus, or other property of the dividing insurer to be allocated to a resulting insurer so long as the policies and other liabilities, and capital, surplus, and other property are described in a reasonable manner.

(c) A plan may refer to facts ascertainable outside of the plan if the manner in which the facts will operate on the plan is specified in the plan. The facts may include the occurrence of an event or a determination or action by a person, whether or not the event, determination, or action is within the control of the dividing insurer or a resulting insurer.

Section 5. Approval of division by dividing insurer.

(a) Except as provided in section 5(b) or section 6, the plan of division of a dividing insurer must be approved:

(1) in accordance with the requirements, if any, in its articles of incorporation and bylaws for approval of a division;

(2) if its articles of incorporation and bylaws do not provide for approval of a division, in accordance with the requirements, if any, in its articles of incorporation and bylaws for approval of a merger requiring approval by a vote of the shareholders of the dividing insurer.

(b) Approval of a division by a dividing insurer is subject to the following transitional rules:

(1) If a provision of the articles of incorporation or bylaws of the dividing insurer was adopted before [*the date of enactment of this act*] and requires for the proposal or adoption of a plan of merger a specific number or percentage of votes of directors or shareholders or other special procedures, then a plan of division may not be proposed or adopted by the directors or shareholders without that number or percentage of votes or compliance with the other special procedures.

(2) If a provision of any debt security, note or similar evidence of indebtedness for money borrowed, whether secured or unsecured, indenture, or other contract relating to indebtedness, or a provision of any other type of contract other than an insurance policy, annuity, or reinsurance treaty, that was issued, incurred or executed by the dividing insurer before [*the date of enactment of this act*], requires the consent of the obligee to a merger of the dividing insurer or treats such a merger as a default, then the provision applies to a division of the dividing insurer as if it were a merger.

(3) When a provision described in section 5(b)(1) or (2) has been amended after the applicable date, the provision ceases to be subject to the respective paragraph and thereafter applies only in accordance with its express terms.

Section 6. Division without shareholder approval.

Unless otherwise restricted by its articles of incorporation or bylaws, a plan of division of a dividing insurer does not require the approval of the shareholders of the dividing insurer if:

(1) the plan does not amend in any respect the provisions of the articles of incorporation or bylaws of the dividing insurer, except amendments that may be made without the approval of the shareholders; and

(2) either:

(A) the dividing insurer survives the division and all the shares and other equity securities, if any, of all of the new insurers are owned solely by the dividing insurer; or

(B) the dividing insurer has only one class of shares outstanding and the shares and other equity securities, if any, of each new insurer are distributed pro rata to the shareholders of the dividing insurer.

Section 7. Regulatory approval of division.

(a) Prior to approving a division, the commissioner may hold a hearing on the terms and conditions of the proposed division after such notice as, under the circumstances, the commissioner considers appropriate. A hearing must be held if the dividing insurer so requests. In determining the appropriate notice of a hearing that should be given, the commissioner may require that the dividing insurer submit a policyholder notification plan. The commissioner may retain such independent experts as the commissioner considers appropriate. All expenses incurred by the commissioner in connection with the proceedings under this section, including expenses for the services of any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed division must be paid by the dividing insurer. The expenses may be allocated in the plan of division in the same manner as any other liability.

(b) The commissioner must approve a division, and any associated merger under section 12, if the commissioner finds that

(1) [*insert standard for approval of a merger of insurers under the state's existing law*];

(2) as a result of the division, and any associated merger under section 12, no policyholder will lose applicable guaranty association coverage in the policyholder's state of residence with respect to policies allocated to one or more new insurers; and

(3) the division and any such merger do not involve a [*voidable transaction*] [*fraudulent transfer*] under [*cite appropriate state statute*].

(c) When determining if the standards set forth in section 7(b) have been satisfied, the commissioner may consider all property proposed to be allocated to a resulting insurer, including without limitation, reinsurance agreements, parental guarantees, support or keep well agreements, or capital maintenance or contingent capital agreements, and the financial condition of the surviving insurer in a merger under section 12.

(d) When determining if the standard set forth in section 7(b)(3) has been satisfied, the commissioner must:

(1) only consider the application of [*cite state voidable transactions act or fraudulent transfer act*] to a dividing insurer that survives the division;

(2) treat each resulting insurer as a debtor;

(3) treat the liabilities allocated to a resulting insurer as liabilities incurred by a debtor;

(4) treat each resulting insurer as not having received reasonably equivalent value in exchange for incurring its obligations; and

(5) treat property allocated to a resulting insurer as "remaining assets" as that term is used in [*cite state voidable transactions act or fraudulent transfer act*].

(e) The commissioner may not approve a division of a dividing insurer unless the commissioner also issues to each new insurer a certificate of authority, accreditation or other authorization, as necessary, to do an insurance business in this state pursuant to [*cite appropriate provision of state law*]. In the case of a new insurer that will be a non-surviving party to a merger pursuant to section 12, the commissioner may waive the application of this subsection or issue a certificate of authority, accreditation or other authorization to the new insurer that is deemed effective immediately prior to the merger.

(f) If the commissioner approves the plan of division, the commissioner must issue an order accompanied by findings of fact and conclusions of law.

(g) Except for the plan of division and any materials incorporated by reference into or otherwise made a part of the plan, all information, documents, materials and copies thereof submitted to, obtained by or disclosed to the commissioner or any other person in the course of the commissioner's review and approval of a division under this section are confidential [*and subject to the provisions of [cite any applicable provision of the state's law on confidentiality of proceedings before the commissioner]*].

Section 8. Amendment or abandonment of plan of division.

(a) A plan of division of a dividing insurer may be amended in accordance with any procedures set forth in the plan or, if no such procedures are set forth in the plan, in the manner determined by the directors of the dividing insurer, except that a shareholder that was entitled to vote on or consent to approval of the division is entitled to vote on or consent to any amendment of the plan that will change:

(1) The amount or kind of shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination of the foregoing, to be received by any of the shareholders of the dividing insurer under the plan.

(2) The articles of incorporation or bylaws of any of the resulting insurers that will be in effect immediately after the division becomes effective, except for changes that do not require approval of the shareholders of the resulting insurer under other applicable law.

(3) Any other terms or conditions of the plan, if the change would adversely affect the shareholder in any material respect.

(b) After a plan of division has been approved by a dividing insurer and before articles of division become effective, the plan may be abandoned without action by the shareholders in accordance with any procedures set forth in the plan or, if no such procedures are set forth in the plan, in the manner determined by the directors of the dividing insurer.

(c) If a plan of division is abandoned after articles of division under section 9 have been delivered to the Secretary of State for filing and before the articles of division become effective, articles of abandonment, signed by the dividing insurer, must be delivered to the Secretary of State for filing before the time the articles of division become effective. The articles of abandonment take effect on filing, and the division is abandoned and does not become effective.

(d) A dividing insurer may not amend or abandon a plan of division after the division has become effective.

Section 9. Articles of division; effectiveness.

(a) If a plan of division is approved as provided in this act, articles of division must be signed and delivered to the Secretary of State for filing. The articles of division must be signed by the dividing insurer or by the insurer that is dividing under the law of another jurisdiction if a new insurer is domiciled in this state. The order of the commissioner approving and authorizing the proposed division, as well as the approval of the regulatory authority in any other jurisdiction where a new insurer is domiciled, must be delivered to the Secretary of State for filing along with the articles of division.

(b) Articles of division must contain all of the following:

(1) The name of the insurer that is dividing.

(2) A statement as to whether the insurer that is dividing will survive the division.

(3) The name of each new insurer created by the division and its domiciliary jurisdiction.

(4) If the articles of division are not to be effective on filing, the later date or date and time on which they will become effective, which must not be later than ninety days after the date of filing.

(5) A statement that the division was approved by either:

(A) the dividing insurer in accordance with this act; or

(B) an insurer domiciled in another jurisdiction in accordance with the law of that jurisdiction.

(6) If the dividing insurer survives the division, any amendment to its articles of incorporation approved as part of the plan of division.

(7) For each new insurer created by the division that will be a domestic insurer, its articles of incorporation as an attachment.

(8) The capital, surplus, and other property and policies and other liabilities of the dividing insurer that are to be allocated to each resulting insurer, but it is not necessary to list in the articles of division each item of capital, surplus, or other property, and each policy or other liability of the dividing insurer to be allocated to a resulting insurer so long as the capital, surplus, and other property, and policies and other liabilities are described in a reasonable manner.

(9) If one or more of the resulting insurers is a party to a merger under section 12, a statement to that effect.

(c) The articles of incorporation of each new insurer must satisfy the requirements of the law of this state, except that they do not need to be signed and may omit any provision that is not required to be included in a restatement of the articles of incorporation.

(d) Articles of division are effective on the date and time of their filing by the Secretary of State or the later date and time specified in the articles of division. The division is effective when the articles of division are effective.

Section 10. Effect of division.

(a) When a division becomes effective, all of the following apply:

(1) If the dividing insurer is to survive the division:

(A) It continues to exist.

(B) Its articles of incorporation, if any, are amended as provided in the articles of division.

(C) Its bylaws are amended to the extent provided in the plan of division.

(2) If the dividing insurer is not to survive the division, the separate existence of the dividing insurer ceases.

(3) With respect to each new insurer, all of the following apply:

(A) It comes into existence.

(B) Any capital, surplus, and other property allocated to it vests in the new insurer without reversion or impairment, and the division is not a transfer of any of that property.

(C) Its articles of incorporation and bylaws are effective.

(4) Capital, surplus, and other property of the dividing insurer:

(A) That is allocated by the plan of division either:

(i) vests in the new insurers as provided in the plan of division; or

(ii) remains vested in the dividing insurer.

(B) That is not allocated by the plan of division:

(i) remains vested in the dividing insurer, if the dividing insurer survives the division; or

(ii) is allocated to and vests equally in the resulting insurers as tenants in common, if the dividing insurer does not survive the division.

(C) Vests as provided in this paragraph without transfer, reversion or impairment.

(5) A resulting insurer to which a cause of action is allocated as provided in section 10(a)(4) may be substituted or added in any pending action or proceeding to which the dividing insurer is a party at the effective time of the division.

(6) The policies and other liabilities of the dividing insurer are allocated between or among the resulting insurers as provided in section 11 and the resulting insurers to which policies or other liabilities are allocated are liable for those policies and other liabilities as successors to the dividing insurer, and not by transfer, whether directly or indirectly.

(7) The shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the holders of those shares are entitled only to the rights provided to them under the plan of division and to any appraisal rights they may have pursuant to section 13.

(b) Except as provided in the articles of incorporation or bylaws of the dividing insurer, the division does not give rise to any rights that a shareholder, director, or third party would have upon a dissolution, liquidation or winding up of the dividing insurer.

(c) The allocation to a new insurer of capital, surplus, or other property that is collateral covered by an effective financing statement is not effective until a new financing statement naming the new insurer as a debtor is effective under Article 9 of the Uniform Commercial Code – Secured Transactions.

(d) Unless otherwise provided in the plan of division, the shares and any equity securities of each new insurer must be distributed to:

(1) the dividing insurer, if it survives the division; or

(2) the holders of the common shares of the dividing insurer that do not assert appraisal rights, pro rata, if the dividing insurer does not survive the division.

Section 11. Allocation of liabilities in division.

(a) Except as provided in this section, when a division becomes effective, a resulting insurer is responsible:

(1) Individually for the policies and other liabilities the resulting insurer issues, undertakes, or incurs in its own name after the division.

(2) Individually for the policies and other liabilities of the dividing insurer that are allocated to or remain the liability of that resulting insurer to the extent specified in the plan of division.

(3) Jointly and severally with the other resulting insurers for the policies and other liabilities of the dividing insurer that are not allocated by the plan of division.

(4) Only as provided in this subsection (a), and not for any other policies or other liabilities under a common law doctrine of successor liability or any other theory of liability applicable to transferees or assignees of property.

(b) If a division breaches an obligation of the dividing insurer, all of the resulting insurers are liable, jointly and severally, for the breach, but the validity and effectiveness of the division are not affected thereby.

(c) A direct or indirect allocation of capital, surplus, or other property, or policies or other liabilities in a division is not a distribution for purposes of the [*cite state business corporation law*].

(d) Liens, security interests and other charges on the capital, surplus, or other property of the dividing insurer are not impaired by the division, notwithstanding any otherwise enforceable allocation of policies or other liabilities of the dividing insurer.

(e) If the dividing insurer is bound by a security agreement governed by Article 9 of the Uniform Commercial Code - Secured Transactions as enacted in any jurisdiction and the security agreement provides that the security interest attaches to after-acquired collateral, each resulting insurer is bound by the security agreement.

(f) Except as provided in the plan of division and specifically approved by the commissioner, an allocation of a policy or other liability does not:

(1) Affect the rights under other law of a policyholder or creditor owed payment on the policy, payment of any other type of liability, or performance of the obligation that creates the liability, except that those rights are available only against a resulting insurer responsible for the policy, liability, or obligation under this section.

(2) Release or reduce the obligation of a reinsurer, surety, or guarantor of the policy, liability, or obligation.

Section 12. Simultaneous merger.

A new insurer may be a party to a merger with a domestic insurer or an existing insurer domiciled in another jurisdiction that is admitted, accredited, or otherwise authorized as necessary to do an insurance business in this state, as required by the law of this state. A merger authorized by this section takes effect simultaneously with the division. The new insurer is deemed to exist before the effectiveness of the merger, but solely for the

purpose of being a party to the merger. The insurance policies, annuities, and reinsurance treaties allocated to the new insurer pursuant to the plan of division become the obligations of the survivor of the merger simultaneously with the effectiveness of the division and merger under this section. The plan of merger is deemed to have been approved by the new insurer if the plan is approved by the dividing insurer in connection with its approval of the plan of division. The articles of merger that are delivered to the Secretary of State for filing must state that the merger was approved by the new insurer under this section.

Section 13. Appraisal rights.

A shareholder of a dividing insurer is entitled to appraisal rights as provided in [*cite appraisal rights provision of the state's business corporation law*] in connection with a division, other than one approved under section 6.

Section. 14. Guaranty associations.

References in [*cite state property and casualty insurance guaranty association statute*] to an "insolvent insurer" are deemed to include an insurer that

(1) divides under this act or a similar law of another jurisdiction, or is created in such a division;

(2) holds or is allocated the policy obligations of an insurer that held a certificate of authority to transact insurance in this state either at the time a policy was issued or when an insured event occurred, by reason of the division, if the division was approved:

(A) in a jurisdiction that allows a division; and

(B) by an insurance regulator having jurisdiction over the division; and

(3) against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the resulting insurer's state of domicile.

Section 15. Regulations.

The commissioner may adopt regulations that are necessary to administer this act.

Section 16. Effective date.

This act takes effect _____.

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

National Council of Insurance Legislators (NCOIL)

Insurer Division Model Act

Sponsored by Asm. Ken Cooley (CA) – NCOIL Vice President

Draft as of March 16th, 2021.

To be discussed and considered during the Financial Services & Multi-Lines Issues Committee on April 17, 2021.

****NOTE --- This document serves as an amendment to the prior version of the Model by way of a Committee substitute. The prior version appears immediately before this document.****

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the "[State] Insurer Division Act."

Section 2. Definitions.

As used in this Act, the following words and phrases have the meanings given to them in this Section unless the context clearly indicates otherwise:

(A) "Asset" means property, whether real, personal, mixed, tangible, or intangible, and any right or interest in the property, including all rights under a contract or other agreement.

(B) "Capital" means the capital stock component of a statutory surplus, as defined in the National Association of Insurance Commissioners' Accounting Practices and Procedures Manual, version effective January 1, 2001, as revised.

(C) "Commissioner" means the State Insurance Commissioner

(D) (1) "Contract holder" means the owner of an annuity contract.

(2) "Contract holder" does not mean a certificate holder of a group annuity contract or any other covered person under a group annuity contract.

(E) "Divide" or "Division" means the act by operation of law by which a domestic stock insurer splits into two or more resulting domestic stock insurers in accordance with a plan of division and this Act.

(F) "Dividing insurer" means a domestic stock insurer that approves a plan of division.

(G) "Domestic stock insurer" means an insurance company that has capital stock and is incorporated under the laws of this state.

(H) "Liability" means any liability or obligation arising in any manner.

(I) "Plan of division" means a plan of division that is approved by a dividing insurer pursuant to section 8.

(J) (1) “Policyholder” means the owner of an insurance policy.

(2) “Policyholder” does not mean a certificate holder of a group insurance policy or any other covered person under a group insurance policy.

(K) “Resulting insurer” means a dividing domestic stock insurer that survives a division or a new domestic stock insurer that is created by a division.

(L) “Shareholder” means a person in whose name shares are registered in the records of a corporation or the beneficial owner or shares to the extent of the rights granted by a nominee certificate on file with a corporation.

(M) “Surplus” means the total statutory surplus minus capital, calculated in accordance with the National Association of Insurance Commissioners’ Accounting Practices and Procedures Manual, version effective January 1, 2001, as revised.

(N) “Transfer” means an assignment; assumption; conveyance; sale; lease; encumbrance, including a mortgage or security interest; gift; or transfer by operation of law.

Section 3. Plan of division - general requirements.

(A) A domestic stock insurer may, in accordance with this Act, divide into two or more resulting insurers pursuant to a plan of division. A domestic stock insurer’s plan of division must include:

(1) The name of the domestic stock insurer seeking to divide;

(2) The name of each resulting insurer created by the proposed division and, for each resulting insurer, a copy of the resulting insurer’s:

(a) Proposed articles of incorporation; and

(b) Proposed bylaws;

(3) The manner of allocating assets and liabilities including policy liabilities, between or among al resulting insurers;

(4) The manner of distributing shares in the resulting insurers to the dividing insurer or the dividing insurer’s shareholders;

(5) A reasonable description of all liabilities and all assets that the dividing insurer proposes to allocate to each resulting insurer, including the manner by which the dividing insurer proposes to allocate all reinsurance contracts;

(6) All terms and conditions required by the laws of this state and the articles of incorporation and bylaws of the dividing insurer; and

(7) All other terms and conditions required by the division.

Section 4. Plan of division - dividing insurer to survive division.

(A) If a dividing insurer will survive a division, the plan of division must include, in addition to the requirements described in section 3:

(1) All proposed amendments to the dividing insurer's articles of incorporation and bylaws;

(2) If the dividing insurer intends to cancel some but not all shares in the dividing insurer, the manner in which the dividing insurer intends to cancel the shares; and

(3) If the dividing insurer intends to convert some but not all shares in the dividing insurer into shares, securities, obligations, rights to acquire shares or securities, cash, property, or an combination thereof, a statement disclosing the manner in which the dividing insurer intends to convert the shares.

Section 5. Plan of division - dividing insurer to not survive division.

If a dividing insurer will not survive a division, the plan of division must include, in addition to the requirements described in section 3, the manner in which the dividing insurer will cancel or convert shares in the dividing insurer into shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof.

Section 6. Amending plan of division.

(A) A dividing insurer may amend the dividing insurer's plan of division in accordance with any procedures set forth in the plan of division, or, if no such procedures are set forth in the plan of division, in a manner determined by the board of directors of the dividing insurer. A shareholder that is entitled to vote on or consent to approval of the plan of division is entitled to vote on or consent to an amendment of the plan of division that will affect:

(1) The amount or kind of shares, securities, obligations, rights to acquire shares or securities, cash, property, or any combination thereof to be received by any of the shareholders of the dividing insurer under the plan of division;

(2) The articles of incorporation or bylaws of any resulting insurer that become effective when the division becomes effective except for changes that do not require approval of the shareholders of the resulting insurer under its articles of incorporation or bylaws; or

(3) Any other terms or conditions of the plan of division that effect a change that may adversely affect the shareholders in any material respect.

Section 7. Abandoning plan of division.

(A) A dividing insurer may abandon its plan of division only as follows:

(1) After the dividing insurer has approved the plan of division without any action by the shareholders and in accordance with any procedures set forth in the plan of division, or if no such procedures are set forth in the plan of division, the dividing insurer may abandon its plan of division in a manner determined by the board of directors of the dividing insurer; or

(2) After the dividing insurer has filed a certificate of division with the secretary of state pursuant to section 11, the dividing insurer may file a signed certificate of abandonment with the secretary of state and file a copy with the commissioner. The certificate of abandonment is effective on the date it is filed with the secretary of state.

(B) A dividing insurer shall not abandon its plan of division after the plan of division becomes effective.

(C) If a dividing insurer elects to abandon its plan of division after the plan has been filed with the commissioner but before it becomes effective, the dividing insurer shall notify the commissioner.

Section 8. Approval of plan of division - articles of incorporation and bylaws.

(A) A dividing insurer shall not file a plan of division with the commissioner until the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws. If the dividing insurer's articles of incorporation and bylaws do not provide for approval of a plan of division, the dividing insurer shall not file the plan of division with the commissioner unless the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws that provide for approval of a merger.

(B) If a provision of a dividing insurer's articles of incorporation or bylaws adopted before the effective date of this Act requires that a specific number of or percentage of the board of directors or shareholders propose or adopt a plan of merger or impose other procedures for the proposal or adoption of a plan of merger, the dividing insurer shall adhere to the provision in proposing or adopting a plan of division. If any such provision of the articles of incorporation or bylaws is amended on or after the effective date of this Act, the provision applies to a division thereafter only in accordance with its express terms.

Section 9. Commissioner approval of plan of division.

(A) After a dividing insurer approves a plan of division pursuant to section 8, the dividing insurer shall file the plan of division with the commissioner. Within ten business days after filing the plan of division with the commissioner, the dividing insurer shall provide notice of the filing to each reinsurer that is a party to a reinsurance contract allocated in the plan of division.

(B) (1) A division does not become effective until it is approved by the commissioner in accordance with this section.

(2) Before approving a plan of division, the commissioner shall:

(a) In large or complex divisions, hold a public hearing on the terms and conditions of the proposed division;

Drafting Note: *Although this Model Act requires the commissioner to hold a public hearing in especially large or complex divisions, some state insurer division statutes provide the commissioner discretion to hold such a hearing regardless of the size or complexity of the division. When considering whether or not to require a public hearing, legislatures should take note that state insurance departments are situated and staffed differently with varying degrees of expertise across the country, and, as such, the size, public interests affected and level of complexity of a division necessary to warrant public hearings may vary from state to state.*

(b) Provide notice of the public hearing required pursuant to subsection (B)(2)(a) of this section to state insurance regulators and appropriate state guaranty associations in state in which the dividing insurer is authorized to do business; and

(c) Be satisfied that the dividing insurer has made reasonable efforts to provide all policyholders, contract holders, reinsurers, and other persons with an interest in the proposed plan of division at least thirty days prior notice of the public hearing if the commissioner determines that it would be unreasonable or unfair to not provide such notice to such other persons. For the purposes of this subsection (B)(2)(c), a notice must:

(i) Provide information regarding the proposed division under consideration and the location, date, and time of the public hearing; and

(ii) If the dividing insurer has the last-known address or last-known e-mail address of the policyholder, contract holder, reinsurer, or other person on file, either be mailed to the last-known address of such person or sent via electronic means to the last-known e-mail address of such person.

(3) The commissioner shall:

(a) Consider any simultaneous merger or acquisition of a resulting insurer as part of the plan of division;

(b) In the case of a simultaneous merger, apply to the resulting insurer involved in the simultaneous merger the requirements of this Act that are applicable to the resulting insurer as merged into the surviving entity in the merger and not to the resulting insurer prior to the merger;

(c) Consider, among other things, all assets, liabilities, and cash flows, the nature and composition of the assets proposed to be transferred in support of the plan of division, and all proposed assets of the resulting insurer, which consideration must include an assessment of the risks and quality, including the liquidity and marketability, of the proposed portfolio of the resulting insurer; consideration of asset and liability matching; and the treatment of the material element of the portfolio based on statutory accounting practices.

(4) After making the considerations described in subsection (B)(3) of this section, the commissioner shall approve a plan of division if the commissioner finds that the following requirements are met:

(a) The financial condition of a dividing insurer, a resulting insurer, or an acquiring party of a resulting insurer, if any, will not jeopardize the financial stability of the dividing insurer or prejudice the interests of its policyholders, contract holders, or reinsurers, in each case, in a manner that is unfair to its policyholders, contract holders, or reinsurers;

(b) The terms of the plan of division are fair and reasonable to the dividing insurer's and any resulting insurer's policyholders, contract holders, or reinsurers;

(c) Neither a dividing insurer, a resulting insurer, not an acquiring party of a resulting insurer, if any, has plans or proposals to liquidate the dividing insurer or any resulting insurer, sell assets of the dividing insurer or of any resulting insurer, consolidate or merge the dividing insurer or any resulting insurer with a person, or make any other material change in the dividing insurer's or any resulting insurer's business or corporation structure or management that is unfair or unreasonable to the dividing insurer's or resulting insurers' policyholders, contract holders, or reinsurers and not in the public interest;

(d) The competence, experience, and integrity of the persons who would control the operation of a dividing insurer if it survives the division, and any resulting insurer are such that it would be consistent with the interest of the

dividing insurer's and any resulting insurers' policyholders, contract holders or reinsurers and the general public to permit the division;

(e) The division is not likely to be hazardous or prejudicial to the insurance-buying public;

(f) The interest of the policyholders of the dividing insurer that may become policyholders of a resulting insurer will be adequately protected by the resulting insurer or acquiring party of a resulting insurer, if any;

(g) The dividing insurer, if it survives the division, and the resulting insurer will be solvent upon the consummation of the division;

(h) The assets allocated to the dividing insurer, if it survives the division, and to resulting insurers will not, upon the consummation of the division, be unreasonably small in relation to the business and transactions in which the insurers were engaged or are about to engage;

(i) The proposed division is not being made for the purpose of hindering, delaying, or defrauding any policyholders, contract holders, or reinsurers;

(j) Each resulting insurer that will be a member insurer of [cite state insurance guaranty fund statute], will be licensed in each line of business in each state where the dividing insurer was licensed with respect to the insurance policies or annuity contracts issued by the dividing insurer that are allocated to that resulting insurer as part of the plan of division; except that, the resulting insurer need not be licensed with respect to any line of business in any state where, at the time of division:

(i) The dividing insurer is not licensed with respect to the line of business; or

(ii) The state does not provide guaranty association coverage or similar coverage with respect to the allocated policies or contracts; and

(k) If the plan of division allocates policies of long-term care insurance, as defined in [insert citation to state insurance code definition of long-term care insurance], the liabilities associated with the allocated policies do not constitute more than a de minimus amount of the insurance liabilities allocated to the dividing insurer, if it survives the division, or to any resulting insurer.

(5) A dividing insurer that files a plan of division shall pay all expenses incurred by the commissioner in connection with proceedings under this section, including expenses for attorneys, actuaries, accountants, and other experts not otherwise a

part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed plan of division. A dividing insurer may allocate the expenses in the plan of division in the same manner as any other liability.

(6) In large or complex divisions, the commissioner shall select and retain an independent expert who shall review the plan of division and issue a report to the commissioner, which report addresses the following:

Drafting Note: *Although this Model Act requires the commissioner to select and retain an independent expert in especially large or complex divisions, some state insurer division statutes provide the commissioner discretion to retain an independent expert regardless of the size or complexity of the transaction. When considering whether or not to require the retention of an independent expert, legislatures should take note that state insurance departments are situated and staffed differently with varying degrees of expertise across the country, and, as such, the size, public interests affected and level of complexity of a division necessary to warrant independent experts may vary from state to state.*

(a) The business purposes of the proposed division;

(b) Capital adequacy and risk-based capital, including consideration of the effects of asset quality, non-admitted assets, and actuarial stresses to reserve assumptions;

(c) Cash flow and reserve adequacy testing, including consideration of the effects of diversification on policy liabilities;

(d) Business plans;

(e) The impact, if any, of concentration of lines of business following the proposed division; and

(f) Management's competence, experience, and integrity.

(7) If the commissioner approves a plan of division, the commissioner shall issue:

(a) An order that is accompanied by findings of fact and conclusions of law; and

(b) A certificate of authority authorizing the resulting insurers to transact the business of insurance in this state; except that the commissioner may waive this requirement if a resulting insurer will not survive a merger simultaneous with the division in accordance with the plan of division.

(8) The conditions in this section for freeing one or more of the resulting insurers from the liabilities of the dividing insurer and for allocating some or all of the liabilities of the dividing insurer are deemed to have been satisfied if the commissioner approves the plan of division in a final order.

Section 10. Confidentiality - records.

(A) All information, documents, materials, and copies of documents and materials submitted to, obtained by, or disclosed to the commissioner in connection with a plan of division or in contemplation of a plan of division, including any information documents, materials, or copies provided by or on behalf of a domestic stock insurer in advance of its adoption or submission of a plan of division, are confidential and subject to the same protection and treatment described in [insert citation to state insurance holding company systems law] for information and documents disclosed to or obtained by the commissioner in the course of an examination or investigation made under [insert citation to state insurance holding company systems law], until the time, if any, that a notice of the hearing contemplated by section 9 is issued.

(B) After the issuance of a notice of the hearing contemplated by section 9, all business, financial, actuarial, and other proprietary information for which the domestic stock insurer requests confidential treatment, other than the plan of division and any materials incorporated by reference into or otherwise made a part of the plan of division that must not be eligible for confidential treatment after the issuance of a notice of the hearing, continues to be confidential, is not available for public inspection, and is subject to the same protection and treatment as described in [insert citation to state insurance holding company systems law] for information and documents disclosed to or obtained by the commissioner in the course of an examination or investigation made under [insert citation to state insurance holding company systems law]. However, if the commissioner determines that the public's interest in making the information available for public inspection outweighs the interest of the dividing insurer in keeping the information confidential, the commissioner may, after notice and an opportunity to be heard, make the information available to public inspection in accordance with [insert citation to state public/open records law].

Section 11. Certificate of division.

(A) If the commissioner approves a dividing insurer's plan of division pursuant to section 9, an officer or duly authorized representative of the dividing insurer shall sign a certificate of division that sets forth all of the following:

(1) The name of the dividing insurer;

(2) A statement disclosing whether the dividing insurer survived the division. If the dividing insurer survived the division, the certificate of division must include any amendments to the dividing insurer's articles of incorporation or bylaws as approved as part of the pan of division.

(3) The name of each resulting insurer that is created by the division;

(4) The date on which the division is effective;

(5) A statement that the division was approved by the commissioner pursuant to section 9;

(6) A statement that the dividing insurer provided reasonable notice to each reinsurer that is a party to a reinsurance contract allocated in the plan of division;

(7) Articles of incorporation and bylaws for each resulting insurer created by the division. The articles of incorporation and bylaws of each resulting insurer must comply with the applicable requirements of the laws of this state. The articles of incorporation and bylaws may state the name or address of an incorporator, may be signed, and may include any provision that is not required in a restatement of the articles of incorporation or bylaws.

(8) A reasonable description of the capital, surplus, or other assets and liabilities, including policy liabilities, of the dividing insurer that are to be allocated to each resulting insurer.

(B) A dividing insurer's certificate of division is effective on the date the dividing insurer files the certificate with the secretary of state and provides a concurrent copy to the commissioner, or on another date as specified in the plan of division, whichever is later. However, the certificate of division becomes effective not later than ninety calendar days after it is filed with the secretary of state. A division is effective when the relevant certificate of division is effective.

Section 12. After division is effective.

(A) (1) On the effective date of a division pursuant to section 11, if the dividing insurer survives, all of the following apply:

(a) The dividing insurer continues to exist;

(b) The dividing insurer must amend its articles of incorporation if the amendments are provided for in the plan of division; and

(c) The dividing insurer must amend its bylaws if the amendments are provided for in the plan of division.

(2) On the effective date of a division pursuant to section 11, if the dividing insurer does not survive, the dividing insurer ceases to exist and any resulting insurer created by the plan of division comes into existence.

(3) Each resulting insurer holds any capital, surplus, and other assets allocated to the resulting insurer by the plan of division as a successor to the dividing insurer by operation of law, and not by transfer, whether directly or indirectly. The articles of incorporation and bylaws, if any, of each resulting insurer are effective when the resulting insurer comes into existence.

(4) All capital, surplus, and other assets of the dividing insurer:

(a)That are allocated by the plan of division vest in the applicable resulting insurer as provided in the plan of division or remain vested in the dividing insurer as provided in the plan of division;

(b) That are not allocated by the plan of division remain vested in the dividing insurer if the dividing insurer survives the division and are allocated to, and vest pro rata in, the resulting insurer individually if the dividing insurer does not survive the division; and

(c) Otherwise vest as provided in this section without transfer, reversion, or impairment.

(5) A resulting insurer to which a cause of action is allocated may be substituted or added in any pending action or proceeding to which the dividing insurer is a party when the division becomes effective.

(6) All liabilities, including policy liabilities, of a dividing insurer are allocated between or among any resulting insurers as provided in section 11, and each resulting insurer to which liabilities are allocated is liable only for those liabilities, including policy liabilities, allocated as a successor to the dividing insurer by operation of law, and not by transfer or assumption, whether directly or indirectly.

(7) Any shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the shareholders of those shares are entitled only to the rights provided to the shareholders under the plan of division and any appraisal rights that the shareholders may have pursuant to section 14.

(B) Except as provided in the dividing insurer's articles of incorporation or bylaws, a division does not give rise to any rights that a shareholder, director of a domestic stock insurer, or third party would have upon a dissolution, liquidation, or winding up on the dividing insurer.

(C) The allocation to a resulting insurer of capital, surplus, or other asset that is collateral covered by an effective financing statement is not effective until a new effective financing statement naming the resulting insurer as a debtor is effective under the "Uniform Commercial Code", title 4.

(D) Unless otherwise provided in the plan of division, the shares in, and any securities of, each resulting insurer are distributed to the dividing insurer, if it survives the division, or are distributed pro rata to the shareholders of the dividing insurer that do not asset any appraisal rights pursuant to section 14.

(E) A division that becomes effective pursuant to this Act is not an assignment of any insurance policy, annuity, reinsurance agreement, or other type of contract.

Section 13. Resulting insurers' liability for allocated assets and debts.

(A) Except as expressly provided in this section, when a division becomes effective, by operation of law all of the following apply:

(1) A resulting insurer is individually liable for the liabilities, including policy liabilities:

(a) That the resulting insurer issues, undertakes, or incurs in its own name after the division; and

(b) Of the dividing insurer that are allocated to or remain the liability of the resulting insurer to the extent specified in the plan of division;

(2) The dividing insurer remains responsible for the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division if the dividing insurer survives the division; and

(3) A resulting insurer is liable pro rata individually for the liabilities, including policy liabilities, of the dividing insurer that are not allocated by the plan of division if the dividing insurer does not survive the division.

(B) Except as otherwise expressly provided in this section, when a division becomes effective, a resulting insurer is not responsible for an does not have liability for:

(1) Any liabilities, including policy liabilities, that another resulting insurer issues, undertakes, or incurs in the resulting insurer’s own name after the division; or

(2) Any liabilities, including policy liabilities, of the dividing insurer that are allocated to or remain the liability of another resulting insurer under the plan of division.

(C) If a provision of indebtedness, whether secured or unsecured, or a provision of any contract other than an insurance policy, annuity, or reinsurance agreement that was issued, incurred, or executed by the dividing insurer before the effective date of this Act, requires the consent of the obligee to a merger of the dividing insurer, or treats such a merger as a default, the provision applies to a division of the dividing insurer as if the division were a merger.

(D) If a division breaches a contractual obligation of the dividing insurer, all resulting insurers are jointly and severally liable for the breach. The validity and effectiveness of the division is not affected by the breach.

(E) A direct or indirect allocation of capital, surplus, assets, or liabilities, including policy liabilities, occurs automatically, by operation of law, and may not be treated as a distribution or transfer for any purpose with respect to either the dividing insurer or any resulting insurer.

(F) Liens, security interests, and other charges on the capital, surplus, or other assets of the dividing insurer are not impaired by the division, notwithstanding any otherwise enforceable allocation of liabilities, including policy liabilities, of the dividing insurer.

(G) If the dividing insurer is bound by a security agreement governed by Articles 5 or 9 of the Uniform Commercial Code, or by the substantial equivalent as enacted in any other jurisdiction, and the security agreement provides that the security interest attaches to after-acquired collateral, a resulting insurer is bound by the security agreement.

(H) Unless otherwise provided in the plan of division and specifically approved by the commissioner, an allocation of a policy or other liability may not:

(1) Affect the rights that a policyholder or creditor has under any other law with respect to the policy or other liability; except that the rights are available only against a resulting insurer responsible for the policy or liability under this section; or

(2) Release or reduce the obligation of a reinsurer, surety, or guarantor of the policy or liability.

(I) A resulting insurer is liable only for the liabilities allocated to the resulting insurer in accordance with the plan of division and this section and is not liable for any other liabilities under the common law doctrine of successor liability or any other theory of liability applicable to transferees or assignees of assets.

Section 14. Shareholder appraisal rights.

If a dividing insurer does not survive a division, a shareholder of the dividing insurer is entitled to appraisal rights and to obtain payment of the fair value of the shareholder's shares in the same manner and to the extent provided for a corporation as a party to a merger pursuant to [insert citation to state shareholder right of dissent law].

Section 15. Rules.

The commissioner may adopt rules to administer this Act.

Section 16. Enforcement by commissioner.

The commissioner may take any action within the commissioner's authority to enforce compliance with this Act.

Section 17. Merger or consolidation effective with division.

(A) To facilitate the merger or consolidation of any resulting insurer with and into another company simultaneously with the effectiveness of a division authorized by this Act, a dividing insurer, including its officers, directors, and shareholders, may:

(1) Adopt and execute a plan of merger or consolidation on behalf of a resulting insurer;

(2) Execute and deliver documents, plans, certificates, and resolutions; and

(3) Make any filings, in each case, on behalf of the resulting insurer.

(B) If so provided in a plan of merger or consolidation described in this section, the merger or consolidation is effective simultaneously with the effectiveness of a division authorized by this Act.

(C) On request of the dividing insurer, the commissioner may waive the other requirements of this section with respect to any merger or consolidation involving only domestic stock insurers and may issue the commissioner's final approval of the merger or consolidation as part of the commissioner's approval of a plan of division under this Act.

Section 18. Effective Date

This Act shall take effect _____.

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

National Council of Insurance Legislators (NCOIL)

Remote Notarization Model Act

Draft as of March 16, 2021. This document is intended only as a discussion and conceptual draft as there is no sponsor attached.
To be discussed during the Financial Services & Multi-Lines Issues Committee on April 17, 2021.

AN ACT concerning remote notarial acts, and other acts for executing and verifying certain documents, by notaries public and certain other authorized officials using communication technology.

(A) As used in this section:

"Communication technology" means an electronic device or process that:

(1) allows a notary public or an officer authorized to take oaths, affirmations, and affidavits, or to take acknowledgements, and a remotely located individual to communicate with each other simultaneously by sight and sound; and

(2) when necessary and consistent with other applicable law, facilitates communication with a remotely located individual who has a vision, hearing, or speech impairment.

"Foreign state" means a jurisdiction other than the United States, a state, or a federally recognized Indian tribe.

"Identity proofing" means a process or service by which a third person provides a notary public or an officer authorized to take oaths, affirmations, and affidavits, or to take acknowledgements with a means to verify the identity of a remotely located individual by a review of personal information from public or private data sources.

"Notarial act" means any official act performed by a notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State, or performed by an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgments under […]. "Notarial act" shall include the following: taking acknowledgments; administering oaths and

affirmations; executing jurats or other verification; taking proofs of deed; and executing protests for non-payment.

"Outside the United States" means a location outside the geographic boundaries of the United States, Puerto Rico, the United States Virgin Islands, and any territory, insular possession, or other location subject to the jurisdiction of the United States.

"Remotely located individual" means an individual who is not in the physical presence of a notary public, or an officer authorized to take oaths, affirmations, and affidavits, or to take acknowledgements, performing a notarial act under subsection c. of this section.

"Satisfactory evidence" means a passport, driver's license, or government issued nondriver identification card, which is current or expired not more than three years before performance of the notarial act; another form of government identification issued to an individual, which is current or expired not more than three years before performance of the notarial act, contains the signature or a photograph of the individual, and is satisfactory to the notary public or officer authorized to take oaths, affirmations, and affidavits, or authorized to take acknowledgements; or a verification on oath or affirmation of a credible witness personally appearing before the notary public or officer and known to the notary public or officer or whom the notary public or officer can identify on the basis of a passport, driver's license, or government issued nondriver identification card, which is current or expired not more than three years before performance of the notarial act.

(B) Notwithstanding the provisions of any law or regulation to the contrary, a notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State or an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgements under […] may perform notarial acts using communication technology for a remotely located individual if:

(1) the notary public or officer:

(a) has personal knowledge of the identity of the individual appearing before the notary public or officer, which is based upon dealings with the individual sufficient to provide reasonable certainty that the individual has the identity claimed;

(b) has satisfactory evidence of the identity of the remotely located individual by oath or affirmation from a credible witness appearing before the notary public or officer; or

(c) has obtained satisfactory evidence of the identity of the remotely located individual by using at least two different types of identity proofing;

(2) the notary public or officer is reasonably able to confirm that a record before the notary public or officer is the same record in which the remotely located individual made a statement or on which the remotely located individual executed a signature;

(3) the notary public or officer or a person acting on their behalf creates an audio-visual recording of the performance of the notarial act; and

(4) for a remotely located individual who is located outside the United States:

(a) the record:

(i) is to be filed with or relates to a matter before a public official or court, governmental entity, or other entity subject to the jurisdiction of the United States; or

(ii) involves property located in the territorial jurisdiction of the United States or involves a transaction substantially connected with the United States; and

(b) the act of making the statement or signing the record is not prohibited by the foreign state in which the remotely located individual is located.

(C) If a notarial act is performed under this section, any required certificate shall indicate that the notarial act was performed using communication technology.

(D) A notary public appointed pursuant to the provisions of the [State notary law], or otherwise qualified and commissioned as a notary public in this State, or an officer authorized to take oaths, affirmations and affidavits under […] or to take acknowledgments under […], a guardian, conservator, or agent of such person or, if such person is deceased, a personal representative of the deceased person, shall retain the audio-visual recording created under paragraph (3) of subsection B. of this section or cause the recording to be retained by a repository designated by or on behalf of the person required to retain the recording. Unless a different period is required by rule adopted pursuant to subsection G. of this section, the recording must be retained for a period of at least 10 years after the recording is made.

(E) (1) Notwithstanding the provisions of the [State administrative procedures act], to the contrary, the State Treasurer may, in her discretion, adopt rules or append provisions to the manual distributed pursuant to section [State notary law] as necessary to implement the provisions of this section, which rules or appended provisions may include the means of performing a notarial act involving a remotely located individual using communication technology; standards for communication technology and identity proofing; and standards for the retention of an audio-visual recording created under paragraph (3) of subsection B. of this section.

(2) Before adopting, amending, or repealing any such rule or appended provision pursuant to this subsection, the State Treasurer shall consider the most recent standards regarding the performance of a notarial act with respect to a remotely located individual promulgated by national standard-setting organizations such as the Mortgage Industry Standards Maintenance Organization and the recommendations of the National Association of Secretaries of State.

(F) This act shall take effect immediately.

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

National Council of Insurance Legislators (NCOIL

Telemedicine Authorization and Reimbursement Act (TARA)

Sponsored by Asw. Pam Hunter (NY)

Discussion Draft as of August 25th, 2020

To be ~~introduced and~~ discussed during the NCOIL Health Insurance & Long Term Care Issues Committee meeting on April 17, 2021~~December 10, 2020.~~ ~~September 26, 2020~~

Table of Contents

Section 1. Title.

This act shall be known as and may be cited as the Telemedicine Authorization and Reimbursement Act.

Section 2. Purpose

The Legislature hereby finds and declares that:

(A) The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine.

(B) Geography, weather, availability of specialists, transportation, and other factors can create barriers to accessing appropriate health care, including behavioral health care, and one way to provide, ensure, or enhance access to care given these barriers is through the appropriate use of technology to allow health care consumers access to qualified health care providers.

(C) There is a need in this state to embrace efforts that will encourage health insurers and health care providers to support the use of telemedicine and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services.

(D) The need to access health care services is compounded by the challenges associated with COVID-19, as consumers are experiencing the negative effects the pandemic has on physical, mental, and emotional health that will extend into future years.

(E) Access to telemedicine is vital to ensuring the continuity of physical, mental, and behavioral health care for consumers during the COVID-19 pandemic and responding to any future outbreaks of the virus.

Section 3. Definitions

(A) “Telemedicine” means the delivery of clinical health care services by means of real time audio only telephonic conversation, two-way electronic audio visual communications, including the application of secure video conferencing or store and forward technology to provide or support healthcare delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at an originating site and the health care provider is at a distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(B) “Telehealth” means delivering health care services by means of information and communications technologies consisting of telephones, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient’s health care while such patient is at the originating site and the health care provider is at the distant site; consistent with applicable federal law and regulations; unless the term is otherwise defined by law with respect to the provision in which it is used.

(C) “Store and forward” transfer means the transmission of a patient’s medical information from an originating site to the provider at the distant site without the patient being present.

(D) “Distant site” means a site at which a health care provider is located while providing health care services by means of telemedicine or telehealth; unless the term is otherwise defined with respect to the provision in which it is used.

(E) “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of telemedicine or telehealth, unless the term is otherwise defined with respect to the provision in which it is used; provided, however, notwithstanding any other provision of law, insurers and providers may agree to alternative siting arrangements deemed appropriate by the parties.

Section 4. Coverage of Telemedicine Services

(A) Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

(B) An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through in-person consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

(C) An insurer, corporation, or health maintenance organization shall not require a covered person to have a previously established patient-provider relationship with a specific provider in order for the covered person to receive health care services provided through telemedicine services; however, the establishment of a patient-provider relationship shall not occur via an audio-only telephonic conversation..

(D) An insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through in-person consultation or contact.

(E) An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services;, however, such deductible, copayment, or coinsurance shall be combined with the deductible, copayment, or coinsurance applicable to the same services provided through in-person diagnosis, consultation, or treatment.

(F) No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered

under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

(G) The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in [State] on and after January 1, 20__, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

(H) This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

(I) Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require prior authorization of emergent telemedicine services.

Section 5. Limited Telemedicine License

An applicant who has an unrestricted license in good standing in another state and maintains an unencumbered certification in a recognized specialty area; or is eligible for such certification and indicates a residence and a practice outside [State] but proposes to practice telemedicine only across state lines on patients within the physical boundaries of [State], shall be issued a license limited to telemedicine by the [State] Medical Board. The holder of such limited license shall be subject to the disciplinary jurisdiction of the [State] Medical board in the same manner as if (s)he held a full license to practice medicine.

Section 6. Rules

The [chief State insurance regulator and the chief medical licensing regulator] may adopt rules regulating that are consistent with this Act.

Section 7. Effective Date

This Act shall become effective immediately upon being enacted into law.

Section 8. Severability

If any provision of this Act is held by a court to be invalid, such invalidity shall not affect the remaining provisions of this Act, and to this end the provisions of this Act are hereby declared severable.

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

National Council of Insurance Legislators (NCOIL)

Model Act Regarding Air Ambulance Patient Protections

Sponsored by Rep. Tom Oliverson, M.D. (TX) and Del. Steve Westfall (WV)
Draft as of November 9, 2020. To be ~~introduced and~~ discussed during the Health Insurance & Long Term Care Issues Committee on April 17, 2021~~December 10, 2020.~~

AN ACT to amend the insurance law, in relation to private air ambulance services and consumer protections

Section 1. Section (X) of the insurance law is amended by adding a new subsection (X) to read as follows:

(a) An air ambulance service or other entity that directly or indirectly, whether through an affiliated entity, agreement with a third party entity, or otherwise, solicits air ambulance membership subscriptions, accepts membership applications, or charges membership fees, is an insurer.

(b) An air ambulance membership shall be considered insurance and an insurance product and may be considered secondary insurance coverage or a supplement to any insurance coverage and shall be regulated accordingly by the State Department of Insurance;

Section 2. Air Ambulance Patient Billing Protections:

(a) An air carrier operating air ambulance operations shall, within one year of enactment of this Act, implement a patient advocacy program, which shall include, at a minimum, the following components:

(1) A dedicated patient hotline number and dedicated patient resource email address to process patient billing and claims, and to address patient questions, complaints and concerns;

(2) A dedicated patient advocacy page on the air medical provider's website that is clearly marked as the “patient portal” or “patient advocacy” page, which is easily navigated to and contains clearly-written and comprehensive resources for patients, including:

(A) A layperson's explanation of what to expect during the claims process,

(B) Frequently asked questions and answers,

(C) Frequently used forms,

(D) Information regarding the air ambulance provider's financial assistance or charity care program, and

(E) Additional resources for patients, including but not limited to contact information for the DOT Consumer Affairs Division, state and federal health and insurance regulatory agencies and departments, and other health consumer informational resources;

(3) Dedicated individuals assigned to review patient complaints and disputes about air ambulance billing and to respond to patients, governmental agencies and any other concerned parties no later than 3 months from the date the complaint is received;

(4) The inclusion of the patient hotline number and email address required by paragraph (1) and patient advocacy webpage address required by paragraph (2) on all patient communication materials, including but not limited to websites, brochures, letters, invoices or billing statements that are sent to or made available to patients;

(5) Mandatory yearly patient advocacy training for all air medical provider personnel who have direct interaction with patients and/or their family members via written, verbal or electronic communications; and

(6) A financial assistance or charity care program to assist patients suffering financial hardship with resolving any unpaid balance owed to the air medical provider.

(b) This provision shall not be enforced in a manner that conflicts with federal law, including the federal preemption of state regulation of air carriers.

Section 3. Consumer disclosures.

(a) An entity selling air ambulance membership products shall make the following general disclosures in writing in bold type and not less than twelve (12) point font on any advertisement, marketing material, brochure or contract terms and conditions made available to prospective members or the public:

(1) if eligible and covered by Medicaid or Medicaid managed care, the prospective member is already covered with no out of pocket cost liability for air ambulance services.

(2) if eligible and covered under Medicare and/or a Medicare supplemental plan, the prospective member might already be covered for air ambulance services and should consult with a representative of the Medicare program or a representative of their Medicare Advantage or Medicare Supplemental Plan to determine the level of existing coverage they have for air ambulance and out of pocket costs and whether their plan provider recommends additional supplemental insurance coverage.

Section 4. This act shall take effect one year after enactment.

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

National Council of Insurance Legislators (NCOIL)

Distracted Driving Model Act

Sponsored by Sen. Bob Hackett (OH) and Asm. Ken Cooley (CA)

Draft as of March 16, 2021~~November 9, 2020~~~~August 25, 2020~~

To be discussed and considered during the NCOIL Property & Casualty Insurance Committee on April 18, 2021.~~December 12, 2020.~~ ~~September 24, 2020.~~

Table of Contents

Section 1. Title

This Act shall be known and may be cited as the "[State] Distracted Driving Act."

Section 2. Purpose

This Model provides a structure to strengthen distracted driving laws across the country by establishing a comprehensive hands-free law to curb driver distraction, including manual, visual and cognitive distraction, to reduce highway fatalities, save lives, reduce auto crashes and make roads safer. The Model enables law enforcement to ticket drivers for holding a mobile device and limits use of a mounted or "hands-free" device while operating a motor vehicle, including texting, viewing videos or images, entering data, and talking or broadcasting content. Exceptions are provided for emergencies, for certain voice-activated technology, for

navigation, and for "single swipe" activation as long as the device is not held by the driver or used to engage in viewing distracting content. The increased prevalence of smartphone technology and expansion of its capability and potential for use has exacerbated distraction behind the wheel. Along with heightened public awareness, targeted research, and the development of technology to mitigate risks, the enactment of primary enforcement laws is an important part of the strategy to reduce traffic deaths and life altering crashes.

Section 31 – Definitions

'Stand-alone electronic device' means a portable device other than a wireless telecommunications device which stores audio or video data files to be retrieved on demand by a user.

'Utility services' means and includes electric, natural gas, water, waste-water, cable, telephone, or telecommunications services or the repair, location, relocation, improvement, or maintenance of utility poles, transmission structures, pipes, wires, fibers, cables, easements, rights of way, or associated infrastructure.

'Wireless telecommunications device' means one of the following portable devices:

(1) a cellular telephone;
(2) a portable telephone;
(3) a text-messaging device;
(4) a personal digital assistant;
(5) a stand-alone computer, including but not limited to a tablet, laptop or notebook computer;
(6) a global positioning system receiver;
(7) a device capable of displaying a video, movie, broadcast television image, or visual image; or
(8) Any substantially similar portable wireless device that is used to initiate or receive communication, information or data.

Such term shall not include a radio, citizens band radio, citizens band radio hybrid, commercial two-way radio communication device or its functional equivalent, subscription-based emergency communication device, prescribed medical device, amateur or ham radio device, or in-vehicle security, navigation, communications or remote diagnostics system.

"Voice-operated or hands-free feature or function" means a feature or function that allows a person to use an electronic wireless communications device without the use of either hand, except to activate, deactivate, or initiate the feature or function with a single touch or single swipe.

Section 4~~2~~ – Operation

(A) The driver of a school bus shall not use or operate a wireless telecommunications device, as such as term is defined in Section 3~~2~~ of this Act, or two-way radio while loading or unloading passengers.

(B) The driver of a school bus shall not use or operate a wireless telecommunications device, as such term is defined in Section 3~~2~~ of this Act, while the bus is in motion, unless it is being used in a similar manner as a two-way radio to allow live communication between the driver and school officials or public safety officials.

(C) A driver shall exercise due care in operating a motor vehicle on the highways of this state and shall not engage in any actions which shall distract such driver from the safe operation of such vehicle.

(D) While operating a motor vehicle on any street, highway, or property open to the public for vehicular traffic in this state, no individual shall:

(1) Physically hold or support, with any part of his or her body a:

(a) Wireless telecommunications device; or
(b) Stand-alone electronic device;

(2) Write, send, or read any text-based communication, including but not limited to a text message, instant message, e-mail, or social media interaction on a wireless telecommunications device or stand-alone electronic device; provided, however, that such prohibition shall not apply to a voice-operated or hands-free communication feature which is automatically converted by such device to be sent as a message in a written form; or

(3) Make any communication, including a phone call, voice message, or one-way voice communication; provided, however, that such prohibition shall not apply to a voice-operated or hands-free communication feature or function

(4) Engage in any form of electronic data retrieval or electronic data communication on a wireless telecommunications device or stand-alone electronic device;

(5) Manually enter letters, numbers, or symbols into any website, search engine, or application on a wireless telecommunications device or stand-alone electronic device;

(6) Watch a video or movie on a wireless telecommunications device or stand-alone electronic device other than watching data related to the navigation of such vehicle; or

(7) Record, post, send, or broadcast video, including a video conference on a wireless telecommunications device or stand-alone electronic device; provided that such prohibition shall not apply to electronic devices used for the sole purpose of continuously recording or broadcasting video within or outside of the motor vehicle.

(E) While operating a commercial motor vehicle on any highway of this state, no individual shall:

(1) Use more than a single button on a wireless telecommunications device to initiate or terminate a voice communication; or

(2) Reach for a wireless telecommunications device or stand-alone electronic device in such a manner that requires the driver to no longer be:

(a) In a seated driving position; or
(b) Properly restrained by a safety belt.

(F) Each violation of this Code section shall constitute a separate offense.

Section 5~~3~~ – Penalties

(A) Except as provide for in paragraph (B) of this section, any person convicted of violating this Act shall be guilty of an unclassified misdemeanor which shall be punished as follows:

(1) For a first conviction with no conviction of and no plea of no contest accepted to a charge of violating this Act within the previous 24 month period of time, as measured from the dates any previous convictions were obtained or pleas of no contest were accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than $150.00 and charged two (2) points.

(2) For a second conviction within a 24-month period of time, as measured from the dates any previous convictions were obtained or pleas of no contest were accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than $250.00 and charged three (3) points.

(3) For a third or subsequent conviction within a 24-month period of time, as measured from the dates any previous convictions were obtained or pleas of no contest were accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than $500.00, charged four (4) points, and at the court’s discretion, suspension of the offender’s driver’s license for a period of 90 days.

(B) Any person appearing before a court for a first charge of violating Section 4~~2~~ (D)(1) of this Act who produces in court a device or proof of purchase of such device that would allow such person to comply with such paragraph in the future shall not be guilty of such offense. The court shall require the person to affirm that they have not previously utilized the privilege under this paragraph.

(C) Any person convicted of a violation of any law or ordinance pertaining to speed when the offender also was distracted, as defined in this Act, shall be charged points as follows:

(1~~a~~) when the speed exceeds the lawful limit by thirty miles per hour or more, six (6) points

(2~~b~~) When the speed exceeds the lawful speed limit of fifty-five miles per hour or more by more than ten miles per hour, four (4) points

(3~~c~~) When the speed exceeds the lawful speed limit of less than fifty-five miles per hour by more than five miles per hour, four (4) points

(D) Any person who causes physical harm to property as the proximate result of committing a violation of this Act is guilty of a misdemeanor of the first degree. In addition to any other authorized penalty, the court shall impose upon the offender a fine not less than five hundred dollars and not more than one thousand dollars.

(E) Any person who causes serious physical harm to another person as the proximate result of committing a violation of this Act is guilty of aggravated vehicular assault and shall be punished according to this STATE's CRIMINAL CODE.

(F) Any person who causes the death of another as the proximate result of committing a violation of this Act is guilty of aggravated vehicular homicide and shall be punished according to this STATE'S CRIMINAL CODE.

DRAFTING NOTE: *States should consider aligning property damage, injury, and/or death with equivalent driver intoxication offenses and penalties.*

(G) Section 4~~2~~ (D) and (E) of this Act shall not apply when the prohibited conduct occurred:

(1) While reporting to state, county or local authorities a traffic accident, medical emergency, fire, an actual or potential criminal or delinquent act, or road condition that causes an immediate and serious traffic or safety hazard;

(2) By an employee or contractor of a utility services provider acting within the scope of his or her employment while responding to a utility emergency.

(3) A person operating a commercial truck while using a mobile data terminal that transmits and receives data;

(4) By a law enforcement officer, firefighter, emergency medical services personnel, ambulance driver, or other similarly employed public safety first responder during the performance of his or her official duties; or

(5) While in a motor vehicle which is lawfully parked.

Section 6. Enforcement and Reporting

(A) When a law enforcement officer issues a citation for a violation of this Act, the law enforcement officer must record the race and ethnicity of the violator. All law enforcement agencies must maintain such information and report the information to the [State Agency] in a form and manner determined by the [State Agency]. Beginning one year after enactment, the [State Agency] shall annually report the data collected under this Act to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The data collected must be reported at least by statewide totals for local law enforcement agencies, state law enforcement agencies, and state university law enforcement agencies. The statewide total for local law enforcement agencies shall combine the data for the county sheriffs and the municipal law enforcement agencies.

(B) A law enforcement officer who stops a motor vehicle for a violation of this Act must inform the motor vehicle operator of his or her right to decline a search of his or her wireless communications device and may not:

(1) Access the wireless communications device without a warrant.

(2) Confiscate the wireless communications device while awaiting issuance of a warrant to access such device.

(3) Obtain consent from the motor vehicle operator to search his or her wireless communications device through coercion or other improper method. Consent to search a motor vehicle operator's wireless communications device must be voluntary and unequivocal.

Section 7~~6~~. 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

National Council of Insurance Legislators (NCOIL)

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Adopted by the Property-Casualty Insurance Committee on November 16, 2007, and Executive Committee on November 17, 2007. Amended by both Committees on March 1, 2015. Readopted by the Property & Casualty Insurance Committee on September 24, 2020 and the Executive Committee on September 26, 2020.

Amendments sponsored by Asm. Ken Cooley (CA) – NCOIL Vice President

To be discussed and considered during the Property & Casualty Insurance Committee on April 18, 2021.~~December 12, 2020.~~

Summary

This model provides a comprehensive scheme for the protection of certain policy claimants when a property- casualty insurance company becomes insolvent and is ordered liquidated. The model calls for payment of covered policy claims that the now insolvent insurance company would not be able to pay on a timely basis and most likely would not be able to pay in full. While the model provides for claims payment, it is intended as a statutory remedy and not replacement insurance coverage. Hence, coverage will not always mirror that called for under the insurance policy. Reasonable limits are placed on coverage in order to strike a balance between the need to protect policy claimants when an insurance company becomes insolvent and the need to keep costs to the public, for providing this remedy, at a rational level.

Table of Contents

Section 1. Title

This Act shall be known as the [insert state name] Insurance Guaranty Association Act.

Section 2. Scope

This Act shall apply to all kinds of direct insurance, but shall not be applicable to the following:

A. life, annuity, health, or disability insurance

B. mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks

C. fidelity or surety bonds, or any other bonding obligations

D. credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor debtor transaction

E. insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits

F. title insurance

G. ocean marine insurance

H. any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk or

I. any insurance provided by or guaranteed by government

Drafting Note: In states where the insurance code does not adequately define "ocean marine insurance," the following may be added to Section 3. Definitions:

> *"Ocean marine insurance" includes any form of insurance, regardless of the name, label, or marketing designation of the insurance policy, that insures against maritime perils or risks and other related perils or risks that are usually insured against by traditional marine insurance, such as hull and machinery, marine builders risk, and marine protection and indemnity. Such perils and risks insured against include, without limitation, loss, damage, or expense or legal liability of the insured for loss, damage, or expense arising out of or incident to ownership, operation, chartering, maintenance, use, repair, or construction of any vessel, craft, or instrumentality in use in ocean or inland waterways for commercial purposes, including liability of the insured for personal injury, illness, or death or for loss or damage to the property of the insured or another person.*

Section 3. Definitions

As used in this Act:

A. "Account" means any one of the three (3) accounts created by Section 6.

B. "Affiliate" means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.

C. "Affiliate of the insolvent insurer" means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year prior to the date the insurer becomes an insolvent insurer.

D. "Association" means the [insert name of state] Insurance Guaranty Association created under Section 4.

E. "Association similar to the Association" means any guaranty association, security fund, or other insolvency mechanism that affords protection similar to that provided by the Association. The term also shall include any property-casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.

F. "Claimant" means any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.

G. "Commissioner" means the Commissioner of Insurance of this State.

Drafting Note: States that use the term "Director" or "Superintendent" rather than "Commissioner" should substitute that term in paragraph G and as used elsewhere in this Act.

H. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting securities, by contract other than a commercial contract for goods or non-management services, or otherwise, unless the power is the result of an official position with or corporate office held by the person. Control shall be presumed to exist if any person, directly or indirectly, owns, controls, holds with the power to vote, or holds proxies representing ten (10) percent or more of the voting securities of any other person. This presumption may be rebutted by a showing that control does not exist in fact.

I. 1. "Covered claim" means an unpaid claim, including one for unearned premiums, submitted by a claimant, that arises out of and is within the coverage and is subject to the applicable limits of an insurance policy to which this Act applies issued by an insurer, if such insurer becomes an insolvent insurer after the effective date of this Act and

a. the claimant or insured is a resident of this state at the time of the insured event provided that for entities other than an individual, the residence of a claimant, insured or policyholder is the state in which its principal place of business is located at the time of the insured event or

b. the claim is a first-party claim for damage to property with a permanent location in this state.

2. "Covered claim" shall not include:

a. any amount awarded as punitive or exemplary damages

b. any amount sought as a return of premium under any retrospective rating plan

c. any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, professional health service corporation, or self-insurer as subrogation recoveries, reinsurance recoveries, contribution, indemnification, or otherwise. No such claim for any amount due any reinsurer, insurer, insurance pool, underwriting association, health maintenance organization, hospital plan corporation, or self-insurer may be asserted against a person insured under a policy issued by an insolvent insurer other than to the extent such claim exceeds the Association obligation limitations set forth in Section 6 of this Act.

Drafting Note: Express exclusions set out in (c) above for health maintenance organizations, hospital plan corporations, professional health service corporations, and self-insurers may not be included in many current state laws. Fund counsel should review applicable case law in their states to determine if it is necessary or advisable to add them as part of an amendment package. Funds may want to consider characterizing such an amendment, if adopted, as "clarifying" or "technical."

Option A approach for net worth limitations–Exclude only first-party claims (Note: Amounts paid to third parties may be recovered by Association pursuant to section 9.B of this Act.)

d. any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year prior to the date the insurer becomes an insolvent insurer provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis

Option B approach for net worth limitation–Exclude both first and third-party claims

d. any first-party claim by an insured whose net worth exceeds $10 million on December 31 of the year prior to the date the insurer becomes an insolvent insurer; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis;

e. any third-party claim relating to a policy of an insured whose net worth exceeds $25 million on December 31 of the year prior to the date the insurer becomes an insolvent insurer, provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis. This exclusion shall not apply to third-party claims against the insured where the insured has applied for or consented to the appointment of a receiver, trustee, or liquidator for all or a substantial part of its assets, filed a voluntary petition in bankruptcy, filed a petition or an answer seeking a reorganization or arrangement with creditors or to take advantage of any insolvency law, or if an order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor, adjudicating the insured bankrupt or insolvent or approving a petition seeking reorganization of the insured or of all or substantial part of its assets.

Drafting Note: If Option B for net worth is chosen, drafters may want to consider whether jurisdictional circumstances warrant a carve out from subparagraph e. for workers' compensation claims, personal injury protection (PIP) claims, no-fault claims, and any other claims for ongoing medical payments to third parties. If administrative considerations suggest that an unacceptable interruption in claims payments would occur, such a carve out may be warranted.

f. any claim that would otherwise be a covered claim, but is an obligation to or on behalf of a person who has a net worth greater than that allowed by the insurance guaranty association law of the state of residence of the claimant at the time specified by such law, and which association has denied coverage to that claimant on that basis.

g. any first-party claims by an insured that is an affiliate of the insolvent insurer

h. any fee or other amount relating to goods or services sought by or on behalf of any attorney or other provider of goods or services retained by the insolvent insurer or an insured prior to the date it was determined to be insolvent

i. any fee or other amount sought by or on behalf of any attorney or other provider of goods or services retained by any insured or claimant in connection with the assertion or prosecution of any claim, covered or otherwise, against the Association

j. any claims for interest

k. any claim filed with the Association or a liquidator for protection afforded under the insured's policy for incurred-but-not-reported losses

3. Notwithstanding any other provision in this Act

a. an insurance policy issued by a member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of another insurer, pursuant to a state statute providing for the division of an insurance company or the statutory assumption or transfer of designated policies and under which there is no remaining obligation to the transferring entity (commonly known as "Division" or "Insurance Business Transfer" statutes), shall be considered to have been issued by a member insurer which is an Insolvent Insurer for the purposes of this Act in the event that the insurer to which the policy has been allocated, transferred, assumed or otherwise made the sole responsibility of is placed in liquidation.

b. insurance policy that was issued by a non-member insurer and later allocated, transferred, assumed by or otherwise made the sole responsibility of a member insurer under a state statute *described in subsection shall not be considered to have been issued by a member insurer for the purposes of this Act.*

J. "Insolvent insurer" means an insurer licensed to transact insurance in this state, either at the time the policy was issued or when the insured event occurred, and against whom a final order of liquidation has been entered after the effective date of this Act with a finding of insolvency by a court of competent jurisdiction in the insurer's state of domicile.

Drafting Note: "Final order" as used in this section means an order that has not been stayed. States in which the "final order" language does not accurately reflect whether or not the order is subject to a stay should substitute appropriate language consistent with the statutes or rules of the state to convey the intended meaning.

K. "Insured" means any name insured, any additional insured, any vendor, lessor, or any other party identified as an insured under the policy.

L. 1. "Member insurer" means any person who:

a. writes any kind of insurance to which this Act applies under Section 2, including the exchange of reciprocal or inter-insurance contracts; and

b. is licensed to transact insurance in this state (except at option of state).

2. An insurer shall cease to be a member insurer effective on the day following the termination or expiration of its license to transact the kinds of insurance to which this Act applies; however, the insurer shall remain liable as a member insurer for any and all obligations, including obligations for assessments levied prior to the termination or expiration of the insurer's license and assessments levied after the termination or expiration, which relate to any insurer that became an insolvent insurer prior to the termination or expiration of such insurer's license.

M. "Net direct written premiums" means direct gross premiums written in this state on insurance policies to which this Act applies, less return premiums thereon and dividends paid or credit to policyholders on such direct business. "Net direct written premiums" does not include premiums on contracts between insurers or reinsurers.

N. "Person" means any individual or legal entity, including governmental entities.

Drafting Note: In determining whether this definition of person is appropriate in a particular jurisdiction, fund managers and counsel should consider other applicable definitions of "person" embodied in state codes and case history interpreting existing definitions as applied to the guaranty association.

O. "Self-insurer" means a person that covers its liability through a qualified individual or group self-insurance program or any other formal program created for the specific purpose of covering liabilities typically covered by insurance.

Section 4. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [insert state name] Insurance Guaranty Association. All insurers defined as member insurers in Section 3 shall be and remain members of the Association as a condition of their

authority to transact insurance in this state. The Association shall perform its functions under a plan of operation established and approved under Section 7 and shall exercise its powers through a board of directors established under Section 5. For purposes of administration and assessment, the Association shall be divided into three (3) separate accounts: the account for workers' compensation, the account for auto, and the account for all other claims covered by the Association.

Drafting Note: While the three accounts set out above are typical, states may divide guaranty fund liabilities into other account structures as they deem appropriate.

Section 5. Board of Directors

A. The Board of Directors of the Association shall consist of not less than _____ (__) nor more than _____ (__) persons serving terms as established in the plan of operation. The members of the Board shall be selected by member insurers subject to the approval of the Commissioner. Vacancies on the Board shall be filled for the remaining period of the term by a majority vote of the remaining Board members subject to the approval of the Commissioner. If no members are selected within sixty (60) days after the effective date of this Act, the Commissioner may appoint the initial members of the Board of Directors.

B. In approving selections to the Board, the Commissioner shall consider, among other things, whether all member insurers are fairly represented.

C. Members of the Board of Directors may be reimbursed from the assets of the Association for expenses incurred by them as members of the Board.

Section 6. Powers and Duties of the Association

A. The Association shall:

1. be obligated to pay covered claims existing prior to the order of liquidation, that arise within thirty (30) days after the order of liquidation or before the policy expiration date if such expiration date is less than thirty (30) days after the order of liquidation, or that arise before the insured replaces the policy or causes its cancellation, if he does so within thirty (30) days of the order of liquidation. Such obligation shall be satisfied by paying to the claimant an amount as follows:

a. the full amount of a covered claim for benefits under a workers' compensation insurance coverage

b. an amount not exceeding $10,000 per policy for a covered claim for the return of unearned premium

c. an amount not exceeding $300,000 per claim for all other covered claims; provided, that for purposes of this limitation, all claims of any kind whatsoever arising out of, or related to, bodily injury or death to any one

person shall constitute a single claim, regardless of the number of claims made, or the number of claimants

Drafting Note: A state may wish to enact a higher claim limit depending on cost- of-living issues in the state.

In no event shall the Association be obligated to pay a claimant an amount in excess of the obligation of the insolvent insurer under the policy or coverage from which the claim arises. Notwithstanding any other provisions of this Act, a covered claim shall not include a claim filed with the Association after the earlier of: (a) twenty-five (25) months after the date of the order of liquidation, or (b) the final date set by the court for the filing of claims against the liquidator or receiver of an insolvent insurer.

Drafting Note: Optional language concerning workers' compensation benefits is included below for consideration in jurisdictions where the use of a 25-month bar date may be inappropriate in view of the latent nature of some occupational diseases that do not manifest themselves within this shortened period. This language is as follows:

The requirement of filing within twenty-five (25) months after the date of the order of liquidation shall not apply to claims by injured employees for workers compensation benefits where the basis for the claim is an occupational illness that does not manifest itself within the 25-month period.

Drafting Note: We recommend that the bar date provision set out above be applied only to claims related to liquidations occurring after the effective date of the amendment.

Any obligation of the Association to defend an insured on a covered claim shall cease upon the Association's (i) payment, either by settlement releasing the insured or on a judgment, of an amount equal to the lesser of the Association's covered claim obligation limit or the applicable policy limit or (ii) tender of such amount.

2. be deemed the insurer only to the extent of its obligation on the covered claims and to such extent, subject to the limitations provided in this article, shall have all rights, duties and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The Association shall not be deemed the insolvent insurer for any purpose relating to the issue of whether the Association is amenable to the personal jurisdiction of the courts of any state.

Drafting Note: The provision set out in this subsection 6. A. 2. is intended to be a clarification of the existing law in this state of the extent to which an association shall be deemed the insurer and concerning the nature of the contacts of the association outside of [designate state].

3. allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the Association under this Act subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year prior to the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year prior to the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any one year on any account an amount greater than two (2) percent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. Subject to this stated assessment limit, insurers may be subject to a minimum assessment determined by the Board, not to exceed $XX in any one year. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order that it deems reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.

4. investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other claims. The Association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

5. not be bound by any settlement, release, compromise, waiver, or judgment executed or entered within twelve (12) months prior to an order of liquidation and

shall have the right to assert all defenses available to the Association including, but not limited to, defenses applicable to determining and enforcing its statutory rights and obligations to any such claim. The Association shall be bound by any settlement, release, compromise, waiver, or judgment executed or entered into more than one year prior to an order of liquidation; provided, however, such claim is a covered claim and such settlement or judgment was not a result of fraud, collusion, default, or failure to defend. Further, as to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend, the Association either on its own behalf or on behalf of an insured may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding and shall be permitted to defend such claim on the merits.

6. handle claims through its employees or through one or more insurers or other persons designated as servicing facilities. Designation of a servicing facility is subject to the approval of the Commissioner, but such designation may be declined by a member insurer.

7. reimburse each servicing facility for obligations of the Association paid by the facility and for expenses incurred by the facility while handling claims on behalf of the Association and shall pay the other expenses of the Association authorized by this Act.

8. establish procedures for requesting financial information from insureds and claimants on a confidential basis for purposes of applying sections of this Act concerning the net worth of first and third-party claimants, subject to such information being shared with any other Association similar to the Association and the Liquidator for the insolvent company on the same confidential basis. If the insured or claimant refuses to provide the requested financial information and an auditor's certification of the same where requested and available, the Association may deem the net worth of the insured or claimant to be in excess of [insert proper amount] at the relevant time.

B. The Association may:

1. employ or retain such persons as are necessary to handle claims and perform other duties of the Association

2. borrow funds necessary to effect the purposes of this Act in accord with the plan of operation

3. sue or be sued, and such power to sue includes the power and right to intervene as a party as a matter of right before any court in this state that has jurisdiction over an insolvent insurer as defined by this Act.

4. negotiate and become a party to such contracts as are necessary to carry out the purpose of this Act

5. perform such other acts as are necessary or proper to effectuate the purpose of this Act

6. refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year

7. bring an action against any third-party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all files, records, and electronic data ("claims information") related to an insolvent company that are appropriate or necessary for the Association, or a similar association in other states, to carry out its duties under this Act. In such a suit, the Association shall have the absolute right through emergency equitable relief to obtain custody and control of all such claims information in the custody or control of such third-party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where such claims information may be physically located. In bringing such an action, the Association shall not be subject to any defense, lien (possessory or otherwise) or other legal or equitable ground whatsoever for refusal to surrender such claims information that might be asserted against the Liquidator of the insolvent insurers. To the extent that litigation is required for the Association to obtain custody of the claims information requested and it results in the relinquishment of claims information to the Association after refusal to provide the same in response to a written demand, the court shall award the Association its costs, expenses, and reasonable attorneys' fees incurred in bringing the action. The provisions of this section shall have no affect on the rights and remedies that the custodian of such claims information may have against the insolvent insurers, so long as such rights and remedies do not conflict with the rights of the Association to custody and control of the claims information under this Act.

C. Suits Involving the Association

1. Except for actions by member insurers aggrieved by final actions or decisions of the Association pursuant to Section 6.A.3., all actions relating to or arising out of this Act against the Association must be brought in the courts in this state. Such courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the Association.

2. Exclusive venue in any action by or against the Association is in [designate appropriate court]. The Association may, at the option of the Association, waive such venue as to specific actions.

3. In any lawsuit contesting the applicability of Sections 3.I.2.d. and e. or 9.B.1. where the insured or claimant has declined to provide financial information under the procedure provided pursuant to Section 6 of this Act, the insured or claimant shall bear the burden of proof concerning its net worth at the relevant time. If the insured or claimant fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the Association its full costs, expenses, and reasonable attorneys' fees in contesting its claim.

Drafting Note: Because of the potential impact on guaranty association coverage, it is recommended that the legislation include an appropriate provision clearly stating that the any newly enacted net worth provision applies only to legislation estates commencing after its effective date. If only the new administrative provisions are being added to a pre-existing net worth exemption, it would be possible to apply them to all outstanding claims.

Section 7. Plan of Operation

A. 1. The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.

2. If the Association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

B. All member insurers shall comply with the plan of operation.

C. The plan of operation shall:

1. establish the procedures whereby all the powers and duties of the Association under Section 6 will be performed

2. establish procedures for handling assets of the Association

3. mandate that procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer

4. mandate that procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 5.C

5. establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of claims shall be periodically submitted to the Association or Association similar to the Association in another state by the receiver or liquidator

6. establish regular places and times for meetings of the board of directors

7. mandate that procedures be established for records to be kept of all financial transactions of the Association, its agents, and the board of directors

8. provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within thirty (30) days after the action or decision

9. establish the procedures whereby selections for the board of directors will be submitted to the Commissioner

10. contain additional provisions necessary or proper for the execution of the powers and duties of the Association

D. The plan of operation may provide that any or all powers and duties of the Association, except those under Section 6.A.3. and 6.B.2., are delegated to a corporation, Association similar to the Association, or other organization that performs or will perform functions similar to those of this Association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Act.

Section 8. Duties and Powers of the Commissioner

A. The Commissioner shall:

1. notify the Association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency. The Association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction

2. upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer

B. The Commissioner may:

1. suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer that fails to pay an assessment when due or fails to comply with the plan of operation. As an alternative, the Commissioner may levy a fine on any member insurer that fails to pay an assessment when due. Such fine shall not exceed five (5) percent of the unpaid assessment per month, except that no fine shall be less than $100 per month.

2. revoke the designation of any servicing facility if he finds claims are being handled unsatisfactorily

C. Any final action or order of the Commissioner under this Act shall be subject to judicial review in a court of competent jurisdiction.

Section 9. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned his rights under the policy to the Association to the extent of his recovery from the Association. Every insured or claimant seeking the protection of this Act shall cooperate with the Association to the same extent as such person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent insurer and except as provided in Subsection B. below. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Association shall not operate to reduce the liability of the insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

B. The Association shall have the right to recover from the following persons all amounts paid by the Association on behalf of such person, whether for indemnity or defense or otherwise:

1. any insured whose net worth on December 31 of the year immediately preceding the date the insurer becomes an insolvent insurer exceeds $25 million; provided that an insured's net worth on such date shall be deemed to include the aggregate net worth of the insured and all of its subsidiaries and affiliates as calculated on a consolidated basis; and

2. any person who is an affiliate of the insolvent insurer.

C. The Association and any Association similar to the Association in another state shall be recognized as claimants in the liquidation of an insolvent insurer for any amounts paid by them on covered claims obligations as determined under this Act or similar laws in

other states and shall receive dividends and any other distributions at the priority set forth in [Liquidation Act reference]. The receiver, liquidator, or statutory successor of an insolvent insurer shall be bound by determinations of covered claim eligibility under this Act and by settlements of claims made by the Association or a similar organization in another state. The court having jurisdiction shall grant such claims priority equal to that which the claimant would have been entitled in the absence of this Act against the assets of the insolvent insurer. The expenses of the Association or similar organization in handling claims shall be accorded the same priority as the liquidator's expenses.

D. The Association shall periodically file with the receiver or liquidator of the insolvent insurer statements of the covered claims paid by the Association and estimates of anticipated claims on the Association. Such filing shall preserve the rights of the Association against the assets of the insolvent insurer.

Section 10. Exhaustion of Other Coverage

A. Any person having a claim under an insurance policy, whether or not it is a policy issued by a member insurer, and the claim under such other policy arises from the same facts, injury, or loss that gave rise to the covered claim against the Association, shall be required first to exhaust all coverage provided by any such policy. Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in such other insurance policy and the Association shall receive a full credit for such stated limits, or, where there are no applicable stated limits, the claim shall be reduced by the total recovery. Notwithstanding the foregoing, no person shall be required to exhaust any right under the policy of an insolvent insurer.

1. A claim under a policy providing liability coverage to a person who may be jointly and severally liable with or a joint tortfeasor with the person covered under the policy of the insolvent insurer that gives rise to the covered claim shall be considered to be a claim arising from the same facts, injury, or loss that gave rise to the covered claim against the Association.

2. A claim under an insurance policy shall also include, for purposes of this section:

a. a claim against a health maintenance organization, a hospital plan corporation, or a professional health service corporation; and

b. any amount payable by or on behalf of a self-insurer

c. To the extent that the Association's obligation is reduced by the application of this section, the liability of the person insured by the insolvent insurer's policy for the claim shall be reduced in the same amount.

B. Any person having a claim that may be recovered under more than one insurance guaranty association or its equivalent shall seek recovery first, from the Association of the place of residence of the insured except that if it is a first-party claim for damage to property with a permanent location, he shall seek recovery first from the Association of the location of the property, and if it is a workers' compensation claim, he shall seek recovery first from the Association of the residence of the claimant. Any recovery under this Act shall be reduced by the amount of recovery from any other insurance guaranty association or its equivalent.

Section 11. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

A. The board of directors may, upon majority vote, make recommendations to the Commissioner for the detection and prevention of insurer insolvencies.

B. The board of directors may, upon majority vote, make recommendations to the Commissioner on matters generally related to improving or enhancing regulation for solvency.

C. The board of directors may, at the conclusion of any domestic insurer insolvency in which the Association was obligated to pay covered claims, prepare a report on the history and causes of such insolvency, based on the information available to the Association, and submit such report to the Commissioner.

Section 12. Examination of the Association

The Association shall be subject to examination and regulation by the Commissioner. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the Commissioner.

Section 13. Tax Exemption

The Association shall be exempt from payment of all fees and all taxes levied by this state or any of its subdivisions except taxes levied on real or personal property.

Section 14. Recognition of Assessments in Rates

> *Drafting Note: Insurance companies that are "members" of the guaranty associations provide funds through assessments, as needed, for the guaranty associations' claim payment obligations. A method to recoup such assessments needs to be established in each state. Mechanisms currently employed include 1) permitting member insurers to surcharge policyholders, 2) permitting a premium tax offset for assessments paid by insurers, and 3) permitting premium increases to recoup assessment costs. This Section is left blank so that local authorities may determine the most appropriate mechanism for their states.*

Section 15. Immunity

There shall be no liability on the part of, and no cause of action of any nature shall arise against any member insurer, the Association or its agents or employees, the board of directors, or any person serving as a representative of any director, or the Commissioner or his representatives for any action taken or any failure to act by them in the performance of their powers and duties under this Act.

Section 16. Stay of Proceedings

All proceedings in which the insolvent insurer is a party or is obligated to defend a party in any court in this state shall, subject to waiver by the Association in specific cases involving covered claims, be stayed until the last day fixed by the court for the filing of claims and such additional time thereafter as may be determined by the court from the date the insolvency is determined or an ancillary proceeding is instituted in the state, whichever is later, to permit proper defense by the Association of all pending causes of action.

The liquidator, receiver, or statutory successor of an insolvent insurer covered by this Act shall permit access by the board or its authorized representative to such of the insolvent insurer's records that are necessary for the board in carrying out its functions under this Act with regard to covered claims. In addition, the liquidator, receiver or statutory successor shall provide the board or its representative with copies of such records upon the request by the board and at the expense of the board.

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

National Council of Insurance Legislators (NCOIL)

Fairness for Responsible Drivers Model Act

***Sponsored by Sen. Shawn Vedaa (ND)**
***Draft as of March 16th, 2021.**
***To be introduced and discussed during the Property & Casualty Insurance Committee on April 18, 2021.**

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Fairness for Responsible Drivers Act."

Section 2. Application

This Act applies to a civil action brought to recover damages for injury to or the death of a person, or damage to property, resulting from a motor vehicle accident.

Section 3. Definitions

(A) "Noneconomic damages" means costs for the following:

(1) Physical and emotional pain and suffering.

(2) Physical impairment.

(3) Emotional distress.

(4) Mental anguish.

(5) Loss of enjoyment.

(6) Loss of companionship, services, and consortium.

(7) Any other nonpecuniary loss proximately caused by a motor vehicle accident.

(B) The term “Noneconomic damages” does not include costs for the following:

(1) Treatment and rehabilitation.

(2) Medical expenses.

(3) Loss of economic or educational potential.

(4) Loss of productivity.

(5) Absenteeism.

(6) Support expenses.

(7) Accidents or injury.

(8) Any other pecuniary loss proximately caused by a motor vehicle accident.

Section 4. Prohibition on Recovery of Noneconomic Damages

(A) A person who was an uninsured motorist and who sustained bodily injury or property damage as the result of a motor vehicle accident may not recover noneconomic damages for the person's bodily injury or property damage.

(B) The personal representative of a person who was an uninsured motorist and who died as the result of a motor vehicle accident may not recover noneconomic damages under [insert citation to state wrongful death statute] for the person's death.

(C) The provisions of this Section shall not apply to an uninsured motorist who at the time of the automobile accident has failed to maintain coverage for a period of 45 days or less and who had maintained continuous coverage for at least one year immediately prior to such failure to maintain coverage.

Section 5. Exceptions

The prohibition against the recovery of noneconomic damages in Section 4 does not apply if the person who is liable for the injury, damage or death:

(A) was driving while under the influence of an alcoholic beverage or controlled substance;

(B) acted intentionally, recklessly, or with gross negligence;

(C) fled from the scene of the accident; or

(D) was acting in furtherance of an offense or in immediate flight from an offense that constitutes a felony.

Section 6. Effective Date

This Act shall take effect _____.

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

National Council of Insurance Legislators (NCOIL)

COVID-19 Limited Immunity Model Act

Sponsored by Rep. Bart Rowland (KY)
Co-Sponsored by Rep. Matt Lehman (IN)

Adopted by the Property & Casualty Insurance Committee on February 19, 2021.
To be considered for adoption by the NCOIL Executive Committee on April 18, 2021.

Section 1. Title

This Act shall be known and may be cited as the "[State] COVID-19 Limited Immunity Act."

Section 2. Definitions

(A) "Arising from COVID-19" means an injury or harm caused by or resulting from:

(1) the actual, alleged, or possible exposure to or contraction of COVID-19; or

(2) services, treatment, or other actions performed, not performed, or delayed in response to COVID-19.

(3) The term "arising from COVID-19" includes:

(a) the implementation of policies and procedures to prevent or minimize the spread of COVID-19;

(b) testing;

(c) monitoring, collecting, reporting, tracking, tracing, disclosing, or investigating COVID-19 exposure or other COVID-19 related information;

(d) using, designing, manufacturing, providing, donating, or servicing precautionary, diagnostic, collection, or other health equipment or supplies, including personal protective equipment;

(e) closing or partially closing to prevent or minimize the spread of COVID-19;

(f) delaying or modifying the schedule or performance of any medical procedure; and

(g) providing services or products in response to government appeal of repurposing operations to address an urgent need for personal protective equipment, sanitation products, or other products necessary to protect the public.

(B) "COVID-19" refers to any of the following:

(1) The novel coronavirus known as SARS-CoV-2;

(2) Any mutation of SARS-CoV-2;

(3) The coronavirus disease 2019.

(C) "Person" means any entity recognized in this state and shall include but not be limited to an individual, corporation, limited liability company, partnership, trust, association, church or religious organization, city, county, public or private school district, college, university or other institution of higher education, or other unit of local government.

Section 3. Limited Immunity from Liability

(A) Notwithstanding any other statute to the contrary, any person who acts in good faith in the course of or through the performance or provision of the person's business operations or on the premises owned or operated by the person shall be immune from civil liability for ordinary negligence for any personal injury or death arising from COVID-19, if the person acts as an ordinary, reasonable, and prudent person would have acted under the same or similar circumstances. For purposes of this subsection, ordinary, reasonable, and prudent shall include the adoption of safety measures as set forth in subsection (B) of this Section.

(B) Notwithstanding any other statute to the contrary, there shall be a rebuttable presumption that the safety measures adopted by any person, as defined in Section 2(C) of this Act, are reasonable, as used in subsection (A) of this Section, if those measures conform to the Centers for Disease Control and Prevention guidelines in existence at the

time of the alleged exposure. For purposes of this Section, the rebuttable presumption does not alter the applicable standard of care for medical, legal, or other negligence cases.

(C) Immunity as described in this section shall not apply to acts or omissions that constitute an intentional tort or willful or reckless misconduct as defined in [State Tort Code].

(D) Nothing in this Act shall be construed to modify the application of [State] worker's compensation laws.

(E) The immunity provided in this section is in addition to any other immunity protection that may apply in state or federal law.

Section 4. **Effective Date**

An emergency existing therefor, which emergency is hereby declared to exist, this Act shall be in full force and effect on and after its passage and approval.

Section 5. Sunset Date

The provisions of Section 3 of this Act shall be null, void, and of no force and effect on and after [ ].

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

National Council of Insurance Legislators (NCOIL)

Employer-Sponsored Group Disability Income Protection Model Act

Adopted by the NCOIL Health, Long-Term Care & Retirement Issues Committee on November 19, 2016 and the NCOIL Executive Committee on November 20, 2016. To be considered for re-adoption during Spring Meeting in April, 2021.
Sponsored by Rep. George Keiser (ND)

Section 1. Purpose

The legislature finds that this state's residents, government, taxpayers, employers, workers, and
their families share a common interest in protecting workers' income against the effect of disabling illness and injury. It is therefore the intent of the Legislature to provide tax incentives
to encourage employers to establish group disability income protection plans for their employees
and to enroll eligible employees in those plans.

Section 2. Definitions.

A. "Group disability income protection plan" means a group short-term disability policy and/or
a group long-term disability policy instituted by an employer to provide income benefits to
employee(s) unable to work for an extended period of time due to illness or accident.

B. "Employer" means [reference to applicable definition found in existing state code].

C. "Employee" means [reference to applicable definition found in existing state code].

Section 3. Tax Incentives for Employer Establishment of Disability Income Protection Plan

A. An employer in this state, who establishes a group disability income protection plan after the

effective date of this Act, shall be allowed a credit against annual state income tax liability in an amount equal to 25 percent of the costs of establishing and administering a group disability income plan for employees.

B. Amounts paid by an employer to defray disability income protection plan premiums shall not be included in costs when calculating the amount of tax credit allowed.

C. An employer who has established a group disability income protection plan for employees may claim tax credit under this section for no more than three years.

Section 4. Employer Tax Incentives for Employee Enrollment in Disability Income Protection Plan

A. An employer in this state, who establishes a group disability income protection plan for
employees after the effective date of this Act, or re-opens an existing plan for new enrollees,
shall be allowed a credit against annual state income tax liability in an amount of $100 for
each employee newly enrolled in such group disability income plan.

B. For purposes of calculating an employer's tax credit under this Act, only employees enrolled for the entire tax year and employees newly enrolled upon becoming eligible and enrolled through the end of the tax year shall be considered enrolled.

C. Under this Section, an employer may receive a credit against annual state income tax liability of not more than $10,000 for any tax year.

D. Under this Section, an employer may receive a credit against annual state income tax liability for no more than three years.

[Drafting Note: If state financial resources require a more limited tax credit, either Section 3 or Section 4 could be eliminated.]

Section 5. Effective Date

This Act shall become effective on _____.

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

National Council of Insurance Legislators (NCOIL)

Beneficiaries' Bill of Rights

Adopted by the NCOIL Executive Committee on November 21, 2010, and the NCOIL Life Insurance & Financial Planning Committee on November 19, 2010. Readopted by the NCOIL Executive Committee on February 28, 2016. To be considered for re-adoption during Spring Meeting in April, 2021

Section 1. Short Title

This Act shall be known as the Beneficiaries' Bill of Rights.

Section 2. Purpose

This Act will require complete and proper disclosure, transparency, and accountability relating to any method of payment for life insurance death benefits and require that beneficiaries are fully informed—in bold type and in layman's language—of their options.

Section 3. Definitions

A. "Policy" means any policy or certificate of life insurance that provides a death benefit.

B. "Retained Asset Account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy, including but not limited to the payment of cash surrender value, is
accomplished by the insurer or an entity acting on behalf of the insurer depositing the proceeds into an account, where those proceeds are retained by the insurer, pursuant to a supplementary contract not involving annuity benefits.

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

Section 4. General Requirements

A. An insurer may not use a retained asset account as the mode of settlement unless the insurer discloses such option to the beneficiary or the beneficiary's legal representative prior to the transfer of the death benefit to a retained asset account.
B. A beneficiary shall be informed of his or her rights to receive a lump-sum payment of life insurance proceeds in the form of a bank check or other form of immediate full payment of benefits.

Section 5. Disclosure Requirements

A. A complete listing and clear explanation of all of the life insurance proceeds payment options
available to the beneficiary in written or electronic format shall accompany the tender of other than a lump sum payment of a life insurance death benefit.

B. The use of a retained asset account shall require in the description and explanation pursuant to
Subsection 5(A) the following:

1. The recommendation to consult a tax, investment, or other financial advisor regarding tax liability and investment options;

2. The initial interest rate, when and how interest rates may change, and any dividends and other gains that may be paid or distributed to the account holder;

3. The custodian of the funds or assets of the account;

4. The coverage guaranteed by the Federal Deposit Insurance Corporation (FDIC), if any, and the amount of such coverage;

5. The limitations, if any, on the numbers and amounts of withdrawals of funds from the account, including any minimum or maximum benefit payment amounts;

6. The delays, if any, that the account holder may encounter in completing authorized transactions and the anticipated duration of such delays;

7. The services provided for a fee, including a list of the fees or the method of their calculation;

8. The nature and frequency of statements of account;

9. The payment of some or all of the proceeds of the death benefit may be by the delivery of checks, drafts, or other instruments to access the available funds;

10. The entire proceeds are available to the account holder by the use of one such check, draft, or other instrument;

11. The insurer or a related party may derive income, in addition to any fees charged on the account, from the total gains received on the investment of the balance of funds in the account;

12. The telephone number, address, and other contact information, including website address, to obtain additional information regarding the account; and

13. The following statement, "FOR FURTHER INFORMATION, PLEASE CONTACT YOUR STATE DEPARTMENT OF INSURANCE."

C. The writings produced to satisfy the requirements of this Section shall be in easy-to understand language and bold or at least 12-point type.

Section 6. Insurer Reporting

A. Insurers shall, on an annual basis, report the following information to the [Insert State Insurance Department]:

1. The number and dollar balance of retained asset accounts in force at the beginning of the year;

2. The number and dollar amount of retained asset accounts issued/added during the year;

3. The number and dollar amount of retained asset accounts closed out/withdrawn during the year;

4. The number and dollar balance of retained asset accounts in force at the end of the year;

5. The investment earnings or interest credited to retained asset accounts;

6. Fees and other charges assessed during the year;

7. A narrative description of how the accounts are structured. The description shall include:

(a) all of the different interest rates paid to retained asset account holders during the reporting year and the number of times changes were made during the reporting year;

(b) a list of all applicable fees charged by the reporting entity directly or indirectly associated with the retained asset accounts; and

(c) whether the retained asset accounts were the default method for satisfying life insurance claims;

8. The number and balance of retained asset accounts in force at the end of the current year and prior year segregated within "aging categories" of "up to 12 months," "13 to 24 months," "25 to 36 months," "37 to 48 months," "49 to 60 months," and "over 60 months;

9. The identity of any entity or financial institution that administers retained asset accounts on the insurer's behalf;

10. The number and amounts of retained asset accounts that are transferred annually to the state unclaimed property funds under abandoned property laws; and

11. Any other information relating to retained asset accounts as prescribed by the [Insert State Insurance Department].

B. An insurer shall immediately return any remaining balance held in a retained asset account to the beneficiary when the account becomes inactive. A retained asset account shall become inactive for purposes of this subsection if no funds are withdrawn from the account, and if no affirmative directive has been provided to the insurer by the beneficiary, during any continuous three-year period.

C. All marketing materials, disclosure statements, and supplemental contract forms utilized in connection with retained asset accounts shall be filed with the [Insert State Insurance Department] prior to their use. The commissioner shall disapprove any materials, statements, or forms submitted under this section that are inconsistent with Section 5 or are otherwise untrue, deceptive, or misleading.

Section 7. Unfair Trade Practice

Failure to meet any requirement of this Act is a violation of [Insert State Unfair Trade Practices Statute].

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

Section 8. Effective Date

This Act shall apply to claims for a death benefit under any policy or certificate of life insurance subject to the insurance laws of the state where the beneficiary resides submitted on or after [insert appropriate date].

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

National Council of Insurance Legislators (NCOIL)

Life Insurance Consumer Disclosure Model Act

Adopted by the NCOIL Executive Committee on November 21, 2010, and by the NCOIL Life Insurance & Financial Planning Committee on November 19, 2010. Readopted by the NCOIL Executive Committee on February 28, 2016. To be considered for re-readoption at Spring Meeting in April, 2021

Section 1. Short Title

This Act shall be known as the Life Insurance Consumer Disclosure Model Act.

Section 2. Definitions

A. "Commissioner" means the [insert title per individual state] in this state.

B. "Insurer" means the insurance company that issued the policy.

C. "Insured" means an individual covered by a policy.

D. "Person" means an individual or a legal entity.

E. "Policy" means an individual life insurance policy owned by a person who is a resident of this state, regardless of whether issued, delivered, or renewed in this state.

F. "Policy owner" means the owner of a policy.

Section 3. Notice to Policy Owner Required

A. An insurer shall provide the written notice required by Subsection 3(B) to a policy owner, if an insured is age sixty or older or is known by the insurer to be terminally ill or chronically ill, and if:

1. The policy owner requests the surrender, in whole or in part, of a policy;

2. The policy owner requests an accelerated death benefit under a policy;

3. The insurer sends notice to the policy owner that the policy may lapse; provided, however, that the insurer shall not be required to include the notice required by this paragraph to the policy owner more than one time within a twelve month period from the date of the first notice of lapse of the policy; or

4. At any other time that the commissioner may prescribe by rule.

B. The commissioner shall develop the written notice, promulgated by rule, to apprise policy owners of alternatives to the lapse or surrender of a policy and of the policy owner's rights as an owner of a policy related to the disposition of a policy. The notice shall be developed at no cost to insurers or other licensees and shall be written in lay terms.

C. The written notice shall contain the following:

1. A statement explaining that life insurance is a critical part of a broader financial plan;

2. A statement explaining that there are alternatives to the lapse or surrender of a policy;

3. A general description of the following alternatives to the lapse or surrender of a policy:

(a) accelerated death benefits available under the policy or as a rider to the policy;

(b) the assignment of the policy as a gift;

(c) the sale of the policy pursuant to a life settlement contract, including that a life settlement is a regulated transaction in this state [as applicable]

(d) the replacement of the policy pursuant to [cite any regulation governing policy replacement];

(e) the maintenance of the policy pursuant to the terms of the policy or a rider to the policy, or through life settlement contract;

(f) the maintenance of the policy through loans issued by an insurer or a third party, using the policy or the cash surrender value of the policy as collateral for the loan;

(g) conversion of the policy from a term policy to a permanent policy; and

(h) conversion of the policy in order to obtain long-term care health insurance coverage or a long-term care benefit plan.

4. A statement explaining that life insurance, life settlements, or other alternatives to the lapse or
surrender of the policy described in the notice may or may not be available to a particular policy
owner depending on a number of circumstances, including the age and health status of the insured or the terms of a life insurance policy, and that policy owners should contact their financial advisor, insurance agent, broker, or attorney to obtain further advice and assistance.

Section 4. Penalties

A violation of Section 3(A) shall be deemed an unfair trade practice pursuant to state law and subject to the penalties provided by state law.

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

National Council of Insurance Legislators (NCOIL)

Long-Term Care Tax Credit Model Act

Adopted by the NCOIL Health Insurance and Executive Committees on July 10, 1998. Readopted by the NCOIL Executive Committee on March 2, 2001; July 11, 2003; March 4, 2005; and March 7, 2010; and February 28, 2016. To be considered for re-adoption during Spring Meeting in April, 2021.

Section 1. Title. This Act may be cited as the Long-Term Care Tax Credit Act.

Section 2. Main Provisions.

A. A taxpayer shall be allowed a credit against the state income tax in an amount equal to fifteen percent (15%) of the premium costs paid during the taxable year for a qualified long-term care insurance policy as defined in section 7702B of the Internal Revenue Code that offers coverage to either the individual, the individual's spouse, parent, or a dependent as defined in Section 152 of the Internal Revenue Code.

(Drafting note -- The long-term care tax credit has been defined as 10 percent in some states,
and as much as 20 percent in other states.)

B. No taxpayer shall be entitled to such credit with respect to the same expended amounts for qualified long-term care insurance which are claimed by another taxpayer.

Section 3. Applicability.

A. The credit allowed by this Act may not exceed five hundred dollars ($500) or the taxpayers income tax liability, which ever is less, for each qualified long-term care insurance policy.

(Drafting note -- Legislation varies on this amount as well.)

B. Any unused tax credit shall not be allowed to be carried forward to apply to the taxpayer's succeeding years' tax liability.

C. No credit shall be allowed under this Act with respect to any premium for qualified long-term care insurance either deducted or subtracted by the taxpayer in arriving at [the state's] net taxable income or with respect to any premiums for qualified long-term care insurance for which amounts were excluded for [the state's] net taxable income.

Section 4. {Severability clause}

Section 5. {Repealer clause}

Section 6. {Effective date}

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

National Council of Insurance Legislators (NCOIL)

Peer-to-Peer Car Sharing Program Model Act

Sponsored by Rep. Bart Rowland (KY)

Adopted by the Property & Casualty Insurance Committee and Executive Committee on December 13th, 2019.
Proposed Amendments sponsored Rep. Bart Rowland (KY). To be discussed and considered during the Property & Casualty Insurance Committee Meeting on April 18, 2021.

Proposed amendments indicated by underline and ~~strikethrough~~.

Table of Contents

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. Scope

This Act is intended to govern the intersection of peer-to-peer car services and the state-regulated business of insurance. Nothing in this Act shall be construed to extend beyond insurance or have any implications for other provisions of the code of this state, including but not limited to, those related to motor vehicle regulation, airport regulation, or taxation.

Chapter 3. Definitions

Drafting Note: These definitions need to be read, interpreted and implemented within the limitations placed upon this Act by its scope set forth in Chapter 2.

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, which alternatively agreed upon location shall be incorporated into the car sharing program agreement; or

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

Chapter 4. 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 3 or 4 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 3 or Chapter 4 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 and in the event that a claim occurs in another state with minimum financial responsibility limits higher than [insert minimum limits citation], during the car sharing period, the coverage maintained under subsection (e) shall satisfy the difference in minimum coverage amounts, up to the applicable policy limits.

(g) The insurer, insurers, or peer-to-peer car sharing program providing coverage under (d) or (e) shall assume primary liability for a claim when: ~~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 the peer-to-peer car sharing program does not have available, did not retain, or fails to provide the information required by Section 4 of this Chapter 4; or ~~and~~

(2) a dispute exists as to whether the shared vehicle was returned to the alternatively agreed upon location as required under Section 11(2) of Chapter 3 ~~the peer-to-peer car sharing program does not~~

~~have available, did not retain, or fails to provide the information required by Section 4 of this Chapter 4~~.

~~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 4 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.

(c) Nothing in this Article invalidates, limits or restricts an insurer's ability under existing law to underwrite any insurance policy. Nothing in this Article invalidates, limits or restricts an insurer's ability under existing law to cancel and non-renew policies.

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, car sharing period pick up and drop off locations, 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, settlement, negotiation, or litigation. 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~~ recovery 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 4, 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 6. Regulations

The Insurance Commissioner shall have the authority to promulgate rules that are not inconsistent with and necessary to administer and enforce the provisions of this Act.

Chapter 7~~6~~. 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.*

All Copays Count Coalition

To be discussed during the Health Insurance & Long Term Care Issues Committee on April 17, 2021.

Accumulator Adjustment Program State Model Language

Section 1. Legislative Purpose

(A) The legislature finds that cost sharing assistance is indispensable to help many patients with rare, serious, and chronic diseases afford out-of-pocket costs for their essential, often lifesaving, medications.

(B) The legislature further finds that patients need cost sharing assistance because of the high out-of-pocket cost of medications.

(C) The legislature further finds that when patients face unexpected charges during the plan year, they are less likely to adhere to their medication regimen.

(D) The legislature further finds that lack of patient adherence to needed medicines leads to potential negative health consequences for the patients, such as unnecessary emergency room visits, doctors' visits, surgeries, and other interventions.

(E) The legislature further finds that patients are only able to use cost sharing assistance after they have met requirement(s) for coverage of their medication. Requirements for coverage can include the medication's inclusion on the patient's formulary and utilization management protocols, such as prior authorization and step therapy.

(F) The legislature further finds that health insurers and pharmacy benefit managers (PBMs) have implemented programs, such as accumulator adjustment programs, to restrict cost sharing assistance from counting towards a patient's deductible or annual out-of-pocket limit.

(G) The legislature further finds that as a result of an accumulator adjustment program, a patient is required to continue to make payments even if the patient has already hit an out-of-pocket limit when including cost sharing assistance. As such, the cost sharing assistance depletes leaving the patient responsible for paying the full deductible and meeting the annual out-of-pocket limit for a second time. This means accumulator adjustment programs limit the benefit patients receive from copay assistance programs.

(H) The legislature further finds that patients often are not aware of the inclusion of accumulator adjustment programs in their health plan contracts. Patients tend to learn about these types of programs when they attempt to obtain their medication after their cost sharing assistance has run out, whether at the pharmacy, infusion center, or at home through the mail.

(I) The legislature further finds that accumulator adjustment programs allow health insurers and PBMs to “double dip” by accepting funds from both the cost sharing assistance program and the patient beyond the original deductible amount and the annual out-of-pocket limit.

(J) Therefore, the legislature declares it a matter of public interest that health insurers and PBMs must count any amount paid by the patient or on behalf of the patient by another person towards a patient’s annual out-of-pocket limit and any cost sharing requirement, such as deductibles.

Section 2. Definitions

(A) “Cost sharing” means any copayment, coinsurance, deductible, or annual limitation on cost sharing (including but not limited to a limitation subject to 42 U.S.C. §§ 18022(c) and 300gg-6(b)), required by or on behalf of an enrollee in order to receive a specific health care service, including a prescription drug, covered by a health plan, whether covered under the medical or pharmacy benefit.

(B) “Carrier” OR “Insurer” OR “Issuer” means [cross-reference state insurance statutes and use their existing definitions], and shall include, but not be limited to any health insurance company, nonprofit hospital and medical service corporation, managed care organization, and, to the extent permitted under federal law, any administrator of an insured, self-insured, or publicly funded health benefit plan offered by public and private entities. For the purposes of this section, “insurer” does not include self-insured employer plans governed by the Employee Retirement Income Security Act of 1974 (ERISA) (Pub.L. 93–406, 88 Stat. 829, as amended).

(C) “Health Plan” means a policy, contract, certificate, or subscriber agreement entered into, offered, or issued by a health insurance issuer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services.

(D) “Person” means a natural person, corporation, mutual company, unincorporated association, partnership, joint venture, limited liability company, trust, estate, foundation, nonprofit corporation, unincorporated organization, or government or governmental subdivision or agency.

(E) “Pharmacy Benefit Manager” means any person or business who administers the prescription drug or device program of one or more health plans on behalf of a third party in accordance with a pharmacy benefit program. This term includes any agent or representative of a pharmacy benefit manager hired or contracted by the pharmacy benefit manager to assist in the administering of the drug program and any wholly or partially owned or controlled subsidiary of a pharmacy benefit manager.

Drafting Note: Use existing statutory definitions of “health plan” and “pharmacy benefit manager” when possible.

Drafting Note: If “person” is already in the state’s definition, that includes corporation. Otherwise, can remove “by another person.”

Section 3.

(A) When calculating an enrollee's overall contribution to any out-of-pocket maximum or any cost-sharing requirement under a health plan, a [CARRIER/INSURER/ISSUER] or pharmacy benefit manager shall include any amounts paid by the enrollee or paid on behalf of the enrollee by another person.

Section 4. Enactment

(A) This section shall apply with respect to health plans that are entered into, amended, extended, or renewed on or after January 1, 202##.

Organizations Endorsing Model Language
Allergy & Asthma Network
Alliance for Patient Access
American Autoimmune Related Disease Association
American Cancer Society Cancer Action Network
American Kidney Fund
Arthritis Foundation
California Chronic Care Coalition
Cancer Support Community
Chronic Care Policy Alliance
Coalition of State Rheumatology Organizations (CSRO)
Cystic Fibrosis Research Inc.
Diabetes Leadership Council
Diabetes Patient Advocacy Coalition
Epilepsy Foundation
Gaucher Community Alliance
Hemophilia Federation of America
HIV + Hepatitis Policy Institute
Infusion Access Foundation (IAF)
Immune Deficiency Foundation
International Foundation for Autoimmune & Autoinflammatory Arthritis (AiArthritis)
Little Hercules Foundation
Lupus and Allied Diseases Association, Inc.
Multiple Sclerosis Association of America
National Eczema Association
National Hemophilia Foundation
National Infusion Center Association (NICA)
National Multiple Sclerosis Society
National Psoriasis Foundation
Pulmonary Hypertension Association
Spondylitis Association of America
Texas Rare Alliance
The AIDS Institute

Contact

For questions or concerns about this model language, please do not hesitate to reach out to co-chairs of the All Copays Count Coalition's state subgroup, Lindsay Gill at the American Kidney Fund at lgill@kidenyfund.org and Steven Schultz of the Arthritis Foundation at sschultz@arthritis.org.

Last Updated: February 16, 2021

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
TAMPA, FLORIDA
DECEMBER 9, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in Insurance Underwriting met at the Tampa Marriott Water Street Hotel on Wednesday, December 9, 2020 at 9:30 A.M. (EST). This was the first of two meetings held that day. The second meeting convened at 2:00 P.M. (EST) and is documented in a separate set of minutes.

Senator Neil Breslin of New York, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)*
Rep. George Keiser (ND)*
Asw. Maggie Carlton (NV)*
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)*
Rep. Jim Gooch (KY)*
Sen. Shawn Vedaa (ND)
Rep. Wendi Thomas (PA)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

OPENING REMARKS

Rep. Matt Lehman (IN), NCOIL President, thanked everyone for participating and stated that he is extremely proud to serve as President of NCOIL as the organization takes strides to show leadership on these very important issues, and is delighted and thankful that Senator Breslin agreed to serve as Chair of this Committee. Having conversations like these that the Committee will have today is not easy. But NCOIL cannot sit idly while decisions that can have a huge impact on constituents and the state-based system of insurance regulation in general are made without input from state insurance legislators. Indeed, state legislators are those that have been vested with the authority to make such decisions pursuant to the McCarran-Ferguson Act enacted 75 years ago. In that regard, Rep. Lehman thanked all the interested parties that reached out with constructive feedback on the Committee's work and determined that getting involved with the Committee is the best way to proceed. Rep. Lehman also thanked his fellow

Officers for agreeing to serve on this Committee, as well as the other legislators that volunteered to do so.

In terms of a timeline for this Committee, in Rep. Lehman's discussions with Senator Breslin, they both agreed that there won't be any votes on anything today and the Committee will have to meet again to finalize any work product. Whether that will be via one or multiple Zoom meetings following this meeting, or convening again at the March meeting – or both or neither – will need to be determined depending on how the conversations go today. Rep. Lehman closed by stating that Zoom meetings can be difficult but everyone needs to be patient and wait for their turn to speak. Also, if anyone has any plans on trying to interrupt anyone speaking or providing purely opinion testimony that is not rooted in the law or any data, they are warned that such actions will not be entertained. NCOIL will not tolerate attacks on any individuals or organizations, period.

Sen. Neil Breslin (NY), Chair of the Committee, stated that he wishes he could be there but there is currently a big crisis in NY – a multi billion dollar deficit and while NY isn't unique among states with that problem he had to stay in NY. Sen. Breslin stated that NCOIL deserves credit for taking a lead in discussing these topics. They topics are not addressed at particular companies or people but its really a self assessment and self evaluation to take as much input as possible from as many people in the industry, legislators and consumer representatives. Rep. Lehman has done so much for NCOIL over the years and now as President he is continuing that. NCOIL has done a good job in preparing for this meeting today. Several conversations have taken place leading up to this to set up parameters and this meeting is critically important.

With regard to the McCarran-Ferguson Act, NCOIL has a long history supporting that. NCOIL testified in Congress several years ago regarding that Act and there are periodically attacks on the Act. Federal legislation has been introduced that seeks to intrude on the state based system. NCOIL stands firmly in the belief that unfair discrimination in any and every form is wrong and that is especially true for racial discrimination because of the abhorrent history involved. Forming this committee shows commitment to reviewing the insurance regulatory system in order to determine whether current practices exist in the system that disadvantage people of color because of their status while recognizing that changes in the industry system including determinations regarding rating variables must ultimately be made in a state legislative forum. Sen. Breslin stated that everyone should be familiar with the committee charges but he will review them now.

The Committee is charged with: taking testimony, discussing, and defining the term "proxy discrimination" – an undefined term that has been used by many when discussing insurance rating, and has even been included in regulatory-related documents; and discussing the wisdom of certain rating factors being used in insurance underwriting, such as zip code, and level of education. Sen. Breslin stated that he looks forward to the discussions today to hearing from the speakers. The first panel will provide an overview of the statutory insurance ratemaking framework.

OVERVIEW OF INSURANCE RATEMAKING STATUTORY FRAMEWORK

Laura Foggan, Esq., Partner at Crowell & Moring, LLP, stated that she appreciates the opportunity to speak to the committee and outline the statutory framework governing

insurance ratemaking as part of the overall hearing. Racial injustice has been thrust into the forefront of our minds and our experiences in 2020 by a series of devastating events and the public policy goals of eliminating racial bias and discrimination are being revisited throughout society including in the insurance system and insurance community. As state insurance legislators you have a key role to paly in addressing race and racial justice in the insurance system and this includes the responsibility being advanced by NCOIL and this Committee to examine insurance underwriting fairness.

Later panels today will focus on the definition of "proxy discrimination" and specific rating factors in underwriting. This panels charge is to provide a grounding for further discussion for an overview of the insurance ratemaking statutory framework and in the testimony that follows I therefore describe the current framework and how applicable standards for ratemaking work under current law. To begin with, the state statutory standards established by state legislatures govern insurance ratemaking. Insurer conduct in ratemaking is also overseen by state regulators based on the authority delegated to them to implement these state insurance laws. This reflects the McCarran-Ferguson Act and the delegation to the states of primary responsibility for regulating insurance in this country. While there is some variations in provisions from state to state at their core state laws governing ratemaking forbid insurers from setting rates that are excessive, inadequate or unfairly discriminatory. Those are the core principles in the current statutory framework. Insurance rates cannot be excessive, inadequate or unfairly discriminatory.

Today, our attention is focused laser like on the statutory requirement that rates cannot be unfairly discriminatory. We should begin with recognition of that the term unfairly discriminatory in insurance ratemaking is a term of art. It is a term with a particular and well defined meaning in the context of insurance ratemaking. As the Third Department of the New York Appellate Division said in a case discussing this term: "unfair discrimination is a word of art used in the field of insurance which in a broad sense means the offering of sales to customers in a given market segment identical or similar products at different probable costs." In insurance ratemaking, unfair discrimination is price discrimination that is setting a higher rate for an insurance purchase or group of purchasers that is not actuarially justified by a difference in the cost of providing insurance.

The fundamental concept of the state statutes governing insurance ratemaking is that the rates that insurers set must rest on cost based pricing. Cost based pricing is also known as risk based pricing. The state statutes governing insurance ratemaking make this clear. For instance, the Louisiana statute explains "unfairly discriminatory does not refer to rates that produce different premiums for policyholders with different loss exposures so long as the rate is actuarially justified and reflects such differences with reasonable accuracy." The Nevada statute provides "one rate is unfairly discriminatory in relation to another in the same class if it clearly fails to reflect equitably the difference in expected losses and expenses." The Minnesota statute says the same as do a great number of statutes and almost all use the terms inadequate excessive and unfairly discriminatory.

Courts agree that unfair discrimination is a term of art in the statutory framework governing insurance ratemaking. The Maryland Court of Appeals, MD's highest court, said that unfair discrimination as the term is employed by the insurance code means discrimination among insureds in the same class based on something other than

actuarial risk. The Massachusetts Supreme Court, MA's highest court, made clear that the intended result of the risk classification process is that persons of substantially the same risk will be grouped together paying the same premiums and will not be subsidizing insureds who present a greater hazard. Understanding that unfair discrimination has a particular meaning in the statutory framework governing insurance rates is important. As many commentators have observed, all insurance rating depends on discrimination and differentiation of groups based on actuarial factors. Discrimination in setting insurance rates is expected and necessary. It is unfair under the core legislative framework only if it is statistically, that is actuarially, justified.

Statutes governing underwriting practices set out the principle that unfair discrimination prohibits insurers use of a differentiation that is not actuarially justified. In other words, when a rating factor's predictive value is shown then insurers reliance on that factor is fair under the statutes. As the Massachusetts Supreme Court put it "the basic principle underlying statues governing underwriting practices is that insurers have the right to classify risks and to elect not to insure risks if the discrimination is fair. The intended result of the process is that persons of substantially the same risk will be grouped together." This statutory approach is the framework of cost based or risk based pricing. When actuarial justification for use of a classification is shown, then use of the factor is permitted because there has been a legislative judgment in favor of risk based pricing. The legislative standard reflects a basic belief that price should reflect cost. So, in the insurance context this means that there has been a legislative judgment that tying price to risk is equitable and fair. This legislative judgment makes sense. Not only is there a broad societal norm that you should pay for the costs of what you get but risk based pricing is also consistent with how an efficient market works.

In a competitive marketplace an insurer wants to price its coverage as accurate as possible. It will not use a characteristic with no predictive power in underwriting. Insurers are incentivized to charge different premiums to individuals who pose different predictive risks. This is desirable because charging the same price to individuals with different risks can generate a moral hazard problem where an insured with an undesirable risk profile purchases more insurance and it can encourage adverse selection where a lower risk individual elects not to purchase coverage which has become too expensive – the price is too high because the premium subsidized the riskier actor grouped with the lower risk one. Allowing insurers to set rates and prices in accordance with risk avoids these hazards. That makes the marketplace more efficient and decreases the risk of insurer insolvency.

In short, there is strong public policy supporting the statutory framework of risk based pricing. The existing statutory framework also includes certain protections against injustice in insurance underwriting. For insurance, one fundamental protection against injustice in the risk based system is the requirement of actuarial justification for any factor used to discriminate among insurance purchases. A rate based on any risk classification must predict future costs associated with the risk transfer. There must in other words be a business justification for using the classification. An insurer may not rely on a factor or characteristic due to animus or bigotry. Only a characteristic with predictive power in underwriting is permissible under a risk based pricing system. The rate produced must be an actuarially sound estimate of the expected value of all future costs associated with the risk transfer.

Under current law, there are also some protections against injustice in legislation that specifically prohibits the use of race, religion and national origin as factors in setting rates. Sate legislatures have passed laws forbidding the use of underwriting classifications that are abhorrent to public policy such as discrimination in rates based on race, religion and national origin. Some states have outlawed other rating factors on public policy grounds as well. There are for instance state laws forbidding insurers from setting rates based on sexual orientation, gender or genetic traits. Through public policy determinations made by state legislatures these laws provide an added measure of protection against rating factors that have been found to violate social justice norms even if those factors may have a predictive value in underwriting.

One of the panels that follows will discuss factors that may have a disparate impact on racial and ethic minorities or economic disadvantaged groups. When the benefits of predictive value of such classification are outweighed by social justice considerations, they may be an appropriate candidate for legislative action. The legislative process provides a check on the underwriting process by setting standards after informed discussion of public policy concerning rating factors and an analysis of the actuarial significance of the pricing factor at issue and consideration of all interests at stake. These can be difficult questions because risk based pricing is designed to achieve legitimate busines purposes by tying risk to the price of insurance through actuarial science, by making pricing rational and by protecting against insurer insolvency.

You will also hear testimony about the definition of proxy discrimination. The NCOIL staff's proposed definition of that term can serve to quell confusion about the meaning of this term which recently has appeared in discussions about insurance underwriting particularly in relation to AI and algorithmic protections. Existing law forbids discrimination by using a characteristic without predictive power or a characteristic prohibited by law. If an insurer used a proxy for the purpose of discriminating based on a prohibited rating factor that conduct I submit would be forbidden under existing law. Nevertheless, this could be clarified through the NCOIL staff definition of proxy discrimination.

Whether underwriting decisions are made by humans or machines based on prohibited characteristics or factors chosen as proxies for them, intentional discrimination in underwriting based on race, religion or national origin is not lawful. The existing statutory framework for insurance ratemaking can and should be applied to stop discrimination based on race and consistently within this framework there is also precedent for legislative review and necessary action to address other rating factors that may violate public policy norms. Addressing racial injustice and providing financial protection against risks in a way that is actuarially sound, affordable, sustainable, responsible and accessible for all customers is important and I look forward to further discussion today about race in underwriting and the legislative framework for insurance ratemaking.

Birny Birnbaum, Director of the Center for Economic Justice (CEJ), thanked the Committee for the opportunity to speak and stated that for background purposes, he served as Chief Economist at the TX office of public insurance counsel (OPIC) and then associate commissioner for Policy and Research at the Texas Department of Insurance (TDI). He has deep technical, regulatory and policy experience. For the past 30 years, he has served as an expert witness and consultant to public agencies and consumer organizations on, among other things, unfair discrimination in insurance. He received

his training in economic and statistical analysis at the Massachusetts Institute of Technology.

He stated he has no financial interest in the outcome of today's deliberations. He serves pro bono as the Director of the Center for Economic Justice as a consumer representative. As always, if there any doubts about the evidence and arguments he presents, he requested to be challenged on it and engaged. Mr. Birnbaum spoke a little bit about the Center for Economic Justice. They work on insurance issues because insurance is a miraculous tool for individual and community economic development and well-being and because insurance is the most important tool for resiliency and sustainability. They work on economic and racial justice in insurance to help make insurance available and affordable to the communities most in need of these essential financial tools.

So, lets talk about fair and unfair discrimination in insurance. First, discrimination is not a dirty word. Fair discrimination in insurance is important. Our focus today is on distinguishing between fair and unfair discrimination and how systemic racism in society leads to unintentional unfair discrimination in insurance against communities of color. The word unintentional is very important. Generally, fair discrimination means that there is an actuarial basis for treating individual consumers or groups of consumers differently. We find this in rating statutes and unfair trade practices (UTP) statutes. Rating statutes typically define two types of unfair discrimination. One is actuarial meaning that there must be an actuarial basis for distinctions among groups of consumers. The second type is discriminating on the basis of a protected class characteristic regardless of actuarial basis. The UTP statutes typically define unfair discrimination based on a protected class characteristic. Both the NCOIL P&C Insurance Modernization Act and NAIC P&C Model Rating Law and state laws reflect these two types of unfair discrimination. NCOIL P&C modernization says "For the purpose of this Act, "Unfairly discriminatory" refers to rates that cannot be actuarially justified. It does not refer to rates that produce differences in premiums for policyholders with like loss exposures, so long as the rate reflects such differences with reasonable accuracy." And "No rate in a competitive market shall be considered unfairly discriminatory unless it violates the provisions of section 6(B) in that it classifies risk, on the basis of race, color creed, or national origin. Risks may be classified in any way except that no risk may be classified on the basis of race, color, creed, or national origin.

Similarly, the NAIC P&C model rating law says "Unfair discrimination exists if, after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses." And "Risks may be grouped by classifications for the establishment of rates and minimum premiums. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in
hazards or expense provisions, or both. Such standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the
insured."

The second type of unfair discrimination is discriminating on the basis of a protected class characteristic regardless of actuarial basis. So even if an insurer found an actuarial basis for using race as a factor in marketing, underwriting, claims settlement or

antifraud, the laws prohibit that. And it is not just related to rating. If you were to discriminate in claims settlement on the basis of race that would also be a violation. You'll note that neither model mentions the word "correlation." The reason that correlation is not mentioned is because the actuarial standard requires more than a correlation. A correlation is simply a relationship between two things. But that relationship may not be reliable. The correlation may be spurious, which means that the relationship is random and temporary. Like the example on slide 8 which shows an almost perfect correlation between the divorce rate in Maine and the per capita consumption of margarine. No one would suggest that this historical relationship is anything more than an anomaly and is reliable to predict the future.

Slides 9 and 10 show a spurious correlation in insurance. In the early 1990's, when Mr. Birnbaum was in TX working on these issues a company filed for a homeowners discount based on tenure with the company. The insurer presented a chart similar to the one on slide 9 showing a correlation – a declining loss ratio for policyholders with each additional year with the company. So, somebody who is with us for 5 years has a much lower loss ratio than someone with us for 1 year so we want to offer a tenure discount. It turned out that this was a spurious correlation because the data combined renters and homeowners insurance. When you looked at them separately you found that renters insurance was a consistently higher loss ratio than homeowners insurance. What happens is that with each year more and more renters drop off the book of business whereas homeowners tend to stay on longer. So, what the original chart was showing was simply a growing percentage of homeowners in the book of business with each year of tenure.

There's another important reason why a simple correlation does not meet the statutory rate standards and why insurers don't rely on simple correlations to develop prices. The reason is that various risk characteristics are correlated with one another. Here, we look at correlations between driver age and auto claims and marital status and auto claims and vehicle age and auto claims. Each of these represents a one-to-one relationship – a univariate analysis meaning one variable to predict the outcome. But since we are looking at each predictive variable separately and because the three predictive variables are highly correlated with one another, when we add the variables, we don't have an accurate indication because of overlap among the predictive variables. Stated differently, driver age is not only predicting auto claim frequency, but also predicting marital status. So, what insurers have done for at least the last 30 years is develop new techniques to address problems with univariate analysis. Insurers use a variety of techniques to eliminate correlations among predictive variables in order to isolate each individual predictive variable's unique contribution to explaining the outcome.

So, to give you an idea of where we are at now, a simple correlation is to today's insurance algorithms as a paper plane is to a Boeing 787. On slide 13, I list some of the techniques used by insurers. Each month, the NAIC Casualty and Actuarial Task Force holds a "book club" with a presentation on new techniques insurers are using for pricing. Here are some recent techniques presented: Families of Generalized Linear Models (Variations on Multiple Regression); Gradient Boosting Models; Machine Learning; Hyperparameter Tuning; Neural Networks; Generative Adversarial Networks. Accordingly, the concept of simple correlations, if it ever existed, is simply outdated.

So, how does a multivariate analysis work? Here's a simple illustration of a multivariate model. Let's create a simple model to predict the likelihood of an auto claim: $b0 + b1X1$

+ b2X2 + b3X3 + e = y. X1, X2 + X3 are the predictive variables trying to predict y. Say that X1, X2 + X3 are age, marital status and credit score and we are trying to predict y – the frequency of an auto claim. Let's assume that all three Xs are statistically significant predictors of the likelihood of a claim and the b values are how much each X contributes to the explanation of claim. The important thing is that by analyzing these predictive variables simultaneously, the model
removes the correlation among the predictive variables. By analyzing them simultaneously we're better able to get the unique and independent contribution of each variable to explaining the outcome.

How do we even improve the multivariate analysis. Here is what insures so. Suppose an insurer want to control for certain factors that might distort the analysis? For example, an insurer developing a national auto insurance pricing model would want to control for different state effects like different age distributions, different minimum limits requirements and differences in jurisprudence. An insurer would add one or more control variables. They add another variable to the model and in this case lets call it "state." By including State as a control variable, the correlation of the Xs to State is statistically removed and the new b values are now the contribution of the Xs, independent of their correlation to State, to explaining the likelihood of a claim. So the fact that one state has a much older population than another wont distort the outcomes.

Let's get to the issue of proxy discrimination, a concept the Committee is familiar with because when state legislatures develop legislative districts – for state and federal legislators – they use proxies to identify how people will vote. The party in power seeks to maximize the number of districts whose voters will likely vote for members of their party. So, this is not a radical concept by any stretch of the imagination. But lets look at proxy discrimination against a protected class in insurance. The terms "proxy discrimination against a protected class" and "disparate impact" mean the same – discriminating on the basis of a protected class characteristic using a proxy for the protected class characteristic. I hope we agree that denying coverage or otherwise discriminating against consumers because they are Black Americans or Evangelical Christians is unfair discrimination in insurance. Suppose now that we are in an era of Big Data where insurers have access to massive amounts of personal consumer information, that I found a perfect proxy for either of these protected class characteristics and the effect is identical to discriminating directly on the basis of the protected class characteristics. Should a regulator stop the use of these proxy variables on the basis of discriminating against a protected class? The insurance industry says no – the regulator has no such authority but that of course defeats the purpose of the statutory prohibition against discriminating against protected classes. Regulators disagree with the industry on that position as well.

So, what is systemic racism and how does that play into this? Insurance company CEO's recognize the impact of systemic racism. For example the CEO of American Family said "Floyd's death in Minneapolis is the latest example of "a broken society, fueled by a variety of factors but all connected by inherent bias and systemic racism. Society must take action on multiple levels and in new ways. It also requires people of privilege—white people—to stand up for and stand with our communities like we never have before." So, why do state and federal laws prohibit discrimination on the basis of race? The earlier speaker stated it is because it is abhorrent. Is it just because it offends us? The answer is of course not – it is much deeper than that. Justice Kennedy for the Majority in the U.S. Supreme Court's 2015 Inclusive Communities Opinion

upholding disparate impact as unfair discrimination under the Fair Housing Act said "recognition of disparate impact liability under the FHA lays an important role in uncovering discriminatory intent but it also permits plaintiffs to counteract unconscious prejudices and disguised animus that escape easy classification as disparate treatment." So, here, Justice Kennedy is saying that just looking at intentional discrimination – disparate treatment – was not enough. Prohibitions against unfair discrimination on the basis of race require analysis of disparate impact. Justice Kennedy understood that the legacy of historical discrimination continues today in systemic ways. In some cases directly, some cases, indirectly, unconsciously, and unintentionally.

We continue to see those legacies today – directly and indirectly. Policing and criminal justice; housing; and impacts of COVID. The prohibition against discriminating on the basis of race regardless of actuarial basis in insurance laws is also a recognition of intentional discrimination. Insurance is not immune to systemic racism. There are examples of practices that clearly have a disparate racial impact because they rely upon data in development of the algorithms that are highly biased on the basis of race. But, we have a solution and the solution is not an either or – it's not down to a choice between prohibiting a factor or permitting a factor. The tool to identify unintentional discrimination or proxy discrimination against protected classes is disparate impact analysis. Disparate impact is both the standard for determining whether proxy discrimination is present and a methodology for identifying and minimizing that proxy discrimination within that risk based framework of insurance. So, if we go back to the model earlier – if we put in race as a control factor instead of state we now are able to remove the correlation between our predictive variables and rates. What this does is minimize the racial bias while managing the risk and focus of insurance. In fact, by eliminating correlations with race, we improve risk based pricing.

There is a long history and many approaches to identifying and minimizing disparate impact in employment, credit and even in insurance but the general principle is to identify and remove correlations between protected class characteristics and the predictive variables. So, what if X1, X2 and X3 are not perfect proxies for race, but are somewhat of a proxy for race? Then, the disparate impact analysis – and our simple model – removes that correlation and the remaining values for b1, b2 and b3 are the unique contributions of each predictive variable to explaining the outcome. The result is more – not less – accurate cost-based or risk-based analysis. Why is it reasonable and necessary to recognize disparate impact as unfair discrimination in insurance? There are at least three reasons. First, it makes no sense to permit insurers to do indirectly what they are prohibited from doing directly. If we don't want insurers to discriminate on the basis of race, why would we ignore practices that have the same effect? Second, it improves risk-based and cost-based practices. Third, in an era of Big Data, systemic racism means that there are no "facially-neutral" factors. The big data mining activities often reflect and perpetuate historical patterns of inequity.

Mr. Birnbaum stated that he would like to finished by emphasizing that some of the things that insurers do is a function of their models not trying to predict risk but trying to predict non risk outcomes. Here are some quotes from what insurance executives have told investment analysists. In 2005, the CEO of Allstate explained how they identify the right and wrong types of consumers. Here, he was talking about the use of credit scoring. "Tiered pricing helps us attract higher lifetime value customers who buy more products and stay with us for a longer period of time. That's Nirvana for an insurance

company. Tiered pricing has several very good, very positive effects on our business. It enables us to attract really high quality customers to our book of business. The key, of course, is if 23% or 20% of the American public shops, some will shop every six months in order to save a buck on a six-month auto policy. That's not exactly the kind of customer that we want. So, the key is to use our drawing mechanisms and our tiered pricing to find out of that 20% or 23%, to find those that are unhappy with their current carrier, are likely to stay with us longer, likely to buy multiple products and that's where tiered pricing and a good advertising campaign comes in." These statements were made in the Stone Age of Big Data – 2005.

In 2017, the CEO of Allstate said the "universal consumer view" keeps track of information on 125 million households, or 300 million-plus people. "When you call now they'll know you and know you in some ways that they will surprise you, and give them the ability to provide more value added, so we call it the trusted adviser initiative." Just last month, Progressive's CEO in response to a question from an investment analyst said "yes, we have -- we do incentives and we have different commissions based on the type of customer that we get in namely preferred." So, there are a number of practices that raise concerns about proxy discrimination on the basis of race. One is the increasing use of customer lifetime value scores. By definition, these are algorithms used by insurers that use non cost factors to differentiate among consumers and the factors and data reflect bias against communities of color. Credit based insurance scores reflect that consumer credit data has a disproportionate bias on the basis of race. With criminal history scores, you just have to read some of the DOJ reports on discrimination in policing and you know that criminal history scores will also be based on bias data.

So, what are the benefits and costs of requiring insurers to test for and minimize disparate impact? If racial and economic justice are a priority, if cost-based insurer practices are a priority, if closing the protection gap and making insurance more affordable and available in traditionally underserved communities, then the benefits of requiring insurers to test for and minimize disparate impact far, far outweigh the costs. While there are examples of disparate impact claims brought against insurers under the federal Fair Housing Act that have resulted in improved risk-based pricing, for example challenges based on age and value of the home, industry has not been able to cite a single example of a successful disparate impact claim that has harmed risk-based pricing.

Mr. Birnbaum stated that he would like to close by stating that it is not only reasonable and necessary to test for disparate impact in pricing but in every aspect of an insurers operations. Today's Big Data algorithms and variety of marketing channels give insurers – like other businesses – the ability to micro-target consumers. This ability to micro-target gives insurers the ability to attract or discourage customers even before the pricing stage. Perhaps the area of must concern for us is with claims settlement and antifraud. The goal here is not to punish insurers, but to engage insurers in efforts to identify and minimize systemic racism. We don't claim that insurers are looking for ways to indirectly discriminate against communities of color. Rather, it's about getting insurers to examine their practices for unintentional discrimination and to change those practices within the risk-based framework of insurance. Disparate impact analysis improves, not harms, risk-based practices.

I began by talking about why CEJ works on insurance issues – because insurance is a fundamental economic development and resiliency tool for individuals, businesses and communities. Just as lenders and employers are required to test for unintentional discrimination on the basis of race, so should such testing be part of the DNA of insurers. It is not a great burden on insurers to consider racial impacts as they develop algorithms for marketing, pricing, claims settlement and antifraud. The goal is not to eliminate rating factors, but to eliminate the unneeded racial impact of those factors – it's not a binary choice. The draft amendments to the NCOIL P&C Insurance Modernization Model law fails because it refers only to intentional proxy discrimination. The entire premise of disparate impact analysis is to unearth unintentional discrimination.

Dr. Lawrence "Lars" Powell, Director at the University of Alabama Center for Insurance Information and Research (Center), stated that the Center solves insurance problems with research and education. Dr. Powell stated that the first piece of data he brought is a picture that maps more than 4,000 gatherings of the Black Lives Matter (BLM) movement just in 2020 in the U.S. Nearly every population center in the country is represented and he is not sure if it's gathered scientifically but there is no reason to believe its wrong and it suggests that the problem is important. This is an important part in the history of the country where we have opportunities to make changes where we have the attention of people at all levels of gov't and its important that we move now to improve on this important area. Like with the pandemic what we hear is that we should follow science and data and that is what I want to bring today. As a spoiler on conclusions, while the industry is not perfect the science data of which he is aware of and works with on a daily basis don't currently indicate big problems in insurance especially how it is underwritten and priced.

Dr. Powell stated that he will cover incentives, safety – which is something not often discussed with insurance underwriting and pricing but the two are very much aligned – and evidence. Starting with insurance incentives, if you start with a dollar bill because as an economist that is probably what you would expect him to say is that the only thing an insurance company cares about is making a profit or increasing some sort of performance measure. At the highest level that is true but insurance companies are also run by people and people are imperfect. We have seen over history examples of people bringing their own prejudices and biases into businesses even the insurance business. As long as people are performing functions of companies it is something we need to be vigilant of and investigate and when we find something such as unfair discrimination it is important that we act on it and make sure it doesn't continue. As more transactions begin to occur without people touching them, we have less opportunity to inject our personal biases although there is a possibility of bringing in historical biases that show up in the data. Dr. Powell stated that didn't pay super close attention to Mr. Birnbaum's presentation but he bets he said that. Dr. Powell is not dismissing that but as AI and data analysts get better those are things that we can detect and get rid of in processes like claims and underwriting and customer service

We talked about insurance rating laws and I will restate that the law in all states state that insurance rates need to be accurate and reflect price or reflect risk and cost. This is not something we want to change. Fair discrimination is what makes insurance work. If we cannot classify policyholders or risks into like categories and charge premiums that are commensurate with that risk then the insurance mechanism breaks down and we lose this very economically necessary part of our economy and our daily lives. One thing I want to give you as not my opinion but just some math is that if members of a

protected class have more insured losses than people who do not belong to that class, the use of accurate rating variables will cause protected classes to have higher average insurance premiums. I haven't seen any evidence that shows protected classes are more likely to crash a car because they belong to a protected class. That would be hard to accept. This is largely driven by location. Where you live and where you drive are among the, if not the most, predictive factor for rating auto insurance. It is also very predictive of rating for homeowner or property insurance.

One of the things that we hear as an objection to these measures such as location that result in having people pay more is why don't we just look at the way people drive and use driving variables. So, if you crash your car your rate goes up. There is a great reason – it is because these observed driving behaviors don't provide much information at all. We don't get a very complete picture of how people drive or their propensity to crash just by looking at driving factors. The info they do produce is produced quite slowly over time. For example, if we look at the very worst class of drivers – the riskiest class such as 15 year old males who were just licensed to drive – 20% of that class crashes their car in a given year. The graphic shows that 20% crash and 80% don't crash and you could just as easily say if you're only using driving factors that you have 20% who are correctly classified and 20% who are misclassified. That is in the riskiest group and the one it might be most important to classify.

What about the average driver – the average driver has a 3.5% chance of crashing in a given year so it is going to be quite awhile before we know much at all about these average drivers but we do know these things. We know a lot about people and their propensity to crash because we have these continuous and instant measures of the likelihood of crashing such as where you live and where you drive and your insurance based credit score and age. Driving history is a factor but is actually not as predictive as people think. So, in a lot of ways these arguments about driving history and driving factors and the complaints about non-driving factors is very much a red-herring. It is something you can say that gets uninformed people very interested in helping you make a case.

Lets talk about driving actors. The best driving factors are telematics. If you really want your insurance company to know just how you drive and rate you based on that – that option is available. The last data he could find shows about 5% of current insured drivers take up this option of having a telematic on their cell phone or using the thing to plug into your car. Maybe people aren't aware of this and maybe there needs to be a better job in explaining it. As someone who has turned on the TV in the last 10 years, I have seen a commercial for this. They don't hide this very well that you can get different telematics form different insurers but the reason why this matters and why we don't want to give up on risk based pricing and having accurate insurance pricing is because when the price is less than the risk that its covering your incentive to take risk or care increases. You don't have this marginal incentive of if I don't drive safely I will have to pay more for my insurance. Or my insurance price isn't that high so if it goes up what's the big deal. Indeed, we find that people are able to drive a lot better than they do on average. We know that by looking at telematics. During the 6 months when the device is in your car and you are being evaluated as a driver, people crash much less and drive more carefully. Nobody is surprised by this and it is funny that a lot of people probably think they may not want the device because they don't want to drive the speed limit and brake very carefully especially if they are late to work one day.

Its better to have incentives that make people want to drive better and safer. I am not just saying this because I think it is intuitive and makes sense although I do think its intuitive and makes sense. There are several very well known peer reviewed published academic articles that find that less accurate prices cause losses to increase. More people crash their cars and more people are injured on the job when regulations say you cannot raises rates for whatever reason – when rates don't follow risk. It increases the overall cost and it increases the number of people that have their property damaged, injured and who die. These are good reasons to stick with risk based pricing.

So, what do we do if we don't like to see a differential between some classes and others in crashes. We don't want to see anyone crash. Lets address losses. I do a lot of work with transportation engineers doing some cross disciplinary work and they say it seems silly to change the price of insurance when the losses are there and we have these levers we can pull to decrease the losses. Lets go to these places where people are driving and crashing and replace stop signs with stop lights and add turn lanes and replace the most dangerous intersections with roundabouts. Data shows that such things reduce crashes and save lives. Another issue that my traffic engineering colleagues have found is that some of the differences across groups by a protected class or by income is vehicle maintenance. Driving on tires that you know are going to pop or bust if you get on a highway and go 70 mph is a guaranteed crash and if you don't evaluate the tread on your tires which is a very simple thing to do and there are several public education programs that have spread awareness of things like tire tread and vehicle maintenance and it has shown to make a big difference in the reduction of crashes.

Dr. Powell stated that a handful of studies have come up in the last 5 years that claim to find unfair discrimination and all of the studies have something in common and that is that they don't control appropriately or accurately for the risk of loss. I want to walk through these methodological problems because this is the science that we talk about and want to talk about and address. The way that these studies define risk has been a problem. In some instances they define good drivers and then compare good drivers to bad drivers. In some instances they look at small zip codes where you expect to have a large variation in outcomes and then compare those small zip codes to large zip codes where you don't have a credible number and a lot of the time it is comparing the premium per car without taking into consideration the loss ratio.

Lets start with the Massachusetts Attorney General report in 2018. Nothing about it was dishonest or disingenuous but the skillset that you have to have in order to do a study on something like this is unique. There are not a lot of people that get a Ph.D. anything but especially in risk and insurance. The report compared the zip codes with the highest minority population with the zip codes with the lowest minority population. In a control for loss they go from all drivers on one side to experienced drivers which is drivers with more than 6 years of driving experience and then experienced drivers with excellent driving records which is people that haven't had a moving violation or a crash in 6 years. We just covered this on another slide but what they conclude is that even good drivers are charged more and they imply that is based on their membership in a protected class.

If we do a little math, lets assume that there is a 10% chance of any driver in this high risk location crashing per year. So over 6 years if we do the math with a 10% chance of loss about 53% of people would have had a claim or moving violation and that leaves 47% of people that are still high risk drivers but haven't been identified by this metric yet.

So, what's going on is that we are choosing an excellent driver as one of the bad drivers who hasn't had a loss yet. We don't have to call them a bad driver - you could be a good driver who drives in high risk locations so you are more likely to crash. Because you haven't crashed doesn't necessarily make you less likely to crash going forward. There is about a 50% chance you wouldn't have crashed if 6 years of not crashing is the entirety of your risk measure. Moving onto a study done by ProPublica I believe in 2017, the paper looks at zip codes and defines zip codes as being a minority zip code or non minority or white zip code. A graphic from the study shows premiums on the y axis and losses on the x axis. We see that the minority trend is higher but what's going on here? The line that follows the white neighborhoods goes up with losses and then it goes down. This is Geico and suggesting that Warren Buffet doesn't like to make money because he has chosen to charge white neighborhoods less. That doesn't pass the sniff test. If that was the case it would be abhorrent and we would want to do something about it but we should be open to the idea that maybe something else is going on.

A doctor from the Missouri DOI who I believe has PhD in math or statistics produced a response to this where he takes the same data and makes a different chart. The ProPublica study draws its conclusions within those two red lines that go straight up and down between $250-$400 of loss per year so they have already thrown out the bulk of these non-minority neighborhoods where you see before that a red line in upward trends where premiums tend to appear to depend very much on loss. So you throw all those out and then you look at those only where there appears to be a negative relationship between losses and premiums for the non minority neighborhoods. So, what we have going on here is lets say a zip code has a set number of cars in it – there is a number of vehicles you have to have to get to what is called credibility in a number. When you look at these small zip codes if you have say 50 cars in a zip code and 10 of them have a loss one year and then one of them have a loss for 3 or 4 years well if you happen to catch the year when there were 10 losses the losses per car are going to be really high but their expected risk is going to be really low so you get these observations that are far to the southeast of the chart.

You also see some that are very high on the premiums and very low on the loss and the demographics work out this way that in high minority zip codes you have densely populated places with very credible data and you see again about the same upward trend and relationship between loss and premium. What's also instructive here is that when you look at where the overall result is coming from – its southeast of the blue line because anything below that line is losing money. I find it difficult to say the insurance industry has a systemic problem because they are trying to lose money on a lot of zip codes because they have more white people in them. That seems farfetched and I don't know what brings people to that conclusion. It seems much more obvious that we have a credibility problem with the data. The Missouri doctor went on to perform his own analysis where he pulled a lot of zip codes together by minority population percentage. He pulled 5 years of data together and looked at the loss ratio and what he found was a negative correlation between a minority percentage of the population and price meaning the higher the minority population as percentage of population in a zip code the smaller is the price they pay relative to the loss. That is what the law suggests we are after when we price insurance.

To summarize, its an important topic and I'm not here to minimize it but there are ways that these things happen. Its not impossible to have unfair discrimination in insurance because while insures have an incentive to be accurate they are also run by people who

are imperfect and could potentially impose their own biases and prejudice on the outcome. We're right to be here and vigilant about it but the data that I have seen does not show it there in a measurable and detectable manner. Rating laws require accurate prices and that is a good thing because accurate risk based prices improve the safety of people who are driving or owning homes, etc. The studies' math that claims to show unfair discrimination, every one I have found and reviewed, and I am happy to review others, does not control well for risk and vice versa – every study that controls well for risk does not find unfair discrimination. That's what the data shows. If data showed different then I would be the first person to bring this to your attention and say we need to do something about but its not there.

Dr. Powell stated that there were one or two things heard in the earlier presentations that in the risk of accuracy and data based conclusions he would like to comment on. One of things heard was that if we went through an exercise of removing intentionally the correlation between race or any other protected class and losses when making insurance rates assuming the correlation exists. We were told that makes rating models more accurate. That is simply false. That is taking information out of the model and making it less accurate. That is said unequivocally and is a mathematical identity and not his opinion. It does not improve risk based pricing. Another thing heard was that its inappropriate to have membership in a protected class correlate with prices. Well, we have legally and for the better carved out race and religion and ethnicity as predictors of loss or rates and we have not carved them out as correlates. Like an earlier slide said, if there are differences in losses then any accurate rating variable is going to produce a difference in premium. The purpose of not using membership in protected classes in rating is so that you cant just arbitrarily say well, lets make this group pay more. It makes it impossible to do this and it means you have to correlate things with loss and that is what the whole actuarial process and whole rate review process that the laws govern follows – making sure that these factors are correlative with losses and premiums reflect losses.

Lastly, the amount by which any variable that is used in insurance ratemaking whether it be credit scoring or criminal history or age or anything else – the amount by which that affects the price of insurance is not arbitrary. Its based on how these measures vary with insurance losses. We saw an impressive list of methodologies that insurance companies use to make sure those correlations are isolated and that they are accurate. It seems that some folks want to say that they are used for proxies for something else – its used as an accurate rating variable and if we want rates to be accurate so that we have better safety and outcomes that people see as fair then that is the way the insurance mechanism works best. It is not an arbitrary amount by which we can increase someone rates because they are in a protected class – its all based on the correlation with losses.

Rep. Lehman stated his question is wrapped into a statement. Dr. Powell made a statement that the best indicator of rate is telematics. If that is in fact the case, it leads to the death of the law of large numbers and if we move in that direction does it not send many of these issues by the wayside because the data is purely focused on how someone drives? Rep. Lehman then addressed Mr. Birnbaum's statement about data mining and Rep. Lehman stated that he looks at it as insurers are getting more and more data to try and be accurate in rating but how does that differ from what Apple and Google and Amazon do? They know everything about you with regard to purchasing habits and other things. So, is this something unique to the insurance industry? With all

due respect to Mr. Birnbaum, he made it sounds like wanting the best consumer is a bad thing. Every entity out there does the same thing whether it be retail or services industries.

Mr. Birnbaum stated that the difference between insurance companies doing data mining and Amazon and others is that Amazon and others aren't required to do cost based pricing. They can use data mining to extract profits from any group of consumers they want. The part that's relevant for insurance is that its not that data mining is bad in terms of identifying cost drivers – it becomes bad where the data mining is used on non cost factors. So, when you look at things like customer lifetime value scores or price optimization scores those aren't based on risk or cost factors they are based on non cost factors that are highly correlated with race and that is where the problem comes in. In terms of the other issue raised in terms of does this eliminate the law of large numbers, there is a distinction between an insurance company that insurers 1 million vehicles and by insuring 1 million vehicles they have the law of large numbers. When it comes to then assigning premiums to different vehicles within that pool, that's where they want to identify people who are more risky than other and issuing higher premiums for that. But, assigning premium to different groups of consumers doesn't violate the law of large numbers because you have a book of business that is 1 million.

The other thing Mr. Birnbaum wanted to respond to quickly was some of the strawman arguments that Dr. Powell made and it is not clear what the point was because he made a number of arguments that no one else is really arguing and then he attempts to refute the strawman arguments. One was that some people want insurers to ignore some variables and give up on risk based pricing. No one is really arguing to eliminate risk based pricing or practices. Consumer and civil rights groups are arguing that unintentional discrimination on the basis of race harms both communities of color and risk based pricing and we also argue against the use of non risk related factors in pricing – practices like customer lifetime value scores.

Dr. Powell criticizes various studies showing racial impacts of insurer pricing and claims that the studies fail because losses aren't considered. There are two problems with that argument. First is that the studies do control for loss because they use price to reflect losses just as insurers do. They control for losses by saying that the only factors we are going to vary are the particular attributes under consideration like credit score or gender and they hold everything else constant. Dr. Powell makes some basic mistakes – he equated a higher loss ratio with lower price. In fact, a higher loss ratio may reflect higher prices because it is in a higher claims area. The other mistake he makes is that every study that controls for risk does not find unfair discrimination – that is simply false. The Texas and the FTC studies on credit scores both found a disparate impact as well as a relationship between credit scores and risk of loss.

So, there are a number of problems the most important of which is a claim that any time you add a variable to a model it improves the accuracy of the model. That is not true from a statistical standpoint. And most important, insures introduce variables into models to increase the accuracy of the models yet with the specific intent of not to deploy that variable. So, the idea of using control variables that Dr. Powell said was wrong is in fact a solid and used statistical technique. In fact, insurers presented the use of control variables in their presentations to CASTF. So, although Dr. Powell raises a number of interesting issues it is generally unclear what his point is because the arguments that he is refuting are arguments that Mr. Birnbaum does not know anyone is

making and it doesn't really address the issue of how do you attack unintentional discrimination on the basis of race in insurance. His solution seems to be ignore it because insurers don't discriminate and in fact there is plenty of evidence to show that there is that type of unintentional discrimination.

Rep. Lehman stated that he would like an answer to his telematics question. Dr. Powell stated that one of the things that Mr. Birnbaum mentioned which is correct is that there are a lot of people with cars that buy insurance – something like 220 million vehicles insured in the U.S. So, even if we start classifying people by telematics and all these minute variables about how they drive it still doesn't make an individual label for every person. You are still classifying people into similar groups you just have a lot more information about how they drive. The concern about micro-segmentation is not that its unreasonable – we could see an issue where there are so many classes that the usefulness of those classes in a statistical sense breaks down and the law of large numbers doesn't apply as readily although you don't have to have exactly the same thing in every class for the law of large numbers to work but at that point it is not clear how the insured benefits from using it. If for some reason we are able to identify a person who is 100% likely to go out and cause a multi car fatality crash then I would say that is a great thing and we should make sure they don't drive. We're not there yet and if we were to get there technologically then we would have to make some important choices about how we deploy those things. In response to Mr. Birnbaum's comments, Dr. Powell said that he is certain what he said is right and that Mr. Birnbaum is wrong and that he would be happy to provide more detail on that if requested.

Rep. Lehman stated that he looks forward to discussing the issues surrounding telematics further. Sen. Breslin noted that reasonable minds can differ on these issues and he thanked the three speakers for their remarks.

Asm. Kevin Cahill (NY), NCOIL Treasurer, thanked the speakers and stated that they bring up some interesting points. Asm. Cahill stated that he would like to reflect upon what happens in the NY Assembly Insurance Committee during his experience as Chair of said Committee. Often times when colleagues come to him from one end of the spectrum and ask for specific measures to be implemented under the law he tells them that insurance starts with math. We always start with math and then layer on top of that our policy but we can never ignore the math. That doesn't mean that we have to slavishly adhere to the math it means that we recognize that insurance is based on math and we cant put insurance companies in a position where they will absolutely lose money if we expect them to continue to exist. It is in that context that he offers his comments today.

Asm. Cahill stated that he does not want to have a two person debate be the center of today's meeting but Dr. Powell did preface his comments by saying he didn't pay much attention to Mr. Birnbaums presentation and then preceded to argue against some of the arguments Mr. Birnbaum raised so it is perfectly legitimate for Mr. Birnbaum to respond in kind. Asm. Cahill stated that he would like to ask Mr. Birnbaum a question regarding a term he has used a couple of times when it comes to discrimination. He talked about systematic discrimination and unintentional discrimination and harmful discrimination. Would a more appropriate term be passive rather than unintentional discrimination because of those of us who are determined to say everything is fine and there is no problem we are not doing anything on unintentional we are simply not doing anything.

Mr. Birnbaum stated that is a really good characterization of the issue and it is probably best illustrated in the difference in how unfair discrimination is treated in insurance from other financial service or employer issues. If you are a lender or employer you have to proactively test your processes to look for unintentional or proxy discrimination. With insurance there is no requirement for that so insurers simply don't engage in that process. Referencing back to presentations that different companies make to the CASTF book club in which they talk about their various algorithms and techniques, one presentation was by a company that engaged in telematics. After the presentation I asked if they did any testing to see if the offer of the telematics was unbiased so that the data gathering wasn't biased and did you test the algorithms to see if there was any bias on the basis of race. They replied no since they are not required to do that. That gets at a passive discrimination that Asm. Cahill referred to which is that we are not asking companies to abandon risk based pricing we are asking companies to invigorate risk based pricing by looking at these passive correlations and passive discrimination on the basis of race that nobody wants but you have to take action to see if it exists.

Asm. Cahill thanked Mr. Birnbaum for his comments and stated that he wants to make sure that there is an understanding of what the industry is responsible for and what legislators are responsible for are not exactly the same thing. Yes, insurance companies should maximize profits for shareholders or mutual benefit holders or whatever their corporate structure is and they should also ensure they maintain appropriate reserves and are solvent and able to pay claims. Legislators are required to layer policy on top of that and recognize that when we do so we do so in a way that overcomes systemic and passive discriminatory issues in the system. We do it with great frequency and regularity. If we didn't we wouldn't have flood insurance and we wouldn't have homeowners insurance for a lot of people. In trying to reflect upon the presentations, Asm. Cahill stated that he is getting the impression that to sum up, the point is being made by some is that here is no problem. If that is what is being said, Asm. Cahill asked for remarks as to where there is room for improvement and where legislators can step in to fix whatever may be broken.

Ms. Foggan stated that she thinks there are solutions in existing law that are perhaps being overlooked to some extent. There are tools that are available that do prohibit discrimination and are available for regulators to review circumstances where intentional discrimination is happening whether it is happening based on direct use of a classification or whether it is happening based on purposeful use of a proxy with the intention of discriminating so I think there is something to be said there about existing tools not being perhaps fully utilized. I also think that there are dialogues going on between regulators and companies about new algorithms that are being proposed and innovations in insurance rating and those dialogues are important and they are the start of figuring out how innovation may affect insurance going forward. A cautionary note is to keep in mind the fact that sometimes some solutions that are proposed may stifle that innovation. We have instances where restrictions on rating factors may stifle the usage. These are areas where very serious thought needs to be given to any other action that would be taken.

Ms. Foggan further stated that it is important to reinforce that the actuarial justification standard is a very important standard and there were a lot of comments made about the idea that factors that are not risk based are being used and to the extent that is true and the factors are not actuarially justified I think they are forbidden under current standards and that is something that can and should be pursued. That is a point that perhaps is

lost that in risk based pricing by definition insurers are responsible for providing a justification for use of a factor and that is the actuarial justification for the use of a factor.

Dr. Powell stated that one of things that we have seen some positive benefits from on a small scale is that his Center teamed up with a financial literacy effort from another place on campus where they go into underserved or underprivileged communities and run a financial literacy program that is pretty well attended. Dr. Powell's staff added a portion to that where they would walk people through the process of shopping for insurance online. It doesn't take very long and a lot of them will do it right there with provided tablets and computers and then Dr. Powell's staff will follow up with them months later to see whose insurance premiums have gone down or up and the results were very good. With limited resources that was able to be done in about 5 or 6 counties in Alabama and there is a lot of promise there. The very best consumer tool in many cases for resolving an insurance problem is the ACORD application or going to the market and seeing if you can find a company that has an appetite or a preference for your risk. When you align with the optimal company you will often get the optimal result. Dr. Powell stated that he is happy to share the data from that and would encourage folks in other states to consider this sort of thing especially if threre is an existing financial program to piggy back on.

Rep. George Keiser (ND) stated that he is good friends with Mr. Birnbaum and has been debating these issues on the national scene for a couple of months now and they have different perspectives certainly. One of the points that needs to be made is that all insurance is intentionally discriminatory. There isn't an insurance product that isn't. You can look at me and see that based on my age that if I want to buy life insurance or long term care insurance today the premium is going to be significantly higher than for other folks in this group except for perhaps the Chair. It is discriminatory and I am going to pay a higher premium and it is justifiable. That is a critical point. Mr. Birnbaum did an excellent job in showing the multivariate analysis design. I know you are not statisticians but It is imperative that you understand that given any set of data regardless of how large it is – it still represents that data has 100% variability. We can factor off different parts of it into their contribution to that total variability. That is the x1, x2, x3, x4 categories. The key there is that in reality given the law of large numbers that was referred to earlier you can have a correlation of 0.1 even 0.5 that if your sample size is large enough it can be statistically significant. If a company chooses to use that variable for underwriting they are going to lose a lot money because it is not contributing to the overall risk in a significant manner.

To understand its contribution to overall risk you use the coefficient of determination which is the r factor squared. A 0.1 correlation may be statistically significant. It will account for $1/100^{th}$ of the variability in that data. So, that is the risk side of going too far and why I support the original model which is intentional discrimination. The reality is, I am going to be able with the law of large numbers to show a statistically significant correlation between race and almost any variable in that factor cluster. So, I can show it and argue that is disparate impact and we shouldn't be using that factor. That will totally disrupt the underwriting process and be entirely on the defensive and will eliminate the opportunity for a lot of creative function in the future. I encourage the Committee to understand the impact of limiting factors because they may have a relatively minor correlation but statistically significant correlation with disparate impact or a minority group. Rep. Keiser asked Mr. Birnbaum to comment on that.

Mr. Birnbaum stated that it has been an honor to know and work with Rep. Keiser over the years and he appreciates him digging into some of the details of the statistical analysis of a multivariate analysis. The one area where Mr. Birnbaum disagrees is that if you start with a bunch of variables in lets say a credit scoring model with credit scoring vendors. They look at all of the factors that are in a consumer credit report and transform that into 300-400 different variables and then they data mine the different variables to find the ones that are most predictive and then they analyze those that are most predictive simultaneously because they want to make sure that the variables aren't replicating one another. They want to identify the unique contribution of one particular credit variable to another so that when you look at the credit scoring models that companies submit they only have about 10-15 variables out of the possibility of 300-400 and the reason that they do that is because just adding variables doesn't necessarily help. But when they do the analysis they analyze all the variables simultaneously so the disparate impact analysis that I showed – lets take 3 scenarios.

The first scenario is if one variable is a perfect proxy for race. In that case when you insert race that initial variable turns out to not be predictive because all its doing is predicting race and its not predicting claims. Now lets try a second scenario where there is some correlation between that variable and race but there is some correlation between that variable and the outcome. In that case what the model does is reduce or changes the contribution of that first variable to eliminate the correlation with race and leaves the unique contribution of that variable. All of this is by way to explain that by introducing race and doing disparate impact analysis you are not eliminating factors unless they are truly perfect proxies for ace. What you are doing is minimizing the unintentional or passive discrimination Asm. Cahill talked about and you are improving the risk based pricing of those remaining factors because you are identifying and isolating the unique contribution of that factor to predicting that outcome and hopefully that outcome is expected claims.

Mr. Birnbaum stated that he agrees with Rep. Keiser 1000% in that insurance is all about fair discrimination and all about identifying the most and least risky consumers to not only price it accurately but to give consumers the right price signals so that they can engage in loss prevention activities. Remember that insurance is the most important tool that we have to promote loss mitigation and loss prevention. That is why for example people are charged more for having a DUI or having accidents and that is why people have discounts for having hail or wind resistant roofs. That is all part of the insurance mechanism and that is why we work so hard on insurance because it helps people get more resilient and communities more resilient. It is not just for protecting loved ones its for making sure you can recover when that inevitable catastrophic event occurs.

The Committee then took a 10 minute break.

DISCUSSION ON DEFINITION OF PROXY DISCRIMINATION

Professor Anya Prince at the University of Iowa College of Law thanked the Committee for the opportunity to speak on these important topics. Prof. Prince stated that through the last panel we heard the perspective of insurance regulation both historically and up to today. However, we are at a moment in history that challenges us to reexamine some of these frameworks in light of changing norms. In the past few years there has been a growing recognition of the need to address concerns of systemic racism throughout our

society and additionally there has been an increase in the use of AI and big data in both insurance and beyond. Increased use of this technology however raises concerns that past historical harms will be perpetuated if technology is not introduced with care. As has already been spoken about several times today, AI raises a host of concerns from bias in data to transparency. While all of these concerns are essential to address today I would like to use my time to talk about one very particular concern of AI defined one particular way and that is proxy discrimination.

Prof. Prince stated that if further reference is needed she will be pulling her remarks from a paper she wrote with Prof. Dan Schwarcz regarding proxy discrimination in the age of AI and big data. This is not an issue unique to insurance – the paper was written about the problem at large in society but Prof. Prince said she will focus in on the insurance implications. Regarding the definition of proxy discrimination, as discussed, part of proxy discrimination does tie into disparate impact that is the use of a facially neutral trait in an algorithm that disproportionately harms a protected class but as noted in the paper we don't think that is all of the definition. The definition also has to include that the usefulness and predictive power of the proxy variable comes from the fact that it is correlated to a legally protected characteristic. Notably, in the paper, disparate impact and proxy discrimination are not completely synonymous but rather proxy discrimination is a specific subset of disparate impact.

Before proceeding with examples, Prof. Prince noted that this is a gross oversimplification of these problems given the complexities of multivariate analysis. Lets say that a life insurer is using an algorithm in their model and they find that somebody's Facebook likes are predictive of mortality. There is not anything in particular that would make us imagine that Facebook likes are actually causative of mortality and we may find by digging in deeper that the reason that Facebook likes is predictive of mortality is actually because its proxying for race and that can come up in all sorts of protective traits. We can think of auto insurance where if you are using all sorts of big data in underwriting such as receipts form men's clothing stores which is predictive of auto claims and then you find out that its not that you shop at a men's clothing store but that its predictive because of its tie to gender. In both of those examples it is because they are correlated to the protected trait that's really important and the second part of that is that the protected trait is indeed predictive of auto claims and mortality for all sorts of problematic social reasons in the past. That is the issue to focus on.

Prof. Prince then discussed a chart to contextualize the definition of proxy discrimination within the framework that was talked about in the previous panel about disparate impact laws and disparate treatment laws. Our legal frameworks take into account both disparate impact and disparate treatment although traditionally disparate impact is not traditionally a claim within the insurance realm. We define proxy discrimination really in the middle of disparate impact and disparate treatment – a subset of disparate impact. We can think of intentional proxy discrimination with insurers historically actively using race or actively using something like redlining to proxy intentionally for race. But that is not the problem we are seeking to address in this context. What we are worried about is unintentional proxy discrimination because of the use of certain algorithms. A couple of things to note from that chart is that proxy discrimination is conceptualized as a subset of disparate impact claims but also it shows why its incredibly important not to limit a definition of proxy discrimination to only intentional decisions. Algorithmic proxy discrimination is not intentional discrimination but will engender the very same problematic outcomes as direct intentional proxy discrimination. Additionally, our

definition of proxy discrimination is in some ways distinct from broader disparate impact conceptualizations. For example, disparate impact law allows a defense for legitimate and acceptable business purposes. Since our definition of proxy discrimination assumes that the proxy trait is predictive, the current disparate impact framework may not address the harms in algorithmic proxy discrimination however neither would a disparate treatment framework – this is a new legal problem that arises uniquely out of the use of big data and algorithms.

Our thesis in the paper is that where the law removes the ability to consider a protected trait that is directly predictive of an outcome of interest, algorithmic proxy discrimination is inevitable and this is why this is such a thorny issue in the context of race because we want to have a society where we are not taking race directly into account and proxy discrimination effects may add that effect back into the system. This is notably true even when an insurer utilizing the technology has no intention of discriminating. It is an aspect of the technology that will occur unless corrected for. Prof. Prince stated that she understands that the second half of the day will focus on discussions of specific rating factors and this conversation is incredibly important but if proxy discrimination is not defined to include unintentional algorithmic discrimination then any of the predictive rating factors discussed this afternoon can easily be replaced by an algorithm with enough big data. Additionally, algorithms can be utilized for many different aspects of insurance from marketing to fraud detection to ratemaking. Thus, the problems of algorithmic proxy discrimination extend beyond just ratemaking.

As described by Ms. Foggan, there are many times where insurance laws remove the ability of insurers to use traits that are indeed predictive such as race and gender and other protected traits in state insurance codes. We've decided as a society that those are not acceptable to use even though they are predictive of mortality even though they have some actuarial justification. In other contexts federally we have the Genetic Information Nondiscrimination Act (GINA) and the Affordable Care Act (ACA) that does the same thing in health insurance. This really pits the definition of social discrimination against unfair discrimination as was laid out in the last panel and the question is how do we treat this algorithmic proxy discrimination. Do we think of it more like social problematic discrimination or do we think of it more like unfair discrimination where as long as there is actuarial justification then it is ok. Where the law removes the ability to consider protected traits that are directly predictive, algorithmic proxy discrimination is inevitable.

So what? Why do we care if it is inevitable? There is a lot of conversation that has occurred today to this point. If its predictive of risk then shouldn't we allow insurers to use all sorts of variables as long as they are predictive of risk? Prof. Prince stated that she would argue no if that predictive power is actually the remanent of a predictive power of a protected trait. Our law and society has passed laws that prevent insurers from using certain protected traits because doing so is viewed as being unacceptable and unfair. There are other times where the law disallows insurers from using a predictive trait to encourage socially beneficial actions such as recording incidences of intimate partner violence. Proxy discrimination must be defined to acknowledge the inevitability that an algorithm when given enough big data will find a proxy variable to stand in for a trait that is predictive of the outcome of interest even if that trait is disallowed to be considered.

In our paper we lay out several possible solutions to the problems of proxy discrimination each with varying levels of effectiveness and some of which have been implemented in state insurance regulations to date. Given time constraints I wont go over them in much detail but I am happy to answer questions. What's important to note is that these solutions are difficult for individual insurance companies to implement on their own without legislation encouraging that. Preventing an algorithm from proxying for a protected trait may make it slightly less predictive depending on how you look at it which was part of the conversation between Dr. Powell and Mr. Birnbaum but this is just as true for removing the protected trait itself from consideration. Our social discrimination laws make insurance prediction less accurate and we do that because we don't think that is what society should do so if we then don't allow that predictive power to be proxied for it also may make that a little less efficient and that can be an ok thing because we have already decided that we shouldn't take into account race in underwriting. Because, for race and other protected traits we as a society have already determined that this is a necessary and acceptable tradeoff.

Prof. Prince stated that she would like to highlight ethical algorithms which is a movement in computer science and there is a lot of literature on this on all sorts of contexts including insurance and as shown earlier by Mr. Birnbaum controlling for protected traits in models does two things. It narrows the predictive power of a variable to its unique contributions so if you add a protected trait into the model the variable that is left that is proxying for race will only have the predictive power unique to it. Additionally, if the protected trait is not predictive of the outcome then the corrected variable will stay as powerful as it was before so this is how its not exactly the same as disparate impact because its not just that the variable has a connection to the protected trait but its taking some of its predictive power from that protected trait. As noted by Dr. Powell it is really important to test these as not all insurance models are going to have this problem if its tested for but we need to be able to have insurers actually do that to make sure that there is not socially unfair discrimination in our society.

Prof. Prince stated that that at the very minimum proxy discrimination must be defined to include unintentional algorithmic discrimination or else even the impact and success of our existing anti-discrimination laws are threatened. As such, the current draft definition in the NCOIL Model is insufficient to address the harms because it includes intentional substitutions of a neutral factor but does not address how algorithms will do that just by the nature of the fact that they are algorithms trying to predict the best that they can. Those arguing against inclusion of definitions of proxy discrimination in insurance argue that it may take away predictive power in insurance decisions. However, under our definition of proxy discrimination the actuarial value that the definition would control for comes directly from a protected trait. Without this an algorithm would theoretically be able to use any trait even if it is 100% predictive of race but entirely unpredictive of the outcome of interest once race is taken into account. We advocate for no more than for someone's race or other protected trait from playing any actuarial role in insurance decisions just as what is intended by many state anti discrimination laws. The increasing use of AI demands us to ensure that our existing legal framework address insurance issues of fairness in our systems. Prof. Prince thanked the Committee and stated she looks forward to questions.

Claire Howard, Senior VP, General Counsel & Corporate Secretary at the American Property Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated that APCIA represents over 1000 member companies

who together provide 60% of the home, auto and business insurance and reinsurance in the U.S. APCIA understands the time is now to publicly recognize and address the profound problem with social racial and income quality that exists in our country. We also understand that substantive and durable solutions require the commitment and participation of the various sectors in America's economy including insurance and where necessary gov't action through legislation. We believe achieving substantive and durable solutions for the persistent problem of inequity requires certain things form all stakeholders in other words from the people, sectors and institutions affected.

Developing substantive and durable solutions requires debate, understanding, compromise and thoughtful public policymaking. Thoughtful policymaking requires the participation of stakeholders who are willing to identify the interest they hold in common who will think more broadly and creatively than they have historically which will provide objective support for their position and who will compromise to support public policy that fairly balances their divergent interests to avoid unintended consequences with a more detrimental affect on society as a whole. You need all of that to succeed and APCIA's members stand ready to engage with you in that way.

The specific question on this panel that APCIA has been asked to address is how to define proxy discrimination. You have APCIA's Nov. 5 letter on that subject in your pre-meeting materials in which we cite authority for the declarative statements included in that letter. I'll address certain points in the letter and I am happy to respond to questions after. I'll begin with the top line – NCOIL's staff efforts for defining proxy discrimination has significant merit and comports with well established case law and discrimination principles. APCIA looks forward to working with NCOIL on any refinements NCOIL chooses to make in that definition. My remarks this morning will explain why APCIA supports NCOIL's approach.

In the context of the business of insurance, statutory rating standards have for decades universally prohibited rates that are excessive, inadequate, or unfairly discriminatory as has been well described by others this morning. The term unfairly discriminatory is universally defined as treating policyholders with similar risk profiles differently. This statutory formulation is otherwise known as risk based pricing. Its purpose in large part is to balance policyholder interest in rates that fairly reflect the risk they present and the coverage they purchase on one hand with the industry interests in solvency which requires price to match risk on the other hand. At the end of the day a solvent industry ensures competition and competition promotes availability and affordability of insurance products. Risk differentiation is at the heart of risk based pricing and state rating statutes across the country.

If we think about risk differentiation with policyholders interests in mind, APCIA's position is that the more factors that are considered the less impact any single factor has on pricing or underwriting outcomes. Thinking about risk differentiation from the insurer perspective, the more factors the more precise that the prediction of risk helping to ensure solvency in the aggregate. As insurers compete using their specific set of rating factors, policyholders have more choice. A definition of proxy discrimination must preserve the ability to differentiate among risks for the purpose of meeting policyholder expectations and ensuring a solvent industry. This is not to be understood as an argument for no change because its been that way for so long. Rather we urge policymakers to consider the history and role of state rating statutes and the unintended consequences of enacting an inconsistent definition for proxy discrimination will have on

an essential element of the business of insurance namely risk differentiation and risk based pricing. The approach to defining proxy discrimination proposed by NCOIL staff addresses these concerns. There are two broad categories of discrimination claims and they are first international discrimination in which intent is the primary focus and second is disparate impact discrimination where intent plays no role at all.

A form of intentional discrimination is the legal theory known as disparate treatment which includes proxy discrimination. The similarity in name only to the unintentional form of discrimination called disparate impact can create confusion. In the insurance context, disparate treatment occurs when an insurer treats a policyholder less favorably than others because of the policyholders membership in a protected class. Proxy theory was adopted by the courts as an element of disparate treatment discrimination to recognize that a policy should not be allowed to use a technically neutral classification as a proxy for evading the prohibition against intentional discrimination. Because intent is a primary focus on disparate treatment cases when relying on proxy theory a plaintiff must demonstrate that the defendant was motivated by a discriminatory purpose in choosing a proxy about which the plaintiff complains.

As a form of intentional discrimination, disparate treatment challenges including those that rely on proxy theory ask one question – is there sufficient evidence, either direct or circumstantial, that defendant was motivated by discriminatory purposes in choosing the challenged proxy. If the answer is yes, then the challenged policy must be eliminated. Because defendant's intent is an essential element, plaintiff is entitled to equitable relief and attorney fees but also punitive and compensatory damages depending on the underlying facts of the case. It is very important to distinguish between intentional discrimination, its manifestation as disparate treatment and its analog in proxy discrimination which is a tool for a subset of intentional discrimination and separate that from disparate impact.

In contrast, disparate impact discrimination is inherently different form intentional or proxy discrimination. Disparate impact involves policies that are technically neutral like disparate treatment, but unlike disparate treatment they are not motived by discriminatory purpose although unintentional disparate impact discrimination involves a policy that has an adverse effect on a protected class that is not otherwise justified by a valid business interest. Federal courts applying disparate impact analysis ask a series of three questions. First, does the challenged policy have an adverse effect on a protected class. If the answer is yes then courts ask a second question – is there a valid interest served by the challenged policy. If the answer to that is yes then the final question is whether there is an alternative that serves the same valid interest with less disparate impact and at less cost. If no such alternative exists, then the challenged policy stands and the claim fails. Because intent plays no role, directly or indirectly, in disparate impact claims courts may award equitable relief and attorney fees but not compensatory or punitive damages – a distinguishing element separating from intentional discrimination and disparate impact discrimination and separating it from proxy discrimination. While disparate impact has been used in federal housing law, no state has adopted it as an insurance standard. Moreover, it entails an entirely different analysis than proxy discrimination as NCOIL has implicitly recognized in its proposed definition. Efforts to conflate disparate impact and proxy discrimination which is an element of disparate treatment should be rejected.

In conclusion, NCOIL's approach to defining proxy discrimination prohibits choosing a technically neutral factor that singles out a protected class for the purpose of depriving a policyholder of an insurance related benefit. This definition allows the industry to continue to differentiate among risks as long as the choice of a risk factor is not based on membership in a protected class. To do otherwise would be to take proxy discrimination out of the category of intentional discrimination where it resides currently under the law and place it in the category of unintentional discrimination and in doing so applied to the business of insurance where it has never been applied before by any state legislature.

Said another way, application of proxy theory in the insurance context would conflict with current state law that requires risk differentiation to balance the interests of policyholders and insurers alike and would likely require an overhaul of the underlying statutory framework – namely the prohibition that rates are excessive, inadequate or unfairly discriminatory. The approach for defining proxy discrimination proposed by NCOIL staff is consistent with current law and therefore is an approach APCIA supports. While these remarks address the issue of proxy discrimination, APCIA believes consumers are best protected and they derive the most benefit through robust private market competition and which risk based pricing incorporating a multitude of relevant rating and underwriting factors ensures rates match risk. Thank you for your time and for a deliberative and thoughtful approach addressing these public policy concerns embedded in this critical issue.

The Honorable Nat Shapo, Former Director of the Illinois Department of Insurance, thanked the Committee for the opportunity to speak. Jumping right in, a lot of what he will say is in the paper he wrote which is in the pre-meeting materials. The two points that are most relevant from the paper are, with respect to proxy discrimination, he doesn't think its necessary to define the term. Most state laws now protect social classes and the language in those statutes is generally something to the effect that it prohibits discrimination based on or based upon or some variation of the protected characteristic. I think that such language properly understood is broad enough to sweep in proxy discrimination. I believe the term proxy and its dictionary definition and the way its usually used in the law encompasses an element of intent. If the use of a proxy is intended to sweep in a protected class then that should be seen as "based on" or "based upon" a protected class. Therefore, it can and should be seen as already prohibited under the law.

Also, I don't think we've seen evidence of a significant problem to date with proxy discrimination. Generally, I think policymaking usually reacts to established problems and without establishment of the problem I submit the possibility that it may not be necessary to pursue a proxy discrimination definition but that is obviously the Committee's prerogative and it should proceed as it deems bets. When talking about definitions of proxy discrimination, I think that in the case of actually defining the term the biggest focus should be that it is intentional discrimination – the intent to use an otherwise neutral factor as a proxy for a protected class. The language NCOIL should pursue should be a strict attempt and carefully worded so as to avoid leakage into the concept of disparate impact. The dividing line I think is that intent is intent and effect is effect. They are different concepts and one should be able to draw a line between the two with careful wording. The difference between proxy discrimination defined by intent and disparate impact defined by effect is real and understandable and a well crafted

definition could achieve that. I think the NCOIL staff definition accomplishes that well and I would commend that as an excellent starting point for discussion.

Moving away from that language, there is a concern that such a definition could lead to a slippery slope of a law going towards disparate impact. So, I think the policy choice that I'm getting at is proxy discrimination defined by intent or disparate impact defined by effect. This is a well put together panel that has sketched out different viewpoints on that and today's presentations will be very helpful in framing committee member's views on how to proceed. The CEJ and Prof. Prince gave very well argued presentations and they are essentially advocating for a disparate impact standard. They presented their positions very well and if you are in favor of a disparate impact standard then they have sketched out what that would be. Dir. Shapo stated that he argues against a disparate impact standard here and supports a true intent based proxy discrimination definition. Disparate impact is bad policy in the business of insurance and as referred to in his paper and the NAIC amicus brief to The Supreme Court of the United States (SCOTUS) which is probably the most well articulated written document he has seen that sketches out the principles of why disparate impact does not work well in the insurance context. The NAIC told SCOTUS "in insurance, discrimination is not necessarily a negative term so much as a descriptive one." That goes to Rep. Keiser's earlier point.

The NAIC said "for insurance, fair discrimination is not only permitted but necessary" – again echoing Rep. Keiser. "It promotes insurer solvency through appropriate risk classification and accurate pricing of insurance." That is a very nice and straightforward explanation. The NAIC also said "rationally based neutral risk selection criteria promote insurer solvency through appropriate risk classification and accurate pricing of insurance." That gets to the policy rationale behind the risk based pricing standard. Its good public policy because its good for the public because insurer solvency is in all policyholders interest. Setting those public policy parameters, NAIC then concluded that "the disparate impact approach overthrows state laws that allow insurers to use rationally based neutral underwriting guidelines." The NAIC then got back to policy reasons saying "of concern to state regulators is that improper underwriting can result in the following – an insurer can become insolvent or a potential insured could be improperly discriminated against." So, there are two major policy concerns there. One is solvency by having accurate pricing and the other is the fairness norm of people paying into the company based on their likelihood of taking out through a claim.

Dir. Shapo stated that he believes the NAIC is correct in both those public policy statements and the resulting law. That basically comes down to the idea that disparate impact is incompatible with basic insurance principles. In insurance you have one core standard of risk based pricing and that is actuarial justification and that applies to every rating factor. The exceptions to that rule are codified statutorily with enumerated exceptions such as race, religion or national origin. Those are specific factors that are exempted from the core standard. An insurer can manage risk this way and knows that it is supposed to use factors that follow cost based pricing. It follows this rule and follows the enumerated exceptions to that rule in the code. It's a manageable and rationale system. It is much more difficult to manage risk if you have a second sweeping factor on top of the risk based pricing standard and that's what disparate impact would be. Disparate impact would apply to every rating factor so you would have a cost based pricing standard on every rating factor and then a disparate impact standard on every rating factor and I think that's what the NAIC was concerned about when it wrote about the negative consequences of disparate impact. An insurer cant manage risk that way.

The insurance industry is about predictability. The current system promotes predictably with one standard and codified exceptions. A system where you have two standards at once would be destabilizing for the industry and the opposite of predictable.

Dir. Shapo then discussed a few points made in the earlier presentations which illustrate the divide for policymakers to make their decision. In Mr. Birnbaum's presentations on slide 24 there was a question why is it reasonable and necessary to have disparate impact defined as unfair discrimination in insurance and the answer was that in an era of big data systemic racism means that there are no facially neutral factors. I think that is well articulated but it also sets the dividing line between his position and my position. If you have literally no facially neutral factors, if that's your starting point for discussion, then you are looking at that proverbial slippery slope on disparate impact that you will have no clear standards and no understandable guidelines and every rating factor will be immediately presumptively suspect in that way. If insurers are expecting a challenge on every factor in that way because there are no facially neutral characteristics then in the end you are looking in the end at a qualitatively different industry with different standards and I don't think we've had evidence presented here of a problem in this industry of a system that's not working well and that is biased against protected classes. As a matter of public policy I think that is not preferred.

Dir. Shapo stated that he read Prof. Prince and Prof. Schwarcz's paper as a slightly different take instead of a totally equivalency between proxy discrimination and disparate impact and that instead proxy discrimination is a subset. On slide 4 of Prof. Prince's presentation defining algorithmic proxy discrimination: "Use of a facially-neutral trait in an algorithm that disproportionately harms a protected class; and Usefulness (predictive power) of the facially-neutral trait arises from its correlation with a legally-prohibited characteristic." I think that this is the crux of one of the main premises of the paper and is a poor theme and is a diving line between the two different approaches. To me I start from the premise that if a factor is predictive then the value comes from that predictiveness. It is going down a slippery slope to start questioning whether the predictive value comes from the protected class status. If a factor is predictive then it is predictive and that's the core rule. Insurers don't use factors because they correlate with a protected class – they don't care. Insurance is objective and insurers don't even know the protected class status of their customers. It is important to note the difference to what we have been watching on TV this year. The allegations we've seen in terms of systemic racism usually has to do with something like a policeman or a job interview or a doctor treating the person in front of them differently when they see the person's skin color. Insurers don't do this and cant do it as they don't know the protected class status of their customer and they don't care as their incentive is to price as accurately as possible so that they can have the most financially sound risk pool.

In my paper I quoted something from the credit scoring debate at the NAIC in 2001. The Chair of the NAIC market conduct committee asked proponents of a disparate impact standard for credit scoring – "why would insurers use credit scores if they did not work?" To me that is the crux of my position – insurers are using the factors they use because they work and work means they predict loss. A factor doesn't work if it predicts a protected class it works if it predicts loss. Sometimes a factor might correlate with a protected class but the predictive value of the factor comes from its predictive value not because the insurer is seeking to discriminate against a protected class.

I think there was an allusion in the MO DOI study which responded to a media report of surcharges based on a protected class and the MO DOI did a very careful study on that and found that there was not a protected class surcharge and said "higher rates for urban areas seem to be entirely accounted for by higher payouts." Again, predictive value comes from predictive value not from protected class correlation. I again reference the key question from the NAIC debate – why would insurers use in that case credit scoring and in this case any factor that doesn't work. The MO study and all evidence such as Dr. Powell's indicate that insurers use factors because they work not because they correlate with a protected class. Thus, I support an intent standard for proxy discrimination and getting back to the bottom line here in reviewing the NCOIL staff definition it is a thoughtfully crafted draft and if you choose to produce a model law to codify a proxy discrimination standard this is the appropriate and worthy starting point. Dir. Shapo thanked the Committee for its time and consideration.

Paul Graham, Senior VP, Policy Development at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak. ACLI represents 280 member companies that account for 94% of the assets in the life insurance industry. I note that a lot of what we have talked about this morning is the perspective from the P&C side of things so my remarks may sound a bit different for a number of reasons that we will get into. Mr. Graham began with some background before discussing proxy discrimination. It is important that as part of this life insurers recognize the past that we've had from a discrimination standpoint and we can go back to the 1800s and show that life insurance companies were blatantly discriminating against black Americans by either reducing the face amounts that were paid out as death benefits or denying commissions for policies sold to black Americans. Even in the 1940s 40% of companies were not selling policies to black Americans. Starting at around 1948 the civil rights movement prompted leading companies to adopt race-merged tables and it took all the way until the 1980s to get to the point that any and all race based policies have been eliminated. With a past like that we did end up settling suits that addressed those discriminatory policies in the early 2000s.

Needless to say that is not a great past when it comes to discrimination but it is important to now talk about today. Mr. Graham stated that in listening to the earlier presentations he was envious that they had a lot more information available to them on the P&C side of things because there is a lot more info collected regarding rates and prices. That is not the case on life insurance so ACLI had to purchase the 2018 Macro Monitor Household Survey and all of the info shared today is a result of ACLI analysis of those survey results. First of all the most important stat to show is that 56.8% of all U.S. households own life insurance, while 55.9% of black American households own life insurance. So, there is not really any evidence of from that standpoint that there is a difference whether you are a black or white American of having access to insurance products. Furthermore, the coverage ratio which is defined as the median in-force face amount divided by median income is nearly identical for black American households – 160% coverage vs. 162% coverage. That is an important statistic because as everybody knows as income goes up so do face amounts and so while there is some stats you can find that might lead you to believe that black Americans are not purchasing as much life insurance as white Americans its really a function of their income and not a function of availability and any kind of discriminatory practices.

One thing that is very noticeable is that black American households are more likely to own whole life insurance (22%) than white American households (19%). Where you find

an interesting gap is actually the group insurance side of things where black American households are less likely to own group insurance (34%) than white American households (40%). That is an interesting fact because there is a later slide that shows that younger black Americans are less likely to own insurance than white Americans when they're young and its likely because they are not having access to group insurance but as I think most of us know group insurance doesn't have any medical underwriting and its not really a discriminatory pricing structure so everybody that's within a group is getting the same insurance rate of coverage. I point this out because it cannot be a function of any kind of discrimination that the younger black American households don't have as much insurance.

Another thing to point out which is very interesting is that black American households have utilized the policy loan features at a much greater amount than white American households - 7% to 2%. The importance of that is that life insurance has given black American households access to low cost loans which they might not have in absence of owning a life insurance policy so the industry takes pride that the policy loan feature has allowed black American households access to cash that they might not otherwise have had. The last thing to point out in terms of where we are today is that black American households trust their life insurance agents in the event of their death. More than 80% agreed or strongly agreed with the statement that "I am confident that should I die my life insurance agent will act in the best interest of my beneficiaries." Only 70% of white Americans agreed or strongly agreed with that statement. That is showing that the interactions that black Americans are having with their insurance companies are in fact good interactions.

The next slide shows the age differences at which black Americans and white Americans own their life insurance. You can see that in early ages white Americans have much more prevalence of ownership but once you get to about age 50, its about equal and then in older ages actually black Americans are maintaining their policies right through their death which may not be the case for as many white Americans. That is important because life insurance is one of the best ways to provide inter-generational wealth transfer and black Americans are definitely taking advantage of that so that they can help the next generations with their own finances. Having said that, I think we can do be better as there are still some gaps and its not just gaps among black Americans. Less than 60% of households of any sort own life insurance and that sort of points to the fact that it is a voluntary market and people don't have to buy life insurance and that distinguishes us somewhat from P&C because there if you own a car you basically have to own car insurance and if you have a house with a mortgage you pretty much have to have home insurance but that is not the case with life insurance as it is something that is a voluntary purchase. We recognize that what we're really trying to do is to expand access to affordable financial security in underserved communities and that is the first principle of ACLI's economic empowerment and racial equity initiative.

The other principles that ACLI is following in that initiative is advancing diversity and inclusion within companies and on corporate boards; achieving economic empowerment through financial education; and expanding investments in underserved communities. So, life insurers are taking seriously the past and the present when it comes to racial inequities and doing what we can to do our part towards solving some of the longstanding problems. Lets talk a little bit about expanding access to affordable financial security in underserved communities. ACLI supports innovation and technologies that are part of the solution by driving expanded consumer access and

consumer affordability in the middle market and underserved communities. At the same time, ACALI supports a regulatory framework that eliminates proxy discrimination in the delivery of life insurance to the consumer. Last but not least, ACLI supports removing unnecessary barriers that may impede the ability of people of color to become licensed by or employed with the insurance industry. As you might know, much of insurance today is still sold across the kitchen table so to speak and having more people of color in the profession of selling will in fact increase access to underserved communities.

The best way that we can think of to drive expanded consumer access in addition to making sure that people of color can become agents is by using accelerated underwriting programs. The life insurance industry believes accelerated underwriting programs using algorithms, artificial intelligence and big data increases accessibility to financial products and can help close the gap between the amount of coverage people need and the amount of the coverage they have today. These programs can help do that by making accurate underwriting decisions faster and simpler and less evasively, which today's consumers demand. To that end we have to make sure that whatever we do regarding defining proxy discrimination and regulating it that we cant be discouraged from employing new tools like artificial intelligence as that would be a bit like the proverbial throwing the baby out with the bath water. It is really important that we keep that in mind and we've seen the direct impact of all of this in 2020 because of COVID we've had less ability for agents to sit across the kitchen table and make sales and while certain life insurance sales have suffered to some degree this year and part of that could be economically rather than the inability to contact people, life insurers have been able to continue their missions of helping peoples financial futures by using a "touchless" underwriting process that includes these underwriting algorithms, AI and big data.

Mr. Graham stated that, again, life insurance is quite a bit different than P&C insurance. Everything that life insurers are doing is a guarantee of long term financial planning and that long term financial protection is only available when we can provide a clear picture of peoples health and other factors that are relevant to mortality and morbidity. We get one chance to make a promise that can last 40 years. That is significantly different than the P&C brethren. Fairness in life insurance pricing also requires that both coverage amounts and premiums be based on sound mortality and morbidity expectations of each individual.

I note that both Prof. Prince and Mr. Birnbaum have suggested that the concept of proxy discrimination is comparable across different types of venues. We've got a proxy discrimination type of law on housing and also for employment law and I would suggest that there is a little bit of difference here because in that type of framework its not a risk of anything you are trying to determine. If there is discrimination in housing its not that you are trying to determine whether somebody is black or white and they are going to do something bad to your apartment – its a lot more driven than dislike of that trait of being black or being a person of color. Its not a function of risk. Discrimination in the life insurance and P&C side of things comes from an assessment of risk. So therefore when you think about the discrimination laws of insurance I would suggest that the discrimination laws are there so that insurance companies are not using race as proxy for risk assessment and that's the importance here. Society didn't say since we've decided that we are not going to discriminate against people of color directly that therefore that means that any risk associated with that particular trait should also be tuned out when doing underwriting. So we have to be very careful.

Mr. Graham stated that the most important thing he wanted to say today is that its very important we understand that underwriting has historically been based on factors correlated to mortality and morbidity rather than causative. We have heard a lot of stuff today about correlation – that is not new. Smoking, diabetes and hypertension don't cause deaths. Lung cancer and kidney failure and strokes do. Smoking, diabetes and hypertension are correlated with those diseases so we have to be careful when talking about correlation. At the same time I can show that diabetes and hypertension are correlated with race but that doesn't mean that insurers shouldn't be able to use that so we have to be careful to focus not on eliminating underwriting variables that are not causative because I think that would eliminate almost all underwriting variables.

ACLI has put together a team of doctors, lawyers, actuaries and data scientists to brainstorm ideas on a regulatory framework that keeps all the advantages of accelerated underwriting programs while identifying and correcting potential misuse of the data. We are serious and want to make sure that happens. So far we have not found evidence that there is currently unfair discrimination or proxy discrimination in the delivery of life insurers' products to the consumer. Life insurers want to keep it that way and want to be transparent with our regulators as new technologies are introduced. One large hurdle in detecting proxy discrimination: Life Insurers do not collect racial information. As a result, it is difficult to get data to study and it makes it difficult to study unintentional discrimination. One thing that that we have determined is that eliminating specific underwriting variables is not likely effective in addressing proxy discrimination in underwriting algorithms. Mr. Graham thanked the Committee for its time and stated that he is happy to answer questions.

Sen. Breslin noted that some legislators had questions for the first panel of speakers that were not addressed due to timing issues so they will be addressed now. Rep. Edmond Jordan (LA) stated that he had a question for Dr. Powell and wanted to start with the premise of what is the purpose of the Committee. If it's just to prove that there is no unfair discrimination based on race then I think we pack it up and go home and complete our work. But if its to really get to the root causes of what's really going on then I think we have to have a different discussion. If it's just to prove that we want to control the narrative and outcome I think we have seen this story before. Rep. Jordan stated that he believes he heard Dir. Shapo state that disparate impact is bad policy. If he didn't say that he can clarify.

Dir. Shapo stated that yes his position is that disparate impact is cognizable in certain statutes that specifically evidence an intent and statutory language that encompasses disparate impact whereas the state unfair discrimination statutes don't have disparate impact language. Rep. Jordan stated he has an issue with that because the message sent to protected classes is that we know that it impacts you adversely but it's not intentional so just live with it. If it's a disparate impact we know that is an adverse impact but if you are telling me that no harm no foul since it is not intentional then I don't know necessarily where we go with that because to say that there is no evidence that the system is not working well I would contend that the system is working juts as it was intended to work and that's the problem. If we are going to look at the history of insurance, it was involved in the slave trade. Insurance gave plantation owners the right to insure African Americans as property so if we are going to ignore that and think that protected classes are going to think that this is an industry that has our best interests at heart, then we are fooling ourselves.

If we are doing this because of some response to the pandemic or response that we saw with Floyd and we're going to ignore the systemic issues that deal with systemic racism then I'm really just not sure what we're doing. It reminds me of when we talk about police misconduct in the first place. We have been complaining about that for years and now all of a sudden that people can see it, it becomes an issue and then it causes all of these companies to reevaluate what they are doing to have diversity to deal with insurance. I heard Dr. Powell state that if you are a good driver in a bad area you are going to pay higher rates. I think that ignores all of the history of African American soldiers who fought in WW2 who didn't have access to the GI bill and redlining and Jim Crow and white flight. There are a host of issues that we are not even touching and all of these issues have some underlying factor as it goes into these rates. If we are not going to set the table correctly to make sure that we are starting with the right narrative and right premise then it reminds me of the narrative that crack addiction is a crime and opioid addiction is a disease. We can justify whatever we want to justify along the way and if that's what we are doing that's fine. I appreciate everything talked about thus far but I haven't really heard any solutions to the problem and again, to admit that there might be disparate impact is to me to admit that protected classes are going to be adversely affected but since we cant prove its intentional then the system works just great.

Sen. Breslin stated that this Committee cannot solve 250 years of wrongs. We are an insurance organization and trying to analyze and review the conduct of the insurance industry in particular and to see if there is racism and if there is to correct it. Sen. Breslin stated that he appreciates Rep. Jordan's comments and would welcome talking with him after the Committee.

Dir. Shapo stated that he appreciates Rep. Jordan's comments and brought up a lot of important issues. To be clear, I'm not saying that there is no place for trying to address these concerns. My argument, which is in my paper that discussed more issues than proxy discrimination, is that the system has mechanisms to try and address social unfairness. First and foremost would be the ability to prohibit or restrict rating factors that are found to be socially unfair and where the social unfairness is deemed by policymakers as outweighing the social fairness of actuarial justification. That is why race is expressly prohibited under the law despite the fact that it in the past was used as a predictive factor. It has been determined that the use of race is more socially unfair than the social fairness of its actuarial justification and the law prohibits it and that's based on the public policy reasons largely stated by Rep. Jordan. The system is always there for a policymaker to put a bill in if they think that in individual rating factor is excessively unfairly discriminatory in the way it falls on a protected class. There has been discussion in some submissions here and elsewhere about things like criminal history scores and other things that could lead to bad outcomes in that way. A disparate impact standard is not the only way to address social unfairness.

Rep. Jordan stated that he understands that and noted that he is not asking to solve 250 or 400 years of history but what he is saying is that if you are looking at credit scores and crime data and you are not looking at where the wealth gap initiated in the first place then you are ignoring the elephant in the room.

Mr. Birnbaum stated that he would like to reinforce Rep. Jordan's comments. The issue that we're looking at is what is the impact of systemic racism in society on insurance. The black lives matter movement and protest in wake of the Floyd murder was a

recognition that systemic racism purveys all aspects of our society. The effort here should be to look at how does systemic racism invade insurance and what can be done to address systemic racism within the risk based framework. Rep. Jordan is eloquent in talking about how systemic racism impacts a variety of factors that in turn impact insurance availability and affordability for different communities of color. The industry's position now is that yes we'll address this as long as its limited to intentional proxy discrimination. That is just ridiculous and simply says we are not going to do anything about this problem because if you've already banned intentional discrimination and then say we will ban intentional proxy discrimination its one in the same thing. As Dir. Shapo stated, he already believes that regulators have the ability to stop intentional proxy discrimination. To reiterate, if you are serious about really examining systemic racism in insurance then you really have to look at what Asm. Cahill mentioned regarding passive unintentional discrimination that's a result of the legacy of discrimination over the years.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
TAMPA, FLORIDA
DECEMBER 9, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in Insurance Underwriting met at the Tampa Marriott Water Street Hotel on Wednesday, December 9, 2020 at 9:30 A.M. (EST). This set of minutes documents the second of two meetings held that day which convened at 2:00 P.M. (EST). The first meeting is documented in a separate set of minutes.

Senator Neil Breslin of New York, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)*
Rep. George Keiser (ND)*
Asw. Maggie Carlton (NV)*
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter (NY)*
Sen. Bob Hackett (OH)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)*
Rep. Jim Gooch (KY)*
Sen. Shawn Vedaa (ND)
Rep. Wendi Thomas (PA)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

RATING FACTOR DISCUSSION

Eric Poe, COO of Cure Auto Insurance (Cure), thanked the Committee for the opportunity to speak and first provided some background on himself because it is relevant for his testimony today. Cure is a regional non profit reciprocal exchange that writes private passenger automobile insurance in NJ and PA. Cure insures about 35,000 vehicles and was founded 30 years ago by his mother who was a Clifford D Spangler awarded actuary and his stepfather who was an insurance commissioner in NJ for two terms for 8 years. The unique background about Cure is that it swims in a very large pool of mammoth multibillion dollar publicly traded companies that are here to make profits while Cure is just managing a non profit reciprocal. Cure does not employ the use of education, occupation or credit scores and is the only carrier in NJ that does not employ the use of credit scores since they were regulatorily allowed in 2003. Mr. Poe stated that he put together his presentation about 16 years ago when the re-entrance of Geico for the first time in 28 years it became known to him that they used education and occupation as primary or sole factors in determining eligibility for

insurance carriers and he spent 16 years crusading around the country testifying in FL, NH, and NJ and PA in order to try and ban this practice and raise more awareness about it.

Mr. Poe stated that he believes these practices are about income discrimination that does have a disparate impact on race and he would like to get to that in this presentation. The first slide talks about what I think everybody understands. There are a lot of factors that we use to determine rates in underwriting. I like to say its just underwriting. As a legislature I think we have made a determination that there is a line we are going to draw on what we are going to allow for those factors and that line was drawn in 1964 with the passage of the Civil Rights Act. Most people might not know this but in the year 2000, the NAIC put together a Working Group of a number of insurance commissioners to study how many life insurance companies were still using race as the basis for their rates. Surprising to most is that they actually found there were a number of life insurance companies that used a proxy for race after the passage of the Civil Rights Act in 1964. So, the insurance industry does have a checkered past regarding this and what they found was previous to the actual passage of the Civil Rights Act, life insurance companies had preferred companies in which they gave only white applicants eligibility into and based on you race if you were black you were ineligible for the companies and given much higher rates and worse benefits.

After the passage of the Civil Rights Act what they found was there was only one change made in the underwriting process and that one change was that they eliminated the question of what is your race and substituted the proxy of what is your highest level of education attained and what is your current occupation. In one real life case study, there was a federal class action case against Monumental Life Insurance Company that is public information about their use of proxies. In that scenario the previous company that they used for blacks they substituted the occupations of busboys, dishwashers, garbage collectors, handymen, janitors and unskilled laborers for what they previously used for the company reserved only for blacks. As you can see for the whites there were occupations like office workers and salesman that required four year college degrees.

Mr. Poe stated that for the first half of this session there has been a debate about what to do in these situations. The bottom line that we need to concede as an industry and the consumer advocates need to concede as well is that higher income drivers produce higher profits to our industry. That is just a given and instead of debating whether or not these are actuarially sound practices I would like to concede it. If we concede that now you see the motive behind anything that is a proxy for income and when you have a proxy for income it is going to have a disparate impact on certain classes. So, instead of us going out as an industry and asking the blunt question of how much money do you make and legislators obviously being shocked at that use of factor as the basis of rates we simply adopt proxies for that. At a certain point when does willful blindness equate to intent and the reality is that there are probably not two betters factors in this country for a proxy for income than a person's education or their occupation.

In a real life example in NJ, it was found that the use of education and occupation alone were used as factors when Geico re-entered NJ. Most people don't know this because most of the companies Cure competes with adopt the same trademark name for various different companies for example most people don't know there is Geico Insurance, Geico Indemnity and Geico Casualty. Each of them has separate base rates and in their world get to actually adopt a separate P&L statement and different rates that they get to

file with the DOI based on those entities as separate companies. What is unbeknownst to most people is that when you apply for insurance on their website they will not and have no regulatory requirement to tell a consumer that they are rejected from the preferred Geico company based on their education and occupation alone. A lot of times people ask why hasn't this been more publicly known and why hasn't there been more uproar from the consumer advocates and its because there is no requirement to notify somebody. Unlike the Fair Credit Reporting Act (FCRA) where there is a requirement to explain to somebody that there has been an adverse decision based on their credit score there is no such legislation on the books in the U.S. that requires insurance carriers to disclose when they are going to reject you on that basis.

So, what happens when a consumer goes there and they don't have a high level of education or a high paying job? They might be rejected and when they are rejected they may have a higher rate than somebody else and they leave the website and go to another company or go uninsured. Mr. Poe then reviewed what was found in NJ with regard to the adoption of Geico's criteria for where they use the criteria for the highest base rate standard company – those people are minimally skilled clerks, assistants, postal clerks and stock clerks. That is directly from the actual filing that was found in NJ in 2004 when they reentered the state which is what spurred a lot of legislation that still hasn't been passed. But, to fast forward, what is the motive? As any industry, the motive is to make profits but it goes beyond more than just profits because what happens that most people don't know is that the terms and conditions of most of Cure's industry competitors require that anybody who simply applies for insurance on their website allows that persons information to be shared with every marketing partner of that company regardless of whether or not they buy a policy.

So, earlier there was a discussion with Mr. Birnbaum about what makes this any different from Amazon or any other industry that is trying to make profit and data mine. First, car insurance is mandated in 48 out of 50 states. You are not mandated to buy widgets on Amazon. Second, they capture your information on Amazon or Best Buy when you choose to buy a product for them. What people don't realize is that by simply trying to save money by going to Geico.com you are giving them the information even if you don't buy a policy to take your credit score, credit report, occupation, lease – everything in your credit report and share it with their marketing partner. You can imagine what that would be worth in terms of finding new leads if you're one of these insurance companies that has a data set that they can exchange to reduce their cost to market to future higher income drivers. So that data set is worth a lot of money and it is different from people who voluntarily buy a product.

So, how do we get this past the legislature? Mr. Poe stated that he has been testifying for 16 years on this and the reason why is that his industry has done a really good job in confusing and re-defining what the term risk really means in all of these regulations. I've heard people sit here and talk earlier about the fact that there are regulations or laws in every state that say you cant use a factor that's not unfairly discriminatory or inadequate or any of these criteria that we have in our state laws. That's true unless its actuarially sound. Well, what does that term actuarially sound mean. If you google that term it has many different definitions but what it essentially means is that you are charging premiums to cover your claims costs and expenses. So, how has the industry been able to pass this with all the regulators in the states over the years? Because now in those laws that say you must show that these factors are correlated to risk, all they do is show a correlation to loss ratios. Loss ratios by definition in the industry is simply a

measurement of profitability. If you have a combined loss ratio of 90% you are making a 10% profit. So, if I take a factor that correlates to loss ratios and that's the only thing I need to show to a legislator or regulator to use it, we cant deny this – the reality is that higher income drivers produce better profitability for the industry so any proxy for income will produce the same results. That is why we are here today because as a legislature as that body of law we are here to determine what is the public policy on this and is this country ok with the fact that we are simply going to discriminate against those that are the poorest yet at the same time mandate insurance in 48 out of 50 states.

The commonsense assumption made in this country all the time is a simple application that if you have more accidents you should be paying higher rates. The largest study on this recently was from Consumer Reports that shows people with DWI's and accidents actually pay less for car insurance in this country than those people who have sub 650 credit scores and that flies in light of all of what we are saying in terms of common sense and that is because higher income drivers result in significantly higher profits for the industry. To prove this, the largest study ever done was by Quality Planning Corporation which I think was in 2004. They studied 1 million car insurance policies and tried to figure out what were the most highest propensity of accidents based on occupations. Surprising to most, after students, doctors, attorneys and architects had the highest likelihood of getting in a car accident than any other occupation which flies in light of other studies done by Consumer Reports, investigative TV and a number of other reports.

So, what is the real life impact? The real life impact is that people in this country who do not have four year college degrees that might have a blue collar occupation like a janitor are going to pay on average depending on what study you look at almost twice as much, in some cases 40% but in other cases 100% in this country depending on what state you live in. For the exact same driver with the exact same driving record with the exact same car, that person who is uneducated and has a lower paying blue collar job could be paying more than twice as much compared to what the other white collar wealthier driver would pay.

The best way to look at this in a microcosm as this is a national coalition of legislators is to see what happened in NJ in a vacuum. In NJ in 2004 there was not a single insurance company allowed to write car insurance based on credit scores, education or occupation – not one carrier in the entire market. From the data that we have right now, from 2007 – 2015 in NJ we have increased our uninsured motorist population by 86% in 8 years. Those uninsured drivers are not people who choose to noy pay their bills – this is an unaffordable product in the marketplace. While people in the industry debate this and there is a bill pending in the NJ Senate to ban the use of credit scores and occupation and education in auto insurance underwriting this is irrefutable evidence of the impact that this has on your own state. Insurance is a necessity in 48 out of 50 states and in those states you will see fines if you don't buy car insurance on the car that you own. More importantly, what most people may or may not know, most states have a bar from you bringing a lawsuit for pain and suffering if you are an innocent victim of a car accident if you have a registered vehicle that does not maintain liability insurance within that state. So, in states like NJ or MI if you are driving without insurance or you have a car that is registered and you don't have liability insurance on it and you are rear ended by the wealthiest person in the world and that person has $1 billion in assets you are not allowed to initiate a lawsuit for pain and suffering as a result of not being able to afford car insurance.

The industry loves testifying against me saying we cant get rid of these factors as they are predictive of loss. They are predictive of probability but what are we talking about here? We are talking about public policy. If you eliminate the practice of the use of these income proxies – obvious income proxies – you are not going to see more people run into trees and rear end people. We are talking about a rating factor here and an underwriting practice. We are not talking about eliminating airbags or blinkers or seatbelts. You are not going to see bigger losses as an aggregate in any state you are in you are just going to simply change the way people are charged for car insurance. Really this is a public policy issue and I think its about time with our social justice movement in this country that we need to pay attention to it. There are two bills one in NJ and one in the federal side sponsored by Senator Cory Booker, and Congresswomen Rashida Tlaib, Bonnie Watson Coleman have introduced and we are hoping that this will finally be the time that public policymakers will finally do what's right.

Roosevelt Mosley, FCAS, MAAA, CSPA, Principal and Consulting Actuary – Pinnacle Actuarial Resources, Inc., thanked the Committee for the opportunity to speak. As a way of background he is a principal and consulting actuary with Pinnacle Actuarial Resources. I have about 27 years of experience in the P&C actuarial space. The first 6 years of that working for insurance companies and the last 21 years spent in consulting. My consulting career has been primarily based in personal lines insurance and has included traditional actuarial work like rating plan development, product management and product development as well as advanced analytics. Our clients include insurance companies, regulators, insurance trade associations and even third party data providers to the insurance industry. The comments I provide today however represent my personal comments not necessarily those of any insurance company or industry group. I appreciate the opportunity to provide an actuarial perspective to this conversation. There has been a lot of discussion today regarding some of the actuarial principles and standards and some of the ways factors are used and justified in the insurance industry so hopefully I can provide some perspective on the actuarial angle on some of these issues.

I am a fellow of the Casualty Actuarial Society (CAS) and a member of the American Academy of Actuaries (AAA) and a certified specialist in predictive analytics so as part of my role I work not only with insurance companies but also with insurance regulators. An example of this is coordinating as part of my work with AAA two day long sessions with the NAIC relating to their summer meeting on predictive analytics and the use of big data. As an actuary I have significant experience in the development and analysis of insurance company rating plans and as requested the focus of my comments today are focused on the use of rating factors in the insurance industry and specifically for personal lines P&C insurance. I will also pick up a little bit on some convos that happened today on the use of telematics and usage based insurance (UBI) for private passenger auto insurance to maybe provide an additional perspective on that. Finally, I'll end with some social considerations that are being discussed by this Committee.

First, to frame and provide some context around this issue I want to provide some background relating to some of the actuarial considerations relating to the use of rating factors. More of this will be provided with some of the AAA representatives so I wont get into all of the details and the points they will make but I believe my remarks will provide some context. Simply put, the use of rating factors in the insurance industry really is to help better determine and allocate the relative cost of insurance for particular policies

with different characteristics ensuring that those premiums are adequately matched with the expected losses. In total, insurance company premiums are set to cover expected losses and this gets into the insurance company solvency that was referenced earlier today but in addition to that the premiums also vary based on the characteristics of the policy to reflect differences in expected potential loss and thus the use of rating factors in the insurance industry is to really help satisfy that particular objective.

In terms of the reasons why companies use them I wont get into great detail as some was already covered this morning but I would point the Committee to a document that was produced by the AAA back in 1988 called the Risk Classifications Statement of Principles and this document was actually produced prior to the establishment of the actuarial standards and the promulgation of actuarial standards of practice. However I think the document does detail a couple of considerations relating to the use of rating factors and risk classifications which I think are important to at least create the backdrop of this discussion. The first reason is really for the overall financial soundness of the company and to a certain extent the insurance industry as a whole. To the extent that premiums are able to be matched with loss and are done so in a way that policyholders are charged premiums that commemorate with their expected loss there is essentially an intrinsic equity that's present in the insurance process and that process will help to avoid issues like anti selectin and protect the financial soundness of both the insurance companies and the insurance industry.

The second reason highlighted by the document is enhanced fairness. When rating factors are associated with the expected loss of insureds, no insured feels like they are either getting a really good or bad deal in terms of the costs they are paying for insurance. When the cost for insurance at least for the perception of the insured is higher than the expected value of that insurance then there are economic considerations that come into play that could begin to impact the financial security of the industry. Third is essentially the economic incentive. For most insurance companies and a lot of companies I worked with there are a couple of objectives that many insurance companies have. One is growth and the second is to be able to do so profitably. To the extent that a better classification plan that is on par with some of the competitors they are facing allows them to do this in a way that doesn't require them to necessarily undercut price and then to be able to grow in a financially responsible way.

To sum up at least the background of why companies use these factors it practically comes down to a reality in todays insurance environment. The complexity of rating especially on the personal lines side has been discussed a bit today but there is one primary theme that underlies that insurance companies are trying to accomplish as it relates to the use of rating factors. Either the company is trying to maintain a proper competitive footing and a proper competitive placement in the industry or attempting to be better at identifying risk and charging for that risk and ultimately driving both growth and profit.

Historically speaking this process was relatively straightforward and transparent. When I began my career in 1993 the key factors used by insurance companies was a relative short list certainly relative to today and they were for the most part fairly standard. In the 1990s some companies began to add additional elements to what they were doing but in essence if I had the characteristics of a policy for an insured that was insured by the company I was working for it was fairly easy to go get a rate filing or get a rate manual from another company and determine what that risk would be charged for that other

company. Obviously a lot of that has changed since then and as companies have begun to add more factors there are a couple of things that have happened. One is that it has become more challenging to understand and how to calculate the rate for risk for a competitor. Also, in order for companies to try and maintain some of the competitive advantage that they are trying to go after, some companies have tried to make it harder for companies to figure out exactly what they are doing – not necessarily hiding it from regulators but more so hiding it from companies and maybe filing some pieces under confidential.

So what began to happen as the world became more complex is that insurance companies that weren't maybe as quickly to recognize some of the additional risk classification that was being incorporated, they began to see the results of that both the ability to write the business and the ability to make a profit and it was essentially a lot of these cosmic forces that drove a lot of these companies to follow suit. I provide that background to help set the stage. Having been a part of this process for the past 27 years you can see the progression of a lot of the complexity that's happened in the industry and a lot of that complication has not necessarily come about because insurers are trying to intentionally be discriminatory but really to either establish, reestablish or improve their competitive standing and thus achieve some of the goals that were just mentioned by the previous speakers.

With that as a backdrop lets move to the idea of how companies support or justify the use of a particular rating factor in most states. There are some exceptions but in most states insurance companies have to file their rating plans with state insurance regulators and they must justify the use of those factors with the regulators. The primary way this happens is with the use of insurance company loss experience. The previous speaker referred to loss ratio. There are also a lot of more complex models discussed earlier today that don't incorporate necessarily at the beginning in terms of the analysis the premiums the companies are charging but are more focused on the likelihood of filing claims and the severity of those claims – more traditionally referred to as a frequency and severity analysis. Those analysis really focus on the risk of loss related to certain risk factors and ultimately then the risk of loss is determined for its companies to the premiums that are currently being charged and premium adjustments are then proposed.

Historically the analysis of these factors did occur in more of a univariate fashion – looking at one factor at a time and using some determinations but over time that has swung to more multivariate analysis – analysis that essentially accommodates or incorporates the fact that the distribution of a particular rating factor characteristic is not independent but actually do correlate. There are also cases where maybe insurance companies don't have sufficient internal experience to support the rating factors that they use either because they haven't necessarily been collecting those factors over time or they just may not have enough data internally to maybe support some of the things that they would like to do. The way that has been handled with regulators is either looking at what competitors are doing with those filings or potentially working with data providers and others to generate aggregate experience.

Ultimately the support of these factors really comes down to this idea that making sure that a factor is actuarially sound. The statement of principles on P&C insurance ratemaking which is a document that was developed by the CAS actually defines what actuarially sound means and essentially sums it up in three principles. That the rate is the estimate of future expected costs, the rate provides for all costs associated with that

transfer of risk, and the rate provides for costs associated with the individual risk transfer. So, if a rate meets those three criteria it is then determined as actuarially sound.

An additional question I was asked was based on a lot of this discussion on rating factors was why do some companies choose not to use particular rating factors. The first reason which has bene highlighted today is that the loss experience doesn't justify the use. There are some companies that have evaluated some of the risk factors that may be used by other carriers and determined that it doesn't impact their book of business the way maybe it has for others and have decided not to use it so there have been cases and examples where we can point to that. The second reason is operational. There may be some things that operationally an insurance company cant do from a systems perspective or another perspective so they choose not to use a risk characteristic. The third reason which will pivot into a couple of additional items is really an internal company decision. A company may decide as the gentleman from Cure indicated that for internal reasons that they don't want to use particular factors. We all may have seen one example of this recently when Root insurance announced that within the next 5 years they will be discontinuing the use of credit based insurance scores. The reason as advertised by Root is not because credit based insurance scores haven't been shown to be related at least to expected loss but because they believe that it's the right thing to do to help to begin to eliminate bias in rating. As part of that action they have also called on other companies to do the same.

Speaking specifically of Root I want to talk briefly about some of the considerations related to UBI. While Root is discontinuing the use of credit based insurance scores its not doing so to be left in a vacuum and without a viable alternative. Root is one of a number of companies that we would classify as telematics only. In order to have insurance with Root you have to agree to have them monitor your driving behavior so every policyholder that purchases insurance from Root will be base rated at least in part on their driving behavior as measured by a mobile app. Specifically, Root monitors mileage, distracted driving, braking, turning and time of day driven. In addition to other companies like Root and Metromile which are telematics only many of the major insurance companies also offer telematics options so customers can choose to sign up for these options and as a result rates are determined at least partially on the monitored driving behavior.

The use of telematics is really more of a direct measure of exposure to loss and really more direct than any of the rating factors we have used in the insurance industry. Historically, and this was a concept that was brought up earlier, many of the raring factors that are used today aren't really direct measures of loss exposure they are really what we call proxy measures and allow us to observe something that is potentially relate to the risk of loss. An example of this is prior claim activity. It is well documented and established that if a policy has a prior claim then the likelihood of that policy having a future claim is higher but having a prior claim doesn't necessarily mean or cause you to have a future claim so that is what we mean by proxy variables. Conversely, telematics isn't a proxy variable its really a direct measure of driving behavior and as a result one of the more powerful variables available for pricing today. Given this, its still true as well that telematics really hasn't necessarily become as widely used as its power may indicate. There are a couple of reasons for this. First, the percentage of policies at least right now being rated using telematics is still fairly low on an industry basis. The companies that are telematics only are still pretty small and currently only make up a

small percentage of the marketplace and even for those companies with options at least historically the take up rate for their policyholders hasn't been substantial.

The COVID pandemic has actually increased that pace and is one of the things that has actually helped with the take up rate but its still going to take some time for that volume to grow. There are two other reasons that I think are even more important. UBI is really still in its infancy as it relates to the portion of the rate that is based on telematics. Even for telematics only carriers, many of them still use traditional risk characteristics and still base a significant percentage of the rate on traditional risk characteristics. As an example, based on Root's website, less than 25% of their rate is impacted on driving behavior so the majority of a rate even for a company like Root is still based on primarily the historical rating approaches. Part of this is due to the fact that it takes time to build up experience to build up the analysis and especially as you are talking about how much can telematics data replace some of the traditional risk characteristics its going to take even longer for companies to continue to build that up. While UBI certainly does provide more of a direct measure there are still some potential challenges as it relates to the bias issues and we can come back to that with questions.

I'll end with a couple of comments related to the race in insurance issues. There have been some efforts in states that have either restricted the use of or actually prohibited the use of certain characteristics. A few states don't allow credit based insurance scores and a few states don't allow gender or marital status so some states have at least in a bit of a one off fashion implemented something to deal with some concerns related to the bias in rating. But as I alluded to earlier and has been stated here today the history of the development of some of the more sophisticated rating has really been a function of better matching premium to loss and really hasn't been an issue related to intentionally attempting to try and proxy or discriminate against particular classes. Having said that, we are now faced as an industry and speaking as part of the actuarial profession there is a potential for unintentional bias that has made its way into our rates. Despite it being unintentional, the potential still exists and so as initiated by NCOIL and NAIC identifying this potential and developing solutions for potentially addressing it is a necessary and significant undertaking. But as has become clear by these discussions and discussions at the NAIC and others this is not going to be easy to solve. Defining the issue, determining at what level that particular either rating factor or approaches are unacceptable and then determining the solution to deal with those unacceptable outcomes are going to take time and are going to take collaboration among everyone.

Thera are a number of potential solutions but each of them has advantages and disadvantages so the proposed solutions need to be carefully considered to make sure they will produce desired results, minimize unintended consequences, and ultimately as issues are discussed I encourage the Committee to partner with industry and the actuarial community to research the issues and determine the extent of the problem and identify proposed solutions. I look forward to the work of this Committee and the opportunity to collaborate and remain available to answer any questions I can.

Tony Cotto, Director of Auto and Underwriting Policy at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that on behalf of NAMIC and its more than 1400 local regional and national member companies he appreciates the opportunity to join from Louisville, KY where we are fast approaching 200 consecutive days of protest following the death of Breonna Taylor and just this week our Mayor signed a sweeping Executive Order to join

the fast growing ranks of state and local officials declaring racism a public health crisis. As communities and industries each tackle allegations of racism in their own way we commend NCOIL for engaging on this important topic at hand for the U.S. insurance sector.

Today's session and discussions are critical to the continued evolution and examination of the heart and soul of the insurance business – underwriting, rate making and fair treatment of all policyholders. We look forward to working with you in advancing a constructive dialogue around the entirety of this committee's efforts and applaud your commitment to actuarially sound, data driven policymaking and the fundamental principle of risk based pricing. I also appreciate Asm. Cahill's comments this morning that we have to start these conversations with math. I've seen these ongoing underwriting and rating discussions from many vantage points over the lest decade and a half where I've interacted with many of you as congressional and then NAIC staff then private practice representing carriers then a regulator in KY and now in NAMIC – from any of those views, math is the best place to start. While your counterparts at the NAIC are in the business of regulation and enforcement it must be elected and accountable lawmakers who establish public policy enshrined in the state insurance codes that govern the U.S. system. The laws that members of this body pass in your home states are what ultimately bind insurers and regulators. Although my remarks today are going to focus on rating factors and the use of insurance scores, I'll take a quick opportunity to make some brief broader observations.

First, mutual insurance companies are built on notions of community and inclusivity. The mutual model has a long and proud history of service to minority communities. Second, NAMIC and our members understand that like our legislative bodies and the communities we serve we are stronger when we include diverse backgrounds, skills, knowledge and perspectives of our policyholders, our vendors and our employees. Third and most importantly, NAMIC and its members are adamantly opposed to discrimination on the basis of race and unfair discrimination in general and we support legislative policies to prevent these practices. The elimination of racism improves every aspect of our lives, our relationships, our institutions, and our business communities. With that I will move into my presentation.

Today, I have been asked to provide a brief overview of credit based insurance scoring. For ease of reference to minimize confusion I'm just going to refer to them as insurance scores. As you've already heard from panelists all morning and this afternoon much of the discussion around race in insurance underwriting is rooted in the alleged fairness and validity of rating factors that insurers use and because of this our conversation has to start with why these rating factors even matter. As simple as I can put it – good rating factors are factors that promote accuracy. Rating factors that promote accuracy fuel competition and fuel healthy markets. In turn, those healthy markets increase availability, improve consumer choices and reduce costs. Accuracy promotes competition and healthy markets reduce costs. That's as simple as we can make it. Carriers also have to consider things like credibility, objectivity and other things in concert with actuarial standards and principles. But the bottom line here as policymakers that you have to keep in mind is that when you decide to limit accurate rating factors you are making a tradeoff and that tradeoff is most likely gong to harm small insurers and consumers more than anybody else. The remainder of my remarks are going to be about one of those accurate rating factors – insurance scores.

Many of you have lived through the initial development and the use of these scores since the early 1990s and the development of NCOILs most successful Model on this topic. All the same I thought it would be important to provide a couple of operational notes about insurance scores. First, generally speaking insurance companies purchase these three digit scores from credit reporting agencies. They are end users of an insurance score – they don't develop them by and large. Second, insurance scores are not static – they are snapshots and a picture in time. They change over time as new information is added. Most importantly of all, insurance scores are not credit scores – they are not the same thing. Some of the underlying data is the same but they are not the same thing and not weighted the same way and not used the same way.

To that end I put together a comparison chart putting them right next to each other. These are not the only differences in the scores but they are the ones that seem to come up the most often and cause a lot of confusion. Please focus on the purpose portion because it makes sense and matters what you want to use this score for that you've purchased. Lenders use credit scores because they want to know if they are going to get paid back when they lend money – that's what a credit score is for. An insurance score is not that. Insurers aren't interested in whether or not an insured is going to pay back a loan. They are interested in whether an individual is less or more likely than another individual to experience a loss. Accordingly they are used differently. They are used for rating policyholders and applicants and saying you are more likely than not to have a loss – that is what an insurance score is all about. There are some other points on here regarding whether its determinative and you can use them in isolation and the answer is no – an insurance score is not determinative of whether or not you get a policy an insurance score is not used in isolation its used on combination with the other factors that Prof. Prince and Ms. Mosley have already started talking about a little bit today.

The notion that insurance scores are somehow inherently evil or used in the same way that credit scores were used to prevent people from getting loans is incorrect. Lets talk about what goes into the insurance score and more important lets talk about what doesn't go into the insurance score. This chart here lays out some of the items that go into the score. We've talked a lot today about objective data – these are objective data talking about here when talking about what goes into a score and what does not. They are objectively confirmable data and look at the right column and find that it is chalked full of data that is not used – race, color, national origin – none of those have anything to do with your insurance score. Why? Because your race, color and national origin have nothing to do with how you manage the items that go into your insurance score. Any suggestion to the contrary is deeply offensive. What you look like and where you come from have nothing to do with your insurance score. What you look like and where you come from have nothing to do with whether you pay your bills on time. What you look like and where you come from have nothing to do with how much you use the credit that you have and how responsible you are in your pursuit of new credit. I am happy to tell you that I am a married Hispanic male in KY with a law degree and a 15 year old truck and I work for NAMIC – not one of those things would factor into my insurance score. My insurance score cant tell you any of that because it doesn't matter. What matters is how I behave when people extend me credit.

Next, I'd like to address some of the myths and falsehoods that surround many of the discussions and characterizations of insurance scores. Given this committee's focus lets talk about a claim we've already heard multiple times today that insurance scores are a proxy for race. This particular spurious accusation is in and of itself racist. The

use of these scores is the opposite of racial discrimination because if anything it removes subjectivity and removes an opportunity for racial discrimination by removing subjectivity and removing personal judgment. An insurance score doesn't tell me anything about somebody's race. Insurance scores tell me about behavior.

I haven't heard it yet today but you often hear the notion that consumers don't have any control over their insurance score. Consumers are not some hapless bystanders when it comes to ways that they can improve their insurance score. There are things that we talk about a lot about how can I make it better and what can I do better to lower my rates - pay my bills on time and balance credit mix as not all credit is created equal. A credit card is very different from a mortgage but if you pay down your debts and you don't seek new credit at once in multiple forums or you don't necessarily need or have the capacity to manage there are ways in which consumers can control their insurance scores. I wont march through all of these as you've heard them many times and I'm happy to discuss alter but I do want to hone in on a myth that is a testament to the good work that NCOIL has done and continues to do in this space which is an appreciation and understanding that sometimes life throws you nasty breaking balls and policyholders and insurers need a way to address that. There is the extraordinary life circumstances provisions that are included in the NCOIL Model and that continues to be NCOIL's most successful Model and I think something we've seen throughout COVID responses is that these are extraordinary times and these are what these provisions are for to deal with these extraordinary times and let insurers and policyholders have the flexibility they need to deal with their insurance score issues.

At the beginning of the day Rep. Matt Lehman (IN), NCOIL President, talked about the importance of being data driven and insurance scores have been studied time and time again by independent entities, statisticians, governments, the FTC and the consistent findings across the studies remain that insurance scores are predictive, benefit most consumers, have nothing to do with income level and cannot be used to identify demographic groups which is to say they are not proxies for race. Continued study is a good thing. As the research continues, NAMIC and all of our member companies will continue to review the studies and materials on this and candidly on all rating factors as studies continue to come out as we look at and constantly reassess the value and predictive use of each of these factors. As I wrap up its important to realize that insurance scores work and that benefits consumers. The studies have shown that they benefit the vast majority of consumers and not only a benefit – they are either neutral or beneficial to the vast majority of consumers.

Even some regulators who initially were the most skeptical of insurance scores now accept their validity. That was made clear oddly enough on ' NAIC C committee call when a regulator spoke about having a historical opposition to credit and the use of insurance scores until they saw how they actually work and the fact that they have predictive value. Regulators have come a long way on this and NCOIL has led the way. NAMIC and its members understand that underwriting is a system predicated on and sustained by fair and equal treatment. That means the use of objective standards of risk assessment that apply to every applicant and policyholder. Insurance scores are objective and prohibiting their use will result in higher rates for policyholders of all races. Thirteen years ago Chief Justice John Roberts wrote the way to stop discriminating on the basis of race is to stop discriminating on the basis of race. More recently, the great African American economist Walter Williams who just passed away this week quoted Louisville's own Muhammad Ali in his syndicated column when he said hating people

because of their color is wrong and it doesn't matter which color does the hating it's just plain wrong. We agree and from NAMIC's perspective we are committed to working with you to advance in this area. I am Happy to stick around for questions after the panel.

Marty Young, co-founder of Buckle, thanked the Committee for the opportunity to speak and began with an introduction about himself. He is the co-founder and CEO of Buckle one of the so called insurtechs/fintechs that is part of the movement of digitalized insurance. I come from a background of over 20 years in turnaround restructuring in special situations. I'm known as a chief restructuring officer, COO in companies going through a acute periods of change. I've been involved in and led over $30 billion dollars of transaction value. I'm a West Point graduate, a former U.S. army infantry officer and a Chaplin in the national guard. I am proud to have served in the national guards of MA, NY and currently DE. I am a certified turnaround professional, certified insolvency and restructuring advisor, and have a gov't security clearance. Through my educational background, I have an MBA from the NYU Stern School of Business and a master's degree in operations research from Georgia Tech where I serve on the advisory board of the school of industrial system and engineers of Georgia Tech.

I'll first introduce you to Buckle and then focus more on some of the key issues that the Committee is investigating today and our vantage point that we bring to the conversation. Buckle was founded to provide comprehensive financial services to both gig workers as well as the platforms they work for. So think in terms of Uber drivers, Lyft drivers, Instacart drivers, Amazon drivers – emerging gig economy systems that are evolving. What we saw was that the financial infrastructure needed to provide the insurance and credit for this emerging economy simply didn't exist. What we did was start the process of building the only financial services company solely focused on this new customer segment and system and we built and acquired significant financial infrastructure and we own a 47 state licensed carrier domiciled in IL called the gateway insurance company and we are also in the process of acquiring a couple of additional carriers. We have also built a claims administrator licensed and domiciled in GA, a cell captive carrier in VT and we have numerous strategic partnerships in the reinsurance industry as well as in various types of digital and non digital MGAs. We've assembled a world class mgmt. team including four former senior USAA executives and our goal is to become the USAA of the gig economy and a model very centered in and around serving a group of members that we see is the emerging middle class of the U.S.

So, what is the problem that we are fundamentally solving. That problem is that 40% of American households are subprime and have a 650 or lower credit score and that group of Americans as well as immigrants and other aliens here are all in this sort of group of folks that because of their credit score are heavily penalized in both the credit and insurance industries. The U.S., for the most part, in order to have upward economic mobility, car ownership tends to be one of the key factors in getting that. However, for a subprime household car ownership is also less of a tool of upward mobility and more of a transportation trap. It can often lead to the cycle of economic hardship and cycle of poverty through self reinforcing mechanisms predominantly through credit score. You've already heard several distinguished speakers earlier talk about the issues of credit scores in the insurance industry and from everything we have seen we agree that if you are subprime you are non standard and you can easily pay $50-100 more for your car insurance regardless of where you are in the U.S. Adding insult to injury, many of these folks are also paying 1000% in interest and fees in their auto loan and leases. The

insight we had was that we can help people escape this transportation trap by enabling and supporting gig work at fair prices and effectively move up the socioeconomic ladder.

The way we thought about this was that a person who is subprime in the U.S. – the reason they are such is because predominantly of their income. Nothing drives a credit score more than income. If you have a $15 per hour job in the U.S. you are overwhelmingly subprime. The correlation to hourly wages to credit score is linear across all ages. What we learned was that the folks that are in most need of basically getting a car and moving up the socioeconomic ladder are folks that are making wages in the $10-15 per hour range. If they can somehow move their vehicle which tends to be a very large burden on their lifestyle from a cost to a cost of good sold we can transform the middle class. According to AAA, the cost of owning a car each year is about $9,000 but if you only make $15 per hour you only make $30,000 per year so that means you cant afford $9,000 per year for your car so you end up moving down to the B lots and the non-franchised dealers and the buy here pay here lots and non standard subprime insurance companies and what you see is that because they cant really afford those that a lot of us take for granted in the prime world, they basically have to pay a tremendous amount of extra in terms of their insurance as well as their credit expenses.

What we call this is a credit score tax and this tax because of its impact on insurance and credit results in basically an additional 10-20% more to Uber, Lyft, Doordash and others in their driver supply because the folks driving the gig economy are generally making $10-20 an hour depending on where they are in the U.S. and although their vehicle is being used as a source of revenue generation and things like insurance and even the cost of credit become costs of good sold rather than household costs the reality is that this is squeezing them. Some anecdotes – in Atlanta, GA where we started many of our drivers may have perfect driving records but because third credit score is below 600 they'll pay easily 50-100% more than basically a quoted standard risk. 50-100% more for many of these folks is 11-14% of their annual take home pay so for the folks working in the gig economy the way you have to think about it – your Uber driver that may have gotten you to the conference today is spending 11-14% of their annual take home pay on insurance. When you start adding things like the cost of the car itself and fuel, the tax on the system is absolutely overwhelming. In fact, I submit to you that this credit score tax isn't just detrimental to the drivers but the essential workers in this era of COVID where we all are relying on these drivers to deliver us packages form Amazon and medicines from pharmacies and groceries from Instacart and so on and so forth.

So what's happened is that this credit score tax basically reverberates throughout the entire value chain. In this diagram there are three very distinct demand curves – the rideshare demand curve like Uber and Lyft; the food delivery demand curve which is Grubhub, Uber eats and Doordash and then package delivery demand curve like Amazon and Instacart. Those demand curves intersect the same supply curve because they are all the same drivers. If you look at what's in the supply curve you see sort of the cost of labor but then you start adding in the cost of standard insurance and prime financing.

So as a prime risk as a standard driver my rates are really low. There is a cost of depreciation and maintenance, a cost of insurance that the TNCs have to maintain and then there is an extra cost stuck in the system that is really tied to the credit scores of these drivers. I submit to you that credit score effectively hurts the whole system and if you are a consumer of these services then this cost is basically hurting you as well

because basically if we can eliminate the credit score tax in the system you would see lower costs of rideshare, more work opportunities for gig workers and more revenues for every single TNC.

Our mission is to help people achieve economic freedom and we have eliminated credit score as an underwriting metric from all our underwriting. We don't use credit score. Basically, what we have learned is that by not using credit score and by using very reasonably admitted paper filings with normative factors, nothing crazy that by any means would be controversial, we are able to reduce folks insurance costs by 50% in many cases because of the credit score tax. By doing so this is life changing. Saving $50-100 a month for many people on this call is great but doesn't really move the needle but if you make $15 per hour and $30,000 a year you save $1,200 a year in car insurance, that is transformative. That is the difference between having mac and cheese for dinner and having a sold meal. That's what this is fundamentally about.

The way we approached this was that we realized that in addition to eliminating credit score we also had to re-visit the whole insurance business model. I come from a credit background and have worked with pretty much every major credit institution out there and hedge funds. What I would explain to you is that what the credit industry learned a long time ago was that the idea that somebody would walk into a bank sit down in front of a banker and that banker would make a decision whether or not to issue a loan to that person was a fundamentally flawed model because their bank was trying to maximize the amount of underwriting profit they could make on that person walking through the door. What the banking industry began to realize, and many banks got there before the financial crisis, is that they had to stop focusing on making underwriting profit as fast as possible. The banks that figured that out before 2008 were bullet proof – JP Morgan was bulletproof. Other banks were out there basically trying to make underwriting profit on their borrowers and they ended up in the middle of the financial crisis and some are no longer here today and others have been swallowed up by larger banks. It was decided that credit banks needed to stop focusing on making underwriting profit and focus on the business of originating paper into the capital markets as efficiently as possible.

The model credit paradigm today is you have issuers whether they are credit cards, or car loans or corporates, give investment bankers going out there essentially marketing the book. Yes, banks do originate the paper and they are essential to do that but they actually don't set price, they use the capital market system to set price and they set up servicers to go and do this in scale. To show where we are in 2020, most people on this call today could decide to buy a house and pay a $500 fee to any major bank and get a $500,000 mortgage. If you ask the bank the question who actually is giving out the mortgage they will say it moved out to the market, not the bank. Through this shift in paradigm we are able to sustain it by plugging in effectively all sorts of different balance sheets whether from the Fed, federal gov't or the global capital markets themselves.

The insurance industry, particularly the non-mutuals, need to start thinking this way today and for us to do something so revolutionary like stop using credit scores we had to basically divorce ourselves from the idea that we would make underwriting profit on our members. We would market them and would fairly represent them to the reinsurance industry and let that industry's actuaries do what they do well. In fact, I think the reinsurance industry because they see risk across the entire value chain of all insurers they are actually best situated to set price. Yes, we do have proprietary data and other

tools but by basically acting as a carrier in the model where we are not really making underwriting profit but really marketing the risk profiles of our customers not using credit score into the capital markets in a fee model versus an underwriting model we can bring in market efficiency and eliminate the credit score tax. We have had a tremendous amount of success doing this in Georgia and soon we will launch in most of U.S. in 2021.

Let's talk about the financial infrastructure required to do this. In order to be an actual fiduciary to our members required a whole new framework that we took from modern banking. Most insureds think that the insurance company is their fiduciary agent but nothing is further form the truth. Insurance companies are fiduciaries of the insureds. In fact, insurance agents in many of the exams throughout the U.S. at the state licensing level have questions making sure they understand that they have zero fiduciary duty to the insured – they have 100% fiduciary duty to the insurance company. So, the insurance company in using all these types of underwriting factors are really designed to make as much profit as they can from the insureds. They are thinking the way banking thought 25 years ago and that is not the way it needs to be moving forward. Unfortunately, particularly in the subprime markets a lot of those folks are not well educated and not wealthy and they make huge payments into the insurance industry and they actually believe that insurance companies and agents have their best interest at heart. In this model, we are able to take on that role by basically deconstructing the value chain and setting up a system where we can be their fiduciary and take their data and get into the capital markets and find the best reinsurance structure for them and basically make the market and that's the way modern credit works today and we believe that's the way insurance has to go.

This isn't so much about trying to get to better underwriting factors to get more profit off of insureds but rather redesigning the system as a whole. By doing this we see an opportunity to not just eliminate credit score tax in insurance but also in credit itself. As we build up the platform next to the insurance company which is a credit platform we are getting a lot of interest and traction from the credit markets who agree with us. The idea of using a credit score in order to make a credit decision probably isn't the right way to think about the complex world we live in today. People are complex and their lives are changing. What's happening is that we want to be part of their upward trajectory and encourage and sustain a path toward upward economic mobility. This is less about using credit score and more about creating and enabling a sustainable market driven insurance system.

Dorothy Andrews, MAAA, ASA, Chairperson of the Data Science and Analytics Committee at the AAA, thanked Chairman Breslin and the Committee for the opportunity to appear today to lead off presentations from the AAA. The Academy is the national professional association for actuaries from all practice areas in the U.S. whose mission is to serve the public and the U.S. actuarial profession. The Academy is nonpartisan, objective, and independent. It assists public policymakers on all levels by providing actuarial expertise on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States. In a moment you will also hear from my Academy colleagues, Lauren Cavanaugh and Mary Bahna-Nolan on practice-specific concerns related to your charge. But first, I would like to discuss some of the work and exploratory discussion undertaken by the Academy's Data Science and Analytics Committee, which I chair.

The need for a Data Science and Analytic Committee resulted from the work of the Academy's Big Data Task Force, which was charged to: Understand the impact of big data and algorithms on the role of the actuary; Examine the framework of professional standards to provide guidance for working with these new tools; and work with policymakers and regulators to address issues related to their use. The efforts of task force produced a monograph titled, Big Data and the Role of the Actuary. The charge of the Data Science and Analytics Committee to "To further the actuarial profession's involvement in the use of data science, big data, predictive models, and other advanced analytics and modeling capabilities as it relates to actuarial practice. And, to monitor federal legislation and regulatory activities, and develop comments and papers intended to educate stakeholders and provide guidance to actuaries."

The evolution of the data scientist presents challenges to the actuarial profession. The U.S. Government Accountability Office (GAO) identified a couple of these challenges in the report it issued last year on the benefits and challenges presented by innovative uses of technology. The GAO report states: Models are being developed by data scientists who, unlike actuaries, may not fully understand insurance-specific requirements, such as setting premium rates that are not unfairly discriminatory, and may struggle to measure the impact of new variables used in the models; Data scientists may be unfamiliar with insurance rules and regulations and may not understand how to communicate their work to state insurance regulators. Additionally, data scientists may not adhere to a set of professional standards equivalent in scope and moral and ethical values to those of the actuarial profession. A review of professional standards of organizations such as the American Statistical Association (ASA), the Data Science Association, and the Certified Analytics Professional organization reveals significant differences between their professional standards and those of the American Academy of Actuaries.

The Committee I Chair will develop a Data Science and Analytics Committee Big Data & Artificial Intelligence (AI) White Paper. The purpose of the white paper will be: Demonstrate the high ethical and professional standards that actuaries operate under to deliver value to insureds using objective actuarial, statistical, and AI methods; Discuss the changing nature of actuarial practice and the benefits of big data and predictive algorithms with a growing focus on human behavior to improve risk selection and the customer experience; Examine the work of insurers to control for systemic influences and socioeconomics by rigorously examining and eliminating the potential for biases to impact every step of the modeling process; Consider the willingness of insurers to work with regulators to resolve big data, algorithm, and AI disparate impact concerns and to promote a positive transformation of the insurance industry. It is important to explore resolutions that do not hamper the development of technology that works for the benefit of consumers.

The issue brief is expected to lay out a road map for working with regulators to resolve issues in the following areas: Standards for emerging data sources; Evolution of actuarial standards of practice; Ethical issues related to artificial intelligence models; The reliability and regulation of external data sources; Controlling for systemic influences and socioeconomics; Regulatory concerns impacting the work of the actuary; Impacts of big data to transform the practice of insurance; Behavioral data science impacts on traditional actuarial practice. On this last point, I would like to share a quote from Sherry Turkle of MIT. She states that "Technology does not just change what we do, it changes who we are." This statement reminds us that we have to be mindful and watchful of the

behavioral effects to technology to shape the data we study and the models built upon that data.

Insurance alone cannot solve all the social ills in society, but insurance models certainly should not contribute to them. The committee will provide information to actuaries on protecting consumer data to facilitate that algorithms are: Appropriately transparent; Explainable and interpretable; Free of unfairly discriminatory variables and related proxies; Based on variables with an appropriate relationship to the risk being insured; Appropriately granular to guard against unintended disparate impacts to protected classes; Attended to with human oversight to ensure controls and metrics are in place to monitor the continued fit and appropriateness of models for the purpose they were designed; Validated for quality and reliability by actuaries or experts who understand insurance company target markets, product lines, and insurance liabilities. By providing information in these areas, models can become more accessible for critical review and remediation before being exposed to the public, reducing the likelihood of these models to cause harm.

Finally, because Lauren and Mary in a few moments will be focusing on property/casualty and life actuarial concerns, I would like to spend a moment to relate some of the work the Academy is doing on health equity. While this is an initiative that is being worked on by another group than the one that I chair, I will provide you with just some highlights of this effort; once the Academy has had a chance to publish preliminary outcomes early next year, we can be available to NCOIL to more closely address them with you. This work has been undertaken to further the U.S. actuarial profession's commitment to health equity throughout the health care system by looking at current practices that potentially perpetuate or exacerbate adverse health outcomes experienced by people of color and/or historically underrepresented groups.

Specifically, the work is organized around issues concerning benefit design, provider contracting/network development, pricing, and population health. Questions that are currently being probed include: Does the use of historical data embed disparities in projections? Are assumptions appropriately determined and applied? And what sorts of analyses should be performed to explicitly identify inequities? So, again we will keep NCOIL apprised of the Academy's progress on this work as it progresses. With that, I will conclude my portion of the Academy's prepared remarks and will now recognize my colleague Lauren Cavanaugh.

Lauren J. Cavanaugh, MAAA, FCAS, Vice President, Casualty stated that on behalf of the Casualty Practice Council (CPC) of the Academy, I commend the NCOIL for organizing this exploration of important questions regarding race and insurance. Thank you for inviting me and other representatives of the Academy to share our thoughts with you. I will speak specifically to P/C insurance, while my colleagues will address other practice areas. My comments today will address: Certain actuarial guidance that is relevant to today's discussion; Data quality considerations; Disparate impact analysis; and Use of socioeconomic factors in auto insurance.

First and foremost I'd like to highlight that there is helpful actuarial guidance related to the issues at hand. Mr. Mosley referenced them in his remarks – there are a series of documents called the actuarial standards of practice and they provide guidance on techniques, applications, procedures and methods that reflect appropriate actuarial practices in the U.S. I think it will provide helpful background info to you as you make

certain determinations in the future. One standard I'd like to put particular focus on is the standard on risk classification. This standard provides some perspective on the question of unfair discrimination in rate setting and as the Committee continues to look into these topics I want to note that in order to properly discuss unfair discrimination its important to have a clear definitions of fairness. Fairness is defined in many different ways and what may seem fair to some will seem unfair to others. For U.S. actuaries when we focus only on the question of fair insurance rates we are guided by our actuarial standards and using the risk classification standards in guidance we see that rates within a risk classification system would only be considered equitable or fair if differences in rates reflect material differences in expected cots for those risk characteristics. Mr. Mosley discussed this as well.

What we mean by expected costs is for example in auto insurance that would be the expected cost would be driven by the expected number of auto claims and the average cost if a claim occurs. In order for a particular risk characteristic or classification to be considered fair it would be if that risk characteristic reflected a material difference in expected costs – either the frequency of claims or the average cost if a claim occurred. This is demonstrated if it can be shown that the experience correlates to a particular risk characteristic. There can be significant relationships between risk characteristics and expected outcomes where a cause and effect relationship cannot be demonstrated and that is all included in the risk classification standards and provides a healthy backdrop when you consider the question of fairness in insurance rating.

Others actuarial standards provide helpful guidance on these related topics would include our standard on data quality and I'll speak about that shortly. There are a few others listed in my comment letter. I would like to move to address some of the specific topics being looked at. One area that we think should be addressed is the use of data in these risk classification systems and when I use that term I mean the systems that are used in order to get to the premium. Data available in pricing P&C insurance coverage has been increasing and with that the industry has moved from relatively road rating classifications to increasingly segmented classification structures. Others on the panel have discussed that as well. The actuarial standard on data quality says that an actuary should review data for reasonableness and consistency unless in the actuaries professional judgment such review is not practical or not necessary and oftentimes there are practical limitations to what the individual actuary can do review in the growing volume of available data.

In 2017 and again in 2019 the auto insurance committee of the AAA worked with the NAIC to conduct forums on predictive modeling and in insurance the question of data quality was discussed. One of the ideas that rose from those discussions was a concept of one or more independent third party organizations that could verify and certify the various external databases that might be used by insurers in their predictive models or other data analysis. Of particular interest to this committee are concerns whether some of the external data sets that are being used in risk classification structures might contain hidden biases or serve as proxies for prohibited characteristics. Hidden racial biases or other biases like proxies for prohibited characteristics would be one of the things that a third party organization could look into. Some other related issues that could be addressed with this mechanism would be to address issues of accuracy and relevance of the data – how old is the data being used? When an insurer pulls data from multiple sources related to the same insured name John Smith how certain are we that we are getting the right John Smith. These are all questions on data integrity that may be

addressed by a new way of looking at regulating the way external data resources are used by insurers and we are happy to discuss that further with NCOIL.

Turning to the topic of disparate impact analysis, investigation into whether risk characteristics have a disparate impact on certain protected classes could provide insights into key questions regarding unfair discrimination. For example, it has historically been established that there is a material difference in expected cost for drivers that have no motor vehicle violations versus those that do. If law enforcement practices differ based on race however, risk characteristics that use motor vehicle violation history may have difference expected cost differential for black Americans than for white Americans. We think that looking into this issue of whether there is disparate impact and investigating that might be proper.

I also wanted to mentioned the use of socioeconomic factors in auto insurance ratemaking. As discussed earlier more data has been used and with the advancement of technology risk characteristics that may be more direct indicators of outcomes are increasingly being utilized and we heard a lot about that today. Rating variables that are linked to facts about driving behavior like those derived from telematics like vehicle safety features and UBI may reduce the predictive power of other variables that could be seen as indicating only proximal effect such as insurance scores. While historically those insurance scores have been seen to be very predictive that predictive power may diminish as we use more and more of these other variables. Thank you and that provides an overview of my comments and we look forward to discussing further with you.

Mary J. Bahna-Nolan, MAAA, FSA, CERA, at the AAA, thanked NCOIL and the Committee for providing her the opportunity to present to today. I am Mary Bahna-Nolan, a life actuary and volunteer for the Academy. I would like to reiterate the points of my fellow Academy members, Dorothy and Lauren, that we share the goal of identifying and exploring issues pertaining to race, diversity, and inclusion and ways to address practices that could create barriers to obtaining insurance coverage, or conversely provide incentives for inclusion to, insurance products. My comments will focus more specifically on considerations pertaining to life insurance and life insurance risk selection.

While the issues that the Committee is looking at are transcendent on all lines of insurance, an important issue that distinguishes life insurance from other types of insurance is that the purchase of life insurance is a voluntary transaction between a consumer and an insurance company. Further, the purchase is an independent, or stand-alone decision not mandated as a result of another purchase (e.g. obtaining a mortgage). This emphasizes the importance of the risk selection or the underwriting process to ensure the insurability of the applicant, the suitability of the insurance from both the financial need for the insurance, and the ability to pay for the insurance. As such, the determination of the insurability is often a factor of both medical and nonmedical data.

The risk selection or underwriting process is often only done prior to a policy or contract issuance with rates that are, at some level, guaranteed for the life of the policy or contract and for contracts that are non-cancellable by the insurer, other than for non-payment of premium lack of policy performance. The underwriting process for life insurers has a long history of change as new learnings and research, tools, products,

data, and computing power have evolved. What hasn't changed is that the risk classification process is foundational to the underlying principles of insurance. The purpose of underwriting is to align the risk characteristics with an expected outcome and to group similar risk pools.

The process of risk classification involves gathering data to understand the applicant's unique risk profile, including personal, financial, and health-related data provided by the applicant. In many cases, verification of such data is obtained through additional data sources and/or review of the applicant's medical records. The collection of this data helps to align an applicant's risk profile with the aggregated risk profile used by the insurer in establishing product price for a particular risk class. This risk alignment is often demonstrated by statistical or other mathematical analysis of available data. This data may include direct experience of a carrier or reinsurer, medical or clinical research data, and expert opinion. In the risk selection process, it is common that different paths and/or data elements are gathered for individuals based on what is disclosed on the application or learned throughout the process, the age of the applicants, or the amount of insurance requested.

Throughout the history of underwriting, new data sources and ways to use data have arisen. New data or data sources should be evaluated to assess their impact on risk classification. When new data is evaluated, it is evaluated for its protective value as an additional piece of data or replacement for existing data element(s) in the risk classification process. Mortality studies and/or retrospective studies are often used to assess the value of data that are or can be used for underwriting. Any changes to risk classification systems are evaluated and built into a product's design and pricing. Regulations are in place that govern data that may be used in the underwriting processes such as HIPAA, FCRA, and the Unfair Trade Practices Act.

In life insurance, actuaries and underwriters have different but interdependent roles related to risk classification. Actuaries: Determine insurance pricing and risk pool characteristics; Develop mortality assumptions for each risk pool; Analyze changes to risk classification because of the impact to critical actuarial activities; and Determine policy reserves through modeling and risk management. Underwriters: Follow established risk classification principles that differentiate fairly on the basis of sound actuarial principles and/or reasonable anticipated mortality experience; Are accountable for developing the underwriting process and classifying applicants into risk pools; and Assign risks to groups based on the benefit costs of the risk pool.

Actuaries and underwriters work together to align risk classification with mortality expectations for each risk pool. Changes in the risk selection process are often analyzed to understand the impact a change may have on risk selection and the potential for adverse selection. New data sources are analyzed as to their relevance, credibility, and quality. Analysis around new data inputs includes whether the data is fit for purpose, does not unfairly discriminate or include unintended bias, and appropriately classifies risks. In addition, compliance with existing laws such as HIPAA, FCRA and Unfair Trade Practices is an important consideration in how data is used and provides consumers the ability to know and agree to which data is used in the risk classification process and the ability to dispute inaccuracies in the data.

Recently, there has been an increased effort in the life insurance industry to lessen the more invasive and time-consuming elements of the risk selection processes such as the

collection of bodily fluids (e.g., home office specimens [HOS] and blood) and physical measurements, often collected from a third-party paramedical professional that comes to an applicant's home or place of work. These changes are often described as "accelerated underwriting," and are not limited to the removal of fluids and other measurements. Accelerated underwriting is another part of the ongoing evolution of underwriting. There is often a trade-off between the predictability of mortality experience and evaluation time. Different risk classification methods and tools may impact the overall level of mortality but also the expected pattern of mortality, including the time it takes for the benefits of underwriting to wear off. The use of alternative data, predictive models, and algorithms may be used to reduce the added expected mortality cost from removal of more traditional underwriting data (i.e., fluids). Time is required to understand and realize the true impact of the emerging risk classification methods on the consumer experience.

The use of predictive models and algorithms, along with additional data sources, may be used to forecast probabilistic outcomes around relative mortality or risk. Models incorporate statistics to identify interdependencies among data elements and correlation to the risk characteristics being studied. Algorithmic underwriting is not new to life insurance. Underwriting guidelines have long been based on various algorithms. The use of predictive models and improved computing power has helped to remove some of the human application or judgements in the algorithms historically used. Of particular interest noted by this Special Committee are concerns as to whether the use of alternative, nonmedical data sources and the use of predictive models and algorithms inject hidden biases or serve as proxies for prohibition of risk selection based on protected class information, most specifically race. The use of algorithms or an alternative data source does not remove actuaries or underwriters from adherence to the principles of risk classification; risk classification must be based on sound actuarial principles related to actual or reasonably anticipated experience to assign risks to groups based upon the expected cost or benefit of the coverage or services provided.

There is a strong correlation between socioeconomic factors and mortality/morbidity experience. The racial aspect of socioeconomic differences is systemic beyond insurance application. Life insurers do not collect information or directly use protected class information of race, religion, education, or ethnicity in their risk classification or rate-setting processes. Therefore, additional analysis and judgment is necessary to ensure proxies are not unintentionally discriminatory against one of these protected classes while not removing the ability to correctly identify mortality and morbidity differentials important to the risk classification and risk pools established.

Actuaries are bound by a code of conduct. The purpose of this Code of Professional Conduct is to require actuaries to adhere to the high standards of conduct, practice, and qualifications of the actuarial profession, thereby supporting the actuarial profession in fulfilling its responsibility to the public. Actuarial standards of practice (ASOPs) are developed by the Actuarial Standards Board and are binding on members of the U.S.-based actuarial organizations when rendering actuarial services in the U.S. The Actuarial Standards Board regularly adds and updates ASOPs. Failure to meet applicable standards of practice is a violation of the Code of Professional Conduct that may result in an actuary being brought before the Actuarial Board for Counseling and Discipline ("ABCD"). An adverse ABCD finding can result in discipline ranging from reprimand to expulsion from U.S. based actuarial organizations.

Lauren discussed three of the relevant ASOPs that also apply actuarial standards related to risk classification for life insurance: ASOP No. 12 on Risk Selection, ASOP No. 23 on Data Quality, and ASOP No. 56, which became effective October of this year, on Modeling. In addition, the following are some of the more relevant ASOPs which also apply pertaining to the risk selection process for life insurance and the analysis of data and models in this process: ASOP No. 25, Credibility Procedures; ASOP No. 54, Pricing of Life Insurance and Annuity Products; Setting Assumptions (currently being drafted).

The purpose of ASOP No. 25 is to provide guidance to actuaries with respect to selecting or developing credibility procedures and the application of those procedures to sets of data. This applies to the risk classification process when the actuary is evaluating subject experience for potential use in setting assumptions without reference to other data and in the identification of relevant experience and the selection and implementation of a method for blending the relevant experience with the subject experience, including the relevance and applicability of alternative data sources and model inputs. Such relevant experience should have characteristics similar to the subject experience, where the characteristics the actuary should consider include items such as demographics, coverages, frequency, severity, or other determinable risk characteristics that the actuary expects to be similar to the subject experience. In addition, the ASOP requires consideration for the homogeneity of the data and the actuary should consider the homogeneity of both the subject experience and the relevant experience and consideration that within each set of experience, there may be segments that are not representative of the experience set as a whole.

ASOP No. 54 provides guidance to actuaries when performing actuarial services with respect to the pricing of life insurance and annuity products, including riders attached to such products. This standard is applicable when a product is initially developed or when charges or benefits are changed for future sales. The other ASOP around the setting of assumptions helps to provide guidance when they perform those services around assumption setting which would include the mortality levels the risk categories and risk classification or risk cohorts or pools. As Lauren noted, the full list of ASOPs is extensive, and it is certainly possible that guidance from others not noted above may prove useful to the Special Committee's ongoing discussions. Again, I appreciate having this opportunity to share with NCOIL thoughts on the important issue of race in the risk selection and classification process for life insurance and look forward to working with this Special Committee as you seek to address important questions that have been raised.
Rep. Lehman stated that his question goes to Mr. Cotto and Mr. Poe. When we start talking about all of this data that goes into all of these factors, as the risk expands should that criteria change? For example, I believe with Cure the maximum coverage I can get is $25,000 per person and up to $500,000 per occurrence. Mr. Poe replied no and stated that Cure is statutorily mandated as an admitted carrier and like any other carrier is required to offer up to $250,000 worth of coverage per person on bodily injury – we have all the standard coverages.

Rep. Lehman asked what percentage of Cure's policies are those types of limits. Mr. Poe stated that he would say 75% of Cure's book is state minimum liability coverage because Cure is basically the only insurer that doesn't use credit scores and is the place of last resort of people of lower income. Rep. Lehman stated that his concern deals with more sophisticated buyers and different criteria for higher risks. If a carrier is going to put out for me such as a $500,000 underlying with a $2 million umbrella - if they are

going to put $2.5 million on the line every time my 16 year old gets in the car should there be some criteria to that that's different then someone that's putting out the state minimum limits? The other question deals with data being collected – how much of the data is accessible by me? Clients have asked me in the past if they can take the scoring data that has been collected by the carrier and have access to it when they shop for insurance.

Mr. Poe stated that regarding exposures, that is built into the rates. For every coverage that we offer for every carrier in the country we have a base rate associated for what that coverage is and as you buy more coverage we have a factor that multiples times that base rate. So if you have bodily injury coverage with any company for car insurance you have what's called a filed base rate and lets say its $100. That $100 has to associate with the lowest amount of coverage that you are offering so if its bodily injury coverage and the minimum for the state is $15,000 we actuarially come up with a base rate for $100 for that amount. If you buy $250,000 worth of coverage for bodily injury there will be a multiplier which is what we call a relativity that's multiplied by that $100 so someone with a $250,000 bodily injury limit is going to have a 2.3 and 2.3 times $100 is $230 and that is how we develop the rate.

The problem is that if there is a carrier that only wants to give lower rates to higher income drives you are stuck with that model of always having a base rate of $100 so the only way to eliminate that and give preferred rates to those with higher income is to create multiple affiliates with the same trademark name. That's why in NJ there are two Allstate's, two State Farm's, and three Geico's because that way you can have different base rates based on a criteria like an income proxy that will first be applied to you as a driver. So first you answer the question do you have a four year college degree and a high paying job. If the answer is no then you are only eligible for the higher base rate company so its similar to what we saw in the 1960s with redlining and housing. Regarding what Mr. Cotto testified to just because objective factors are involved in your insurance scores then they are not necessarily having a racial impact to me flies in light of the whole reason why we are having this meeting. Obviously there are proxies to a factor so you might not use race as a question for car insurance but if you have a corollary proxy for race then you can have an effect that would be obviously impacting race which is the whole point of this meeting.

Mr. Cotto stated that he appreciated Mr. Poe's explanation on base rates because that is important to consider. As to the question of whether higher risks have more or higher criteria I think that comes into the policy realm that legislators have to decide. If someone wants additional coverage I think it logically makes sense that you would ask more questions. I think that's the general sound direction to go. In terms of the data question and how much consumer access there is, on the credit side that is governed by federal law and consumers can obtain their credit report and in fact its encouraged that consumers check their credit report regularly to see if there are any mistakes. That's a good thing. If you are getting at whether consumers can see how the rate is calculated and how much each factor weighs the answer to that is no.

Mr. Poe stated that one of the things we've talked about is insurance scores and why it does or doesn't correlate to income. I've sat for hours with statisticians who create the insurance scores – they have to be 90% correlated to credit scores otherwise they wouldn't buy credit scores from the agencies that create them. The differences are very minute. More importantly, what most people don't realize is that when we talk about

credit scores being objective and everyone having an equal opportunity – the highest element if a FICO credit score, 35% of it, has to do whether you pay your bills on time – payment history. Number two is credit utilization, 30%, how much available credit you have and how much you use of that available credit. Your available credit is 100% tied to what you state as your annual income.

The reason why income is so correlated to credit scores is that if you take a poor person and a rich person and they all pay their bills on time then that 35% weight factor has become irrelevant so the second most important factor in your credit score is going to be how much of your available credit is being used right now. And when you are poor and make $30,000 per year they don't give you a $30,000 credit line they give you a $1,000 credit line and if you use $900 of it you are using 90% of your credit limit so your credit score will drop at least 90 points simply because you used $900 of that $1,000 credit line. A lot of people debate whether credit scores correlate to income. That is why they do – because your salary is the basis of credit available.

Rep. Lehman stated that he had to leave the meeting in order to deal with an issue back in Indiana. Rep. Lehman thanked everyone for participating in this process. A lot of information was presented and it was done respectfully. The video and audio recordings will be available on the NCOIL YouTube channel for review. The Committee will discuss next steps once everything is analyzed.

Rep. Edmond Jordan (LA) thanked everyone for presenting today and stated that his question is for Mr. Poe. Regarding lack of notification if an applicant is rejected for insurance, are there any states that in fact require that notification. Secondly, is there any development of some legislation around having access to your insurance score. Mr. Poe there is simply no legislation in any state he is aware of that requires a carrier if it rejects you on the basis of your education or occupation that you get notified of it. The FCRA requires notification of people in writing when you have an adverse decision based on credit. One of the things that happens in NJ with Geico is that you are not allowed to reject a driver based on just their education or occupation alone but Geico complies with that by having three companies in NJ and saying that we are a group of companies so we comply by not as a group rejecting a driver based on education or occupation alone. But they are rejected by each of the preferred companies based on those criteria so they are able to say you are eligible for the third company that we write that complies as a group with the prohibition laws.

Asm. Ken Cooley (CA), NCOIL Vice President, stated that he has a question generally for anyone that wants to answer it. I am going to make an analogy to climate change. Climate change has risen in importance and we have seen companies look at what is the pathway that they can do given their enterprise to do more on climate change and then to promote that fact and tout it and make it part of their narrative. The question would be in this present environment just as we've heard with Buckle and Root what do you think the role of marketplace forces is of companies really trying to do something different to give them an edge. That's not to take away from the analysis today but its more to get at there are plenty of companies out there that actually saw a niche opportunity to do something different than the rest of the marketplace and went after that and excelled big time. We have a competitive marketplace but what are your thoughts that given the current environment like the climate change environment that companies might try to differentiate.

Mr. Poe stated that the reality is that here is no competition for lower income drivers in our marketplace and that is because they produce the highest losses and the highest expenses. The industry can make enough money, billions of dollars, form high income drivers so why would they be in this quadrant. If you talk about Root its early in infancy and has grown exponentially very quickly and we have to wait for loss results to come in. If you look at other companies like SafeAuto they only write in states in which they are permitted to only write the state minimum liability insurance so they cap their total exposure to a certain extent.

In the marketplace we are in there is simply no competition. Mr. Poe stated that 45% of those that leave Cure go uninsured and we are the place of last resort. It simply costs more money to deal with people calling you every day saying I cant make the payment so can I make this. And people that get into car accidents if you are lower income you are going to file every small claim that you can because anything over $500 is something that you cant afford. Wealthier people have $1,000 in their bank account so if they get in a fender bender in a supermarket they can pay $1,000 out of pocket to not file a claim with their insurance company. Its simply not a competitive market in the lower quadrant of say the lower 25% of income earners in the country.

Mr. Birnbaum stated that he would like to tie into the climate change analogy. If you look at what regulators are doing with climate change they are really focusing a lot on company disclosures and asking companies to make climate risk disclosures and those disclosures are public the idea being that by forcing companies to think and act on those issues and then make them public investors and members of the public can evaluate how companies are dealing with the issues. I think that's a really good analogy for how to deal with some of the issues of systemic racism in insurance. Asm. Cooley stated that from a CA perspective there are a lot of companies that are trying to brand themselves in that area and not at the end of a gov't order. Admittedly, someone is not going to be there if they don't think they can make money but if they find a way to do something which takes innovation maybe it does open a path.

Sen. Breslin stated that's a win-win-win if they participate and there should be for the insurer some reward other than profit. At the end of the day there should be some other gov't reward if they are required to turn over their data.

Mr. Young stated that in Buckle's view data is a public good. Our data is really owned by our members. We use our data to go and advocate for our members and get them the best price of insurance in the reinsurance markets. The Buckle insurance model is really built upon the thesis that what drivers need, the bottom third of the socioeconomic specter, is an advocate that can take their data, run market force processes into the capital markets themselves and then basically be that honest broker between the real risk taker which is not the insurance industry. The real risk taker needs to be the reinsurance industry. I've restructured over $30 billion of debt across automotive, financial services, telecommunications, and other industries and my observation of the insurance industry is that we are at the beginning of the restructuring cycle of the insurance industry.

You see the major insurers like State Farm and Geico are not that different from the major banks pre 2008 which were struggling to make underwriting profit and investment returns in order to support large books of business that my not be sustainable in the current model. The key to this is to figure out how do we get the insurance industry out

of insurance the same way that the banks realized they had to get out of writing loans and figure how to create the systems and move the risk out to the markets and change the financial interests and incentives across the entire value chain. Buckle has learned that is the only way to solve the problem for the gig economy and get around the issue of credit score and other factors. To the question of if there is a global warming phenomenon happening in insurance, I would say yes. What you are going to see in the next few years are huge write downs on surplus capital as a result of bad bets on commercial real estate, fixed income instruments, and underwriting. I think if you were to talk to any of the senior executives across the major insurers that they would not publicly acknowledge it but they would probably agree that is the case.

Asm. Cooley asked if any other panelists had any thoughts. Ms. Bahna-Nolan stated that from a life perspective the industry is working very hard to try and find ways to gain access and get to the under and uninsured marketplace. There is a huge gap and huge needs and purpose that life insurance serves. It has been a struggle to try and access that. There are carriers that are making good attempts. Removing some of those barriers and the cost of life insurance and getting that down to something that is reasonable and getting at the barriers to make it easier for individuals to apply and qualify for the insurance is very much front and center. I cant speak for every carrier but can for many in terms of those focus areas.

Asm. Cooley then stated that these are very difficult conversations and he is a lawmaker and believes in the power of gov't to protect people and prod them. At the same time we are talking about how do we change us from where we are to something different. There is no better statement about the process of innovation that I would relate to this conversation than what Thomas Edison said: "There can be no progress until a sufficient umber of people become dissatisfied with the way things are and this can only happen when they are brought to think beyond the limits to which they are accustomed." I see this conversation showing how do you get in the head of the founder of Statefarm that he could approach he insurance marketplace with a template that defied how people thought it had to work and soon had the biggest insurance company in the nation although it had to fight lawyers all the way. I think there is room for prescriptive activity but I also think you need to be thinking beyond the ways of which are accustomed. I think the conversation today and the statements made by Rep. Jordan expressed carefully we have to think beyond those limits and that is very important.

Mr. Mosley stated that as we have discussions like this, variables like credit based insurance scores, education and occupation oftentimes get a lot of the discussion but one of the things that has continued to occur in the insurance industry is the idea of innovation or companies continually trying to improve upon their approach to risk based pricing. Companies didn't find credit based insurance scores put them in and then stop. There has been a continuing push for companies to continue to try and find ways to differentiate themselves and better approach matching premiums to cost and the result of that has been a lot of additional elements and improvement that may not be on the scale of credit based insurance scores but there have been a lot of additional things that have come into play which get at trying to continuing to improve matching price to risk. There may be continuing trouble spots but we need to think about how to better address the issue and not just settle on the status quo. So even beyond those variables that get a lot of attention there is a lot of work in companies going on because if they are successful in doing that it helps them achieve their goals.

Ms. Andrews stated that when we talk about collecting data like race we also have to consider what kinds of abuses can occur as a result of that type of data collection – how is it going to be handled and who is going to be handling it to make sure it's not abused. When it comes to models, building a model is not a perfect science. Two companies can build a model using the exact same variables but if the underlying data is different you can get very different results so its very important when talking about results of models that we understand what the shortcomings of the underlying data is and we're not just making generalizations about one company's models and then applying it across the spectrum.

Mr. Cotto stated that we are all for innovation but the way you do that is not to prohibit things that are accurate predictors. When you prohibit things you risk undermining solvency and you start to raise rates for everybody. Carriers keep getting better and better because they are competitive and want policyholders. Sen. Breslin stated that carriers want more information and it has become more incumbent to make sure the information is protected and used properly. Mr. Cotto agreed.

Sen. Breslin thanked everyone for all of the information today which will give the Committee a great deal to work with to come up with a finished product. Thank you to all of the legislators that participated as well and I look forward to working with everything going forward.

ADJOURNMENT

Upon a Motion made by Rep. Keiser and seconded by Asm. Cooley, the Committee adjourned at 5:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
TAMPA, FLORIDA
DECEMBER 10, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Tampa Marriott Water Street Hotel on Thursday, December 10, 2020 at 11:30 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. George Keiser (ND)*
Asm. Kevin Cahill (NY)*

Other legislators present were:

Sen. Matt Lesser (CT)*
Rep. Martin Carbaugh (IN)
Sen. Andy Zay (IN)
Sen. Mike Gaskill (IN)
Sen. Paul Utke (MN)
Sen. Shawn Vedaa (ND)
Asw. Pam Hunter (NY)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Asm. Ken Cooley (CA), NCOIL Vice President, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 24, 2020 meeting.

UPDATE ON PANDEMIC BUSINESS INTERRUPTION COVERAGE PROPOSALS

Deirde Manna, Senior VP, Head of Government and Industry Affairs at Zurich North America (ZNA), stated that ZNA is one of the top five commercial property & casualty

writers in the U.S., has 9,000 employees in the U.S., and 3,000 employees at its headquarters in Schaumburg, Illinois which is right outside of Chicago. ZNA is one of the top writers in the construction area as well as one of the top writers in the auto space. Ms. Manna said today she would like to provide the Committee with an update on the proposals that are out there to deal with prospective pandemics. Ms. Manna stated that her colleague, Peter Caminiti, Property Technical Director at ZNA, will walk through ZNA's proposal.

With regard to the update on dealing with prospective pandemics from an insurance perspective, there are several proposals out there. At the beginning of the pandemic, Marsh came out with some ideas which led Congresswoman Carolyn Maloney to introduce the Pandemic Risk Insurance Act (PRIA). Chubb testified at a recent NCOIL meeting regarding its proposals, and the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC) have introduced what's called the Business Continuity Protection Program (BCPP). In the BCPP, outside of the distribution, insurers do not have a role to play. The policyholders community, led by Charles Landgraf, has also testified at a recent NCOIL meeting regarding their ideas. While all of those proposals are out there, the main focus is on the next Congress to see how it will deal with this issue. While the timing isn't clear, it is believed that as soon as January we will see some legislation introduced.

Regarding ZNA's concept, the word concept is important because ZNA does not view it as a competing proposal. Rather, ZNA wanted to bring ideas to the table and bring ideas to the discussion on how to deal with prospective pandemics. ZNA's CEO, Kathleen Savio, recognized early on that the federal crop program could be used as a model to look at future pandemics. ZNA is the second largest crop writer in the U.S. and it saw merit in that concept. ZNA put its underwriters and crop professionals and its risk claims employees together to create the concept so it was not put together by lobbyists. ZNA is completely aligned with the industry that pandemics are not insurable. But, ZNA believes insurers have a role to play and a role in society and a role as experts in risk management and a role in dealing with emerging and evolving risks. After developing the idea, it was put in a model which showed that the idea had significant merit and that is what will be discussed today.

Mr. Caminiti stated that ZNA began working on the concept to ensure stability and predictability to businesses. ZNA was focused on a very specific part of the problem which was initial shutdowns as a result of the pandemic. ZNA would like to make sure that it is has solutions available in the future that are ready to go. ZNA is aligned with the industry that a pandemic in and of itself is not insurable and that the federal government has to have a key role at the table to help the industry with a solution. While ZNA's concept differs from other proposals there is tremendous alignment among all proposals. ZNA was trying to accomplish with its concept the goal of bringing additional ideas to the discussion as ZNA did not develop a specific proposal but rather just a concept with ideas to help shape the conversation so that it works for all stakeholders.

Mr. Caminiti stated that while a pandemic is uninsurable, ZNA believes that it is manageable and there are ways to manage portions of the risk and insurers have a critical role to play in that process. It is very important that insurers are present and part of the solution so that risk mitigation techniques can be brought to the table. One thing that is very important when talking about these concepts is that coverage must be

affordable as sufficient take up rates must be achieved as we don't want to find ourselves in a position in the future that because of insufficient take-up rates we have ad-hoc disaster relief. That is part of the reason why ZNA's concepts have all insurers participating in the process to make sure that there is a widely accessible product and that the federal government is a key partner in this to help ensure affordability.

Mr. Caminiti stated that the problem ZNA is focused on solving is really the shutdown period and the concept used to manage that can also be used to help things like event cancellation and other lines of business. A lot of the concept is very similar to other proposals that are out there. The concept deals with a standalone federally regulated product which is similar to the federal crop program. ZNA is the second largest writer in the federal crop program so it is drawing on a lot of its experience with that program. ZNA wants to make sure there is a widely available product in that market so it would require all carriers to participate and offer the product. It would be a take-all-comers approach. Customers would not be required to purchase it but carriers would be required to offer it. The coverage itself would cover 80% of operating expenses for up to a three month duration. The problem that is trying to be solved is the initial period of shutdown and making sure that there is available and predictable coverage.

Regarding the claims process, part of the problem that businesses face is liquidity so a traditional indemnity adjustment process for claims wouldn't work. We know that on business interruption for property policies that process can take months and months to adjust claims. We need to ensure that funds get to businesses quickly so ZNA is using a parametric insurance model which is trigger based coverage. Rather than a claimant submitting the necessary documentation, etc. to begin a claims process and investigation and get accountants and lawyers involved, this would be based on a trigger process similar to other proposals where you have a federal trigger and a state level trigger which would immediately begin triggering coverage and getting funds flowing to customers. ZNA believes there is a big role for it to play from a risk mitigation standpoint and by getting all carriers involved new risk mitigation techniques can be developed and available for customers.

Mr. Caminiti stated that pricing would be set by the federal government and affordability is very important. That is where looking to the federal crop program is important as for that program to be successful there is an element of subsidy required by the federal government to make that program affordable. Pandemic has the potential to differ from crop in that crop is a frequency based event as every year premium is collected and claims are paid. Pandemic is more akin to earthquake where you have many periods of no activity from a loss perspective and then you have very significant and severe events. Where the federal government can really help from a pricing standpoint is take a long term view of pricing and set rates to make sure that while actuarially sound they can collect sufficient premium over a 50 or 100 year period to ensure that funds are available to cover those types of events. That is something that private insurers would not be able to do in terms of taking that long of a time horizon. The federal subsidy idea is based on a pricing philosophy more so than a taxpayer funded idea but of course the taxpayer would have to be there to backstop the program in the event that events happen with a higher degree of frequency.

Having carriers required to participate puts insurers in a difficult position because it is risk that they did not see as insurable but ZNA's concept would require coverage to be offered. The relief valve for the insurance industry in the concept, drawing from the

federal crop program, is the ability to then cede that risk back to the federal government at the carrier's decision. ZNA has proposed three separate reinsurance pools, similar to the federal crop program, where the carrier decides based on their risk appetite and financial strength and the lines of business they offer and the states they operate in and the types of customers they serve how much risk they want to retain and how much they want to cede back to the federal government. One of the pools has a 100% ceded option and that is recognizing that not all carriers are created equal and it may be a risk that they just cant participate in. Their participation is really through being part of the program, serving customers, making the product available to them and offering them risk mitigation but they cant be forced to take risk. If carriers do have appetite for risk, there is a 95% ceded risk option so the carrier would retain 5% of the risk and a 90% option with the carrier retaining 10% of the risk. Carriers would have the option to participate across all of the pools with no minimums or maximums on what they can put into any one of the pools.

So, an insurance company can say there are certain types of risk such as a restaurant where it is may be too high regardless of the size of the carrier so all of that business will be placed in the 100% pool. But, there may be other types of industries where there is some appetite to share risk with the federal government and that would be placed in either the 95% or 90% pool. That allows the ability to get all carriers to participate in the program and all carriers serving their customers but giving the carrier the option on how much risk they retain so there is certainty to the customer with how much coverage is available to them and certainty to the industry with how much risk is retained. The idea is that you will have policyholders coming to carriers and then carriers would be deciding which policies are ceded into certain reinsurance pools.

Mr. Caminiti stated that as part of its work on modeling, ZNA worked with the Bureau of Labor Statistics which provided granular information about businesses across the U.S. by industry and number of employees in order to get a sense of their expense structure. A simulation model was built that allowed ZNA to make assumptions around coverage available, the take up rates for available coverage, and the carrier behavior regarding how much risk they would retain. Based on the assumptions ran, a $1.1 trillion dollar monthly event was used which is pretty similar to what a lot of experts say COVID-19 equated to, for 3 months. Based on the simulation, because only 80% of expenses are covered and due to other assumption regarding take up rate, it was thought that it would be a $1.6 trillion insured event under the concept. From there, it was gathered the types of employers that would be receiving that – roughly two-thirds of the $1.6 trillion would flow towards businesses with less than 500 employees. Also, the federal government would retain 99% of the loss so the insurance industry would contribute $15 billion towards the $1.6 trillion. That is a number that is not necessarily significant for the problem but is certainly significant for the industry. Because of the flexibility for the carriers to make their own decisions based on assumptions made, it is thought that the vast majority of the $15 billion industry burden would be borne by the largest carriers who would be willing to take some of the risk.

The modeling also allows to simulate potential outbreaks based on certain states. One of the things that the ZNA concept does not have is a cap to the federal backstop and that is very important because depending on how a pandemic could spread in the future the modeling allows it to be seen how the federal caps could be eroded based on how the pandemic moves across states. So, the modeling can show that the top 5 states based on insurance purchased would account for 42% of the total loss or $661 billion of

insured losses (CA, TX, NY, FL, IL). So, if you are not one of those top five states you run the risk of potentially piercing that federal backstop cap which is why ZNA believes it is important that a federal program does not contain such a cap.

Sen. Hackett stated that he likes the idea of the three ceded pools. One of the problems seen is that the federal aid to different industries is different. An example is that the hotels could not qualify for PPE for the most part in Ohio because they could not take on additional debt pursuant to the federal program. Sen. Hackett asked therefore if a consistent reaction from the federal government is needed. Mr. Caminiti stated that the concept is designed such that there is coverage available to all businesses so it would be a company's individual choice whether or not to purchase it but that 80% coverage of operating expenses for up to three months is the coverage that is available. The pooling mechanism is more of an arrangement between the insurer and the federal government to manage that risk but as far as the customer is concerned, all customers in the concept are created equal. There is a difference based on company size because it would be prudent for their premium to be higher and the amount of coverage available to them to be capped so that they don't take a disproportionate share of the relief but coverage is available to everyone.

Sen. Hackett stated that in Ohio there is a big movement to try and get businesses to stay open and protect them at the same time. One of the things that was passed was liability protection to the businesses. Sen. Hackett asked if the federal government has stepped in there. Businesses want protection in case they operate and then employees come down with the virus. Mr. Caminiti stated that liability protection is an important part of the legislation that is currently being considered by Congress but is not something that ZNA has worked on with its concept. The concept focuses on helping to make sure that businesses have liquidity. Sen. Hackett stated that he understands that but thinks that could be part of the premium calculations in terms of making sure businesses are allowed to keep operating.

Rep. Matt Lehman (IN), NCOIL President, stated that he is in favor of bringing the carriers in to some form of participation similar to the Terrorism Risk Insurance Program (TRIP). However, when that is done the issue becomes what are the small carriers doing in terms of participation. There are some small mutual companies that may not be able to take on the same amount of risk as others. With regard to the pricing to the consumer, there are certain parts of the country that are more susceptible to terrorism than others and that is reflected in the price. Rep. Lehman asked Mr. Caminiti if when the simulators were run premium was simulated to figure out what it would be for a small restaurant in a small town. With regard to a pandemic, you can assume that it is going to be much greater in metropolitan areas but that may not be the case.

Mr. Caminiti stated that one of the key ways ZNA landed on its concept was so that they could think about the small mutuals referenced by Rep. Lehman versus national carriers. ZNA believes its concept works for those small mutuals because they are being asked to participate in the program but they are not being forced to retain risk. And market distortion is not being created by then saying if that carrier chooses not to participate, another carrier will which will potentially disrupt that other carrier's ability to retain their customers. It is important to make sure that any solution does not disrupt the market and that is part of the reason why it is important to give all carriers a means of participating but then give them the means of how much risk they want to retain so that mutual can continue to serve customers but decide they don't want any of the risk.

With regard to pricing, because pandemic does behave differently than other perils ZNA thought about pricing more so on customer size. That was looked at based on the frequency of event which relates to the point about the federal government being able to subsidize rates. When you look at a 50 year return period that would equate to a 2% charge to the limits provided. So, if you are a decent sized restaurant and have $1.2 million dollar annual operating expenses, three months would be $300,000 and 2% of $300,000 would be the premium charged for the coverage protection. So, thinking along that 50 year return period, it would be 2% for businesses with less than 500 employees and probably 3% for larger companies.

Rep. George Keiser (ND) stated that he looked at the triggers in ZNA's concept and stated that it started to look like cancer insurance in that the triggers cant be met. When administrations are telling businesses that they can operate at 25% capacity, especially without serving alcohol, there is no way they can make it. The pandemic is going to put them out of business and they are not going to qualify under the triggers. Meeting the triggers is very difficult and it doesn't address the reality of the impact of a pandemic on small businesses. Mr. Caminiti stated that is part of the reasons why ZNA thinks a public-private partnership is so important. A private solution without working in conjunction with the public sector wouldn't work for some of the reasons stated by Rep. Keiser. The triggers were one of the things discussed very often internally at ZNA and whatever they work out to be it is going to be so important that the product works hand in hand with the government response. One of the things that remains an issue is how to deal with partial closures. How do you deal with essential entities that have not been ordered closed but are being affected? There is certainly room to continue working on the triggers as they will be so important by the people who are actually signing the orders. It has to work hand in hand with the public response in order to make sure it meets the intended purpose which is to solve a liquidity problem during a period of shutdown or disruption in the beginning stages of a pandemic.

Rep. Keiser stated that he recognizes the important of a public-private partnership. But everyone can see that the federal government is really struggling with the next phase and the minute the private sector is put into the mix, the public sector is going to back off and say if you didn't buy the right insurance why should we be bailing you out for that financial closure. Accordingly, it is not as simple as just having a public-private partnership.

Ms. Manna stated that as get further into the pandemic, more things are learned and more data is obtained and all of that will go into the concept as this is not a final proposal.

New York Congresswoman Carolyn Maloney, Chair of the U.S. House Committee on Oversight and Reform and lead sponsor of PRIA, thanked the Committee for the opportunity to speak about PRIA – HR. 7011. The bill is very important and personal because of 9/11. After 9/11, the economy of New York completely shut down. Nothing could be built and insurance could not be obtained for even a hot dog stand. Lloyds of London offered insurance but it was incredibly expensive. Building could not be completed because insurance companies would not cover any property against terrorist attacks at a terrorist attack site such as New York.

Congress recognized that if companies couldn't get terrorism insurance then there would be no more construction and millions of jobs would be lost. Accordingly, Congress came together in a bi-partisan way to solve the problem and pass the Terrorism Risk Insurance Act (TRIA) which successfully unlocked the terrorism insurance market, got the economy moving again, and put men and women back to work. While NCOIL is committed to preserving state authority over the regulation of insurance, just like it recognized federal action was needed to address terrorism risk insurance with TRIA, it's safe to say that we all recognize federal action is needed again to address the pandemic risk insurance challenge and that is what is trying to be accomplished with PRIA.

Since the pandemic was declared, tens of thousands of small businesses have closed their doors permanently across the country. Entire industries like travel, tourism, film, conventions, and hospitality have been upended. Small business owners who purchase business interruption policies expected pandemic related losses to be covered only to find their claims unexpectedly denied by their insurers. To make matters worse, insurers have recently re-written policies to guarantee that future pandemic related losses will never be covered. So, for the remainder of this pandemic and future ones, small businesses and entire industries have no way to protect themselves from pandemic related losses. We simply cant continue to expose our economy and small businesses to this level of risk and expect them to recover. We cant expect our economy to be resilient in the face of pandemics if we are left gambling that Congress can cobble together an emergency bailout. Just look at Congress now – it still hasn't passed another PPE bill for small businesses and other things that people need. We know the federal government will step in during the next crisis so why not be proactive and develop a long term solution.

PRIA is that long term solution. It would create a forward looking public-private risk sharing federal program supported by a robust federal backstop that would require participating insurers to offer BI insurance policies including event cancellation that cover pandemics. To be clear, PRIA is not retroactive; it is a forward looking solution and it would create a totally voluntary program. Insurers can opt in to the program and policyholders aren't required to purchase pandemic risk insurance, but if businesses want to buy pandemic insurance then under PRIA they could.

The program would be triggered once three conditions are met. First, the pandemic has to be declared and certified by HHS. Then the total insured losses for the pandemic have to exceed $250 million which is a very small amount. Finally, each participating insurer has to pay a deductible equal to 5% of the premiums they earned in the previous year. Once those three conditions are met, the federal government would start sharing losses with the private sector. Specifically, the private sector would bear 5% of the losses and the federal government would bear the remaining 95%. The program is currently capped at $750 billion and the Treasury Secretary will determine the risk sharing split beyond the cap.

Importantly for states, the bill also says that for participating insurers any exclusions that are in effect on the day of enactment that specifically exclude losses covered under PRIA are void and any state approval of those exclusions is preempted unless the exclusion can meet certain criteria such as written approval from the policyholder. States were consulted on that provision which strikes the right balance. Since PRIA has been introduced, a PRIA coalition has been formed consisting of more than 2,000 endorsing organizations. A PRIA working group, which NCOIL is a part of, has also

been formed. Also, just before Thanksgiving, the House Financial Services Committee held a hearing on PRIA. In light of the progress made in the past few months, Congresswoman Maloney stated that she feels confident that there is a very real window of opportunity between now and the end of the first 100 days of the Biden Administration to get the bill passed.

Sen. Hackett asked what has been the biggest hurdle in getting support for PRIA and moving it forward? Congresswoman Maloney stated that she has never written a bill that has as much as support as PRIA. Even before it was written, calls were being received from people wanting to sponsor it. So, there is a massive amount of support for it particularly from real estate and small businesses. Every piece of legislation is extremely difficult. Congresswoman Maloney stated that she is working on a bill that has been worked on for 15 years to just get a women's museum on the mall. This bill is particularly hard because it is so massive. Unlike TRIA which involved only the places in the country that were terrorist targets, this is for every single neighborhood in the country because when the pandemic hit it hits every state and neighborhood.

It is concerning that given the way the world is today we will be hit with another pandemic so why not get ready for it. A lot of things were done to help small businesses but it was hard to really negotiate them piecemeal and right now there is a short term target of getting a relief package for small businesses in the next COVID bill but a lot is needed for a long range plan. It was very difficult in the beginning because there was competition from 100 other legislative proposals for COVID relief many of which dealt with the same issue as PRIA. It took some time for the pandemic insurance cases to work their way through the courts but the recent House Financial Services Committee hearing on the bill was a critical step towards obtaining support within the Body. The hearing demonstrated that there is an overwhelming need for a public-private partnership like this and there were expert witnesses that testified saying that it is absolutely doable. Many were saying it was not but major industry stakeholders testified that it was doable and that they wanted to work in making it happen. Having a hearing was a critical step in the legislative process as it sets it up for a markup later down the line.

When PRIA was first introduced, some argued that pandemic risk was fundamentally uninsurable under any circumstances and that a program with a public-private risk sharing mechanism wasn't workable. Since then, there is a broad consensus that has been formed from many stakeholders, including some insurers, saying pandemic is insurable with a public private partnership program supported by an appropriate federal backstop. That consensus was on display at the hearing. Insurers like Chubb and Zurich have released pandemic risk insurance proposals of their own as have other policyholder groups. Even insurers who didn't originally support federal legislation on this issue have come around and come out with their own proposal recognizing that pandemic risk insurance is a viable product. Making the bill bi-partisan is an important step as it cannot be signed into law without that. Due to technical difficulties with Zoom, Congresswoman Maloney's remarks ended here.

Rep. Lehman stated that he would like to go back to the 2% math in ZNA's concept. If a restaurant that has $600,000 per year in revenue, the premium looks like flood insurance and is almost unaffordable for that one peril. Rep. Lehman asked how many people are going to buy a product that costs $1,500 per month and covers only one peril. If you can't make it affordable, it will become like flood insurance where nobody buys it and the

system goes broke. Sen. Hackett stated that ties into the statements made earlier by Rep. Keiser regarding the triggers. Rep. Lehman stated that he would like to discuss this issue further and more data would be nice.

Mr. Caminiti stated that the issues raised by Rep. Lehman are indeed a challenge and that is why requiring federal participation is so important because even when taking something like a 50 year return period view, it still creates a premium that can be challenging for businesses. That is why ZNA is framing this is a concept and more work is needed particularly on the importance of a federal government subsidy. Sen. Hackett stated that it is so hard to get Congress to agree on anything because of politics.

DISCUSSION ON CANADA'S LIFE AND HEALTH INSURANCE MARKETPLACE RESPONSE TO COVID-19

Stephen Frank, President & CEO of the Canadian Life and Health Insurance Association (CLHIA), began with a snapshot of the Canadian life and health insurance marketplace. Broadly, carriers in Canada do not do both property & casualty and life & health business. There are a few that do both but by and large companies either specialize in life & health or P&C. In the Canadian context that would essentially mean the three lines of business of life coverage, health insurance and retirement. There are about 64 individual companies that operate in this space and when you add up all of the subsidiaries and affiliates you get roughly 160 that compete on the market. To provide some context in terms of the number of lives covered, the population in Canada is about 36 million so 70-75% of the industry is touched by the industry in one way or another.

With life insurance, it is by and large sold on the individual market in Canada. There is some bundled life coverage with a typical employer benefit plan but the majority of it is sold through an individual channel. Companies in Canada over the past 30 or 40 years have by and large outsourced their distribution which is done primarily through independent advisor and broker channels. One of the big impacts of COVID has been the relationship with independent advisors in order to support them and continue distribution. An average plan in Canada is about $420,000 of coverage.

On the health side, it is the exact opposite scenario. The vast majority is sold through employer programs – health benefits offered through employee benefit packages which is very similar to the U.S. Generally, people are a little surprised in the role CLHIA plays in Canada. There is a view that there is Medicare in Canada which is government-covered and that is true for hospital costs, physician costs and a portion of prescription drugs but beyond that it is really up to individuals to self-insure through an employer or other types of coverage. About 30% of total spend in Canada is actually paid privately and the vast majority of that is through a group plan. Things covered are prescription medications, dental coverage, paramedical, and travel insurance which is important because that is a big challenge in the industry in a global lockdown scenario.

The majority of retirement solutions are offered through an employer relationship that has group savings programs or a defined contribution benefit plan. Retirement savings products are also distributed such as annuities but through an independent broker. About 75% of the group pension plans in Canada are administered by the private sector. The bulk would be done through union arrangements or civil service arrangements. Each of them had a pretty significant impact through the crisis.

Mr. Frank then began discussing some of the challenges the industry faced in the beginning stages of the transition during COVID. The first was getting its workforce to transition to working from home and continue providing Canadian's service. This was a surprisingly smooth transition. A lot of work was needed with provincial and federal governments in Canada to designate certain industries as essential. The insurance industry was deemed essential which allowed it a skeleton staff to go to work and maintain IT systems and claims systems. Roughly 90-95% of insurance industry workers in Canada are working from home at the moment.

Within the first week, there were hundreds of thousands of Canadians traveling. Mr. Frank was among them. Getting everyone home was an enormous undertaking and for the industry, everybody was trying to active their travel claims so working through eligible amounts and getting people home safely was a real challenge on call centers for the first few weeks. Ironically, the reverse issue happened fairly quickly which was those that were abroad felt they would be better off staying where they were. A significant effort was needed to explain to people that their coverage had risks associated with it in a pandemic scenario and it was important to come home. There was a month period where a lot of collaborative messaging was done stressing the importance to come home.

On the healthcare side, many of the benefits are the same in the U.S. If you want to qualify for a disability benefit you are going to need a physician visit and some kind of attestation from a physician. All the processes that were in place in terms of doctor's notes and prior authorizations were ground to a halt so steps were needed to allow those benefits to continue. As an industry, collective decisions were made regarding waiving wait periods and forgoing doctor's notes. An effort was made to not make it a competitive issue but rather just doing the right thing for customers so there was a lot of forbearance introduced and over time there are decisions that need to be made regarding what should stay and what should go.

There is also a lot of commercial traffic that flows between Canada and the U.S. in terms of truck drivers bringing food or medication across borders and they needed to have health coverage in place in order for them to agree to do that. Generally, coverage would not be offered like that in a pandemic scenario as they would be encouraged to stay home but the industry needed to step up and provide some unique solutions to allow that cross-border traffic to continue. All of these issues were raised in the first two to three weeks of COVID so that was a very frantic period.

Then things settled into a new normal and things froze in place and the industry really wanted to work with government on employee support initiatives to keep employers solvent and keep the employer-employee link to the highest extent possible to make sure benefit plans were maintained. Accordingly, the system was froze and that was a supply shock, not a demand shock. It was thought that once the pandemic passed that would be the best way to accelerate recovery and the industry didn't want people to lose access to their benefits. At that time, it was not anticipated that this would last well over a year but that is what it is looking like. A lot of very collaborative work was done with the federal government to introduce historic wage support. At the same time, companies were rolling out direct support in hundreds of millions of dollars to employees in the form of credit refunds, premium refunds, premium deferrals and a lot of that was in recognition of the fact that many of the types of services that employees would generally avail themselves of weren't happening. The good news is that through the crisis today

there has only been a 1% decline in lives covered by the private industry so it has been a very resilient system due in large part to the support that was rolled out.

There was also a reengagement with both prudential and market conduct regulators multiple times a week to ensure the solvency of the industry and ensure that market conduct rules and distribution was still in place and consumers were still being treated fairly. That feeds into the fact that distributors had a lot of paper processes and a lot of requirements in legislation for things like wet signatures and the need to credential exams in person – things that had been identified previously but were never quite got to. A silver lining of COVID was that some of those issues were able to be addressed. Moving to a virtual sales environment and empowering the brokers and advisors to do that and creating a positive virtual experience for clients is a huge lift and that is still being worked on. From the carrier perspective, there were some big changes to underwriting since no fluids were allowed to be obtained and big data become more of an issue– that was an issue when COVID began and is still being looked at today.

Mental health is a growing concern in the pandemic environment. The isolation issues and stress is real and that is being seen in claims data so it has been a huge focus to develop new solutions for virtual health. Virtual health has been accelerated by about 10-15 years as a result of the pandemic so there is a huge amount of activity there in the industry and in employee benefit plans to try and leverage that.

Mr. Frank stated that the current state of the industry is very good as capital levels have actually risen in some cases and sales levels have rebounded. One of the good things about working in the insurance industry, and the life and health insurance industry in particular, is that it has come through COVID very well and is well positioned for the future. From a regulatory and legislative perspective, the priorities the industry had in January and February were put on pause but it is almost time to get back to them. One of the big lifts in Canada is rolling out the new IFRS 17 in 2023 which are new accounting rules and is an enormous change for the industry and it has a lot of capital impacts.

With regard to new product innovation, the snowbirds are beginning to travel again so there are a lot of new products being designed to provide coverage that does include COVID protection. Simplified underwriting also continues and there is a lot of use of big data and virtual solution to try and onboard clients. The shift to the virtual environment is the big theme of the day. It was important to update distributor's capabilities so they have the ability to have virtual client discussions and claims processing and inquiries.

With regard to the next 12-18 months, there is a huge degree of uncertainty as Canada is currently experiencing a second wave of COVID. Vaccines are starting to roll out but it is unknown how long it will take for them to be meaningfully distributed. A big question will be how the inter-relatedness of government and business continues. How that works going forward will be very interesting as a lot of work will need to be done over the next 5-10 years. For companies and the industry, several questions remain: will employees transition back to working in the office; will the low interest rate environment continue; will advisors and brokers continue to learn how to do business in a different way; how will morbidity and mortality resulting from COVID impact the industry; will collaboration between government and industry continue?

Sen. Hackett stated that in Ohio, it has been a pleasant surprise as to how much telehealth has been utilized. One of the things realized is that the level of technology needed is not as great as forecasted by the providers. Sen. Hackett asked Mr. Frank what the experience has been in Canada with telehealth. Mr. Frank stated that the level of use has been amazing. Once you have done it once and you don't have to take the day off work and go to the doctor's office, you probably will never do that again. There is a big interest for employers to start offering such services particularly in the mental health space where the supply of mental health professionals is really concentrated in urban areas. How that interplays with the Canada public system remains to be seen but patients will be the driving force. The expansion of telehealth has been one of the silver linings of the pandemic.

RE-ADOPTION OF MODEL LAW

Upon a Motion made by Rep. Keiser and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to re-adopt the NCOIL Market Conduct Annual Statement Model Act.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Rep. Keiser, the Committee adjourned at 12:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
TAMPA, FLORIDA
DECEMBER 11, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Tampa Marriott Water Street Hotel on Friday, December 11, 2020 at 9:00 A.M. (EST)

Senator Paul Utke of Minnesota, Vice Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Wendi Thomas (PA)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Sen. Andy Zay (IN)
Rep. Kevin Coleman (MI)
Rep. Michael Webber (MI)
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)*
Sen. Bob Hackett (OH)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Bart Rowland (KY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Lehman and seconded by Asm. Ken Cooley (CA), NCOIL Vice President, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 25, 2020 meeting.

THE ABC'S ON EXPERIENCE RATING

Gerald Ordoyne, Director of Experience Rating at the National Council on Compensation Insurance (NCCI), stated that he has been with NCCI for almost 25 years and has been working with the experience rating department for the vast majority of that time. Mr. Ordoyne stated that he will discuss today NCCI's experience rating plan and how it

works with the pricing of the work comp program – the specific plan may not apply to all states but the general concepts of experience rating are pretty similar across different jurisdictions. Experience rating is designed to recognize the differences among individual employers with respect to safety and loss prevention. It does this by comparing the experience of individual insureds to the average insured in the same classification such as roofers to other roofers, clericals to other clericals, and retailers to other retailers. Those differences are reflected in the experience rating modification factor and is based on the employer's individual payroll and loss records. That mod factor could result in an increase, called a debit, which is anything over 1.0; a decrease, called a credit, which is anything under a 1.0; or potentially could calculate to be 1.0 which means there would be no change to the premium that the employer was paying for their work comp policy.

If the rating system went no further than simply manual loss rates or manual loss costs that the carrier was applying to the different exposures, then potentially insurance providers could potentially seek out those employers with better than average experience and avoid the employers with worse than expected experience. So, the experience rating mod is really designed as a part of the overall pricing of work comp.

Thirty-five states and D.C. are NCCI states which are the states that participate in NCCI's experience rating manual on both the intra-state and inter-state basis. The difference between intra-state and inter-state rating basis is that if an employer had a single location in lets say one state, Oklahoma, and that is where their operations were then they would be intra-state rated with just their Oklahoma rated experience. But if they had operations in two or more states and those states were NCCI states and Independent Bureau State— Interstate Participant (IP) states, then they would be interstate rated. The IP states have their own independent rating bureaus that handle the intra state rating portion for those employers but they do participate in the interstate rating plan. So, if there was an employer that had operations in both North Carolina and South Carolina, NCCI would calculate a single modification factor that would apply to the exposure/premium in both of those states. That would be true of any combination of the NCCI and IP states.

There are also states that have their own independent rating bureaus but not part of the interstate rating plan so they calculate an single state mod for all employers that do business in that state. There are also states that have a monopolistic state fund so they also don't participate in the interstate experience rating plan. If, for example, an employer had operations in California and Nevada, CA would be responsible for calculating a modification factor for the California experience and NCCI would calculate a modification factor for business operations in Nevada with just the Nevada experience.

Mr. Ordoyne stated that in 2019, NCCI calculated over 1.2 million experience rating modification factors which were calculated for about 740,000 different employers. Of those employers, about 620,000 were intrastate rated employers which means they simply had operations in a single state. Another 120,000 were the interstate rated employers which are those that have interstate operations among any of those 42 states referenced earlier that participate in the interstate rating plan. That is a lot of work and a lot of data the comes into NCCI. Over the years, NCCI has implemented some systems that do the calculations automatically and for the most part about 80% of the mods are calculated without any manual intervention. So, the insurance provider submits the unit data – the audited payroll and loss records – to NCCI and it goes to the upfront editing

process and passes over to the experience rating department and flows through the calculation engine and then the mod factors are processed and distributed to the necessary stakeholders that need that information either from a carrier perspective to apply that modification to the premium or in most states to the employer so they are aware of what the modification factor is going to be for that current year.

Additionally, NCCI also looks at ownership requests which are important because it is how NCCI makes sure it is using the right experience in the calculation of the modification factor. All the ownership information that flows through NCCI is reviewed manually so while there is some automation around the calculation of the mods, all of the ownership is reviewed manually. Mr. Ordoyne stated that with regard to calculating the mod, in the most simplified format, the experience modification factor is really a comparison of employer's actual losses to their expected losses. Their actual losses are those losses that represent both the paid and reserved amount of any claims that may have happened in the experience period. Expected losses are based on the exposure or in most cases the payroll of the employer. The expected losses are really driven by two factors – the amount of payroll the employer has and the type of business and operation that the employer has. Clearly you would think that a construction business is more likely to have claims than a business that only has workers who sit at their desks the majority of the day. The upfront rates are going to be higher for the construction company than they are for an insurance company but the expected losses are going to be higher as well. The expected losses are based on both a combination of overall payroll - the more payroll the more losses you would expect – as well as the type of exposure and the possibility of risks for that employer in that class code.

In the experience rating calculation NCCI typically looks at three years of experience that ends one year prior to the effective date of the mod being calculated. As an example, for those modification factors that have an effective date of 1/1/21, NCCI is going to use a three year window that ends 1/1/20 and will be looking at 2017, 2018 and 2019 policy periods. Not all employers qualify for experience rating. In NCCI jurisdictions, qualification is based on premium and that is the premium generated by the policies that are part of that three year window. It varies by state. The average premium eligibility across NCCI states is about $9,500 in premium annually but it ranges from $5,500 to $13,000 so there are state differentials that come into play.

Starting in 2017, in most states, that premium eligibility is indexed so it has the possibility of increasing as time goes on. It is tied to the U.S. Bureau of Labor Statistics quarterly census of employment and wages. That is looked at on an annual basis and in some cases a state may see a rise in premium threshold and in other years they may not but it is done to keep pace with inflation and make sure those employers that are too small to quality for experience rating aren't being included in the calculation and getting a mod because they probably don't have enough credibility to warrant getting an experience mod factor.

In the calculation of the mod, the actual losses are based on the actual paid and reserved claims that the employer incurred over that three-year window. Those claims that go into the calculation are broken into two pieces. At a point, which is as of 1/1/21, the split point is $18,000 so all claim dollars up to $18,000 are considered primary and they go into the experience modification calculation at 100%. Any claim dollars over $180,000 are going to go into the calculation but at a reduced amount and that amount really depends on the size of the employer and how much payroll they have generated

over the years. That amount can be as low as 4% or potentially as high as 80% depending on their size.

Often times when you talk about experiencing rating the terms frequency versus severity are used. That means primary versus excess portions of the claim. The primary portion represents the frequency and the excess portion represents the severity. Frequency plays a grater weight in the mod calculation than severity. The fact that the claim happened and that it existed is more important than what the overall claim dollars are. That is not to say that the overall claim dollars are not important but they are not quite as important.

For example, if an employer has a $50,000 claim, the first $18,000 would go in at 100% and those dollars over $18,000 would then go in at a reduced amount. Lets say based on their size the weighting factor was 10% so the $32,000 is only going into the mod calculation at $3,200 so the $50,000 claim in the mod calculation is only going to look like $21,200 – the $18,000 primary and the $3,200 excess. The split point, much like the premium eligibility threshold is also now indexed and can be indexed annually. This was some research that was done by NCCI's actuarial department in the early 2010s and went into effect in 2013. NCCI moved what had been a very static split point and indexed it over a couple of years to what the appropriate amount was which was around the $15,000 mark and now it has been indexed based on inflation annually since then and as of 2021 in most states the split point value is going to be $18,000.

Mr. Ordoyne stated that the claims are taken and split into primary and excess but there are also some other limitations that can occur to a claim. In most states, if the claim is medical only then the claim dollars are going to be reduced by 70%. For example, if an employer had a $2,000 medical only claim and there was no loss time and the employee just had to get stitches and didn't miss any time that would be medical only and that $2,000 claim would only go into the mod calculation as a $600 claim, reduced by 70%. Every state has a state per claim accidence limitation. In terms of frequency versus severity, it can get to a certain point where a claim can get be of such size that any dollars above a certain level aren't adding value to the mod calculation. That dollar amount is based on the state data that actuaries look at as part of the loss cost or rate filing and it can vary anywhere from $150,000 to $500,000 based on the state data. For 2020 it looks to be on average around $275,000. So, if for example an employer had an unfortunate claim that was $500,000, that claim with a $275,000 state accident limit would be capped at $275,000 so the $225,000 above that cap are going to be excluded completely. So, $18,0000 of the claim is going into the mod calculation at full weight but the difference between $275,000 and $225,000 is going in at a reduced rate depending on the employer size and anything above the $275,000 is going to be discarded and not used at all.

There is a secondary claim limitation and a state multiple claim limitation which is an added layer of protection for employers. If for example there is a single accident where multiple employees happened to get injured such as an explosion in a warehouse or a car accident, those claims grouped together would be limited to a value and that value is two times the state accident limitation. So, if a state has a $275,000 individual claim accident limitation then the combination of all the claims in that single accident would be limited to $550,000 in the mod calculation and that is important because it adds another layer of protection for the employer.

There has been a lot of talk in the work comp arena about the impact of COVID-19. From an experience rating perspective, a decision was made earlier this year and a filing was made which resulted in an exclusion of COVID-19 claims from the experience modification formula. It was felt that actuarially that information probably didn't add a lot of value because it wasn't going to be a great indicator for potential claim activity in the future. We expect COVID, hopefully, to be a once in a 100 year pandemic and it is not likely that the same type of claim activity is going to occur in three years for the same employer. So, the filing was made and for any claims reported with certain identifiers that were created to identify that claim as a COVID claim which have to do with the accident date (after December 1, 2019) and other things, it would result in that claim being excluded from the work comp experience rating mod calculation. Something similar was done many years ago following 9/11 and all claims associated with that were excluded from experience rating for basically the same reasons as there just wasn't an expectation that it was going to be a good indicator of future claim activity in the near future.

Mr. Ordoyne stated that as a final layer of protection for the employer, there is a maximum debit modification that can be applied. This is a cap on the mod that would limit how high the mod can go for an employer and it is based on size but it is really a protection for smaller employers that maybe just qualified for experience rating and happened to have a couple of unfortunate claims during the experience period. The cap starts at 1.10 and grows based on the size of the employer. Regarding ownership, NCCI does collect ownership information on employers and it is up to the employer to submit that data to NCCI. It is important because experience rating uses the past experience of the business to calculate the mod factor so it is appropriate that NCCI uses all of the experience of that employer. Changes in ownership could impact the experience that is used in the mod calculation and for purpose of experience rating that past experience could be transferred or combined in the mod calculation. Ownership changes vary quite dramatically from a simple name change to sales or some large mergers as well as new entities being formed.

As an example, in each of three examples (three companies), owner A owns a majority of the business. Based on NCCI's experience rating plan manual rules, because that person (a person or entity) owns more than 50% of all three businesses, the experience of all businesses are going to be combined to calculate a single modification actor that would then apply to all of the businesses and that is true regardless of the business operations and how varied they might be. Another example can be used with a sale. If I own a company and sell that to someone else who wants to start operating that business, when that transaction takes place and the business is sold that experience that was generated while I was the owner also transfers to the new owner because the operations haven't changed and the new owner is just taking over the operations – they inherit the experience. So, the person buying the company is buying the experience as well. Also, let's say the person buying the company also owned another company, NCCI would then calculate a combined mod because that person now owns multiple different businesses.

Mr. Ordoyne stated that he would like to point out that this was a very high level of NCCI's experience rating program and NCCI has a lot of other information at NCCI.com. There is a lot of information and webinars that take you through different levels of detail in the calculation and worksheets. There is also a document called the ABC's of Experience Rating that has ben popular over the years and goes into a lot of detail. In

many cases, that document tends to answer a lot of questions that people may have on experience rating.

Rep. Matt Lehman (IN), NCOIL President, stated that he has always wondered how something that happened to one of his clients is handled by NCCI. His client was an auto company, and they were in a not at-fault accident in the course of employment and paid out about $350,000. It was going to be fully subrogated and the carrier took on the obligation but in the meantime, because it was paid out under work comp, his experience rating took a hit and it cost him about $25,000 per year. It was fully subrogated and they got their money back but they are now on the hook paying that mod. Accordingly, Rep. Lehman asked what research NCCI has done with subrogation and reserving because we also see in the market that there will be a claim setup and they will reserve it for $250,000 and if that doesn't get adjudicated, it pays out at $50,000 but that hits their mod at $250,000.

Mr. Ordoyne stated that from a subrogation perspective, there are specific rules in the experience rating plan manual that state if a claim is subrogated, once the carrier is reimbursed they should be submitting correction reports which then lower the claim value down to just whatever the difference was that wasn't subrogated. In Rep. Lehman's example, if all of that was reimbursed, they would submit correction reports back to the original reporting and then NCCI would then be able to go back and revise the mod. In most states, for any reason, the current mod that is in effect today is revised as well as the prior two year's mods. For subrogation, that time period actually expands for potentially up to five years so it would be the current mod and the four year's prior. In Rep. Lehman's example, once the subrogation was worked out and the carrier got the reimbursement they should then be reporting the correction report which would then trigger a revision at NCCI to revise the current mod and the prior year's mods.

Rep. Lehman asked who's obligation it is to report the subrogation and reimbursement. Mr. Ordoyne stated that once the carrier submits the correction report with the revised claim dollars that will automatically trigger it for that three year window. If it goes into the five year window there might be some communication needed by NCCI but the insured shouldn't have to do anything but if they are not seeing anything done they should raise it with their agent. Mr. Ordoyne stated that with regard to reserving, NCCI cannot respond to questions on carrier practices, especially when it comes to reserving.

Rep. Bart Rowland (KY) stated that with subrogation if NCCI adjusted the mod down for prior years would the carrier be obligated to adjust the premium and refund the customer based on the lower mod. Mr. Ordoyne replied yes as that is in NCCI's experiencing rating plan manual and rules. Because that mod was revised within the revision window as defined in the manual then the carrier would have to issue that refund.

Jeff Klein, Esq. at McIntyre & Lemon, PLLC, asked if occupational disease is treated the same way. Mr. Ordoyne stated that he did not get into occupational disease as there is a whole separate claim limitation for occupational disease that is a bit more complex and it is not really seen that much. Claims for occupational diseases would go into the mod calculation and there is a separate layer after that but it is not common.

DISCUSSION ON FLORIDA'S WORKERS' COMPENSATION INSURANCE MARKETPLACE RESPONSES TO COVID-19

Geoff Bichler, Esq., Founding Member & Managing Partner at Bichler & Longo, PLLC, stated that the starting point for these issues is always going to be the state work comp statute. The Florida statute relating to occupational disease and exposure is very stringent and prohibits claims for toxic exposure and injury or disease. The statute (440.02) states that "An injury or disease caused by exposure to a toxic substance, including, but not limited to, fungus or mold, is not an injury by accident arising out of the employment unless there is clear and convincing evidence establishing that exposure to the specific substance involved, at the levels to which the employee was exposed, can cause the injury or disease sustained by the employee."

That standard has been in place since 2003 reforms to the Florida work comp Act and have created a lot of problems for injured workers who have attempted to bring these types of claims so you don't see many of these cases brought. That may be why NCCI stated that this issue is not that common because most states have similar restrictive language relating to occupational disease and exposure claims. That is the starting point and has to inform any consideration of liability or immunity or additional legislation that may be looked at to try to limit claims related to COVID. Further, Florida law has a specific occupational provision which is in Florida statute 441.51 that has similar language to the statute just discussed. The bottom line is that there are very restrictive and difficult standards in Florida.

A recent Florida appellate case that was very anticipated as it related to COVID was released in November with re-hearing denied in January just before COVID cases began in Florida. The case involved an occupational exposure and a death claim. There was a concurring opinion from Judge Wolf who is a very prominent jurist in Florida and features regularly in constitutional decisions in Florida and said the case and *Gibson* "reject the use of overwhelming circumstantial evidence to prove the statutory requirements of clear and convincing evidence in toxic exposure cases. Direct proof of the level of exposure to the toxic substance is simply not available in a great number of toxic exposure cases. I am, therefore, not convinced that workers' compensation is a viable alternative to the tort system for workers that are injured by toxic exposure at the work place. Either the court system or the Legislature must deal with this problem."

Mr. Bichler stated that as an advocate that represents injured workers and primarily first responders, this was a reversal of the trial judge that had found in favor of the widow of the worker who died following a very clear exposure to a toxic substance in the workplace and the evidence was overwhelming. From Florida's perspective, there is a very thin edge as to what may be constitutional and not in these types of circumstances.

When this issue first began and was looked at with COVID, it was clear that statutory protections would be needed. A lot of states have implemented presumptive legislation which is quite controversial but in Florida there is a history of presumptive legislation being passed to protect first responders. There was work done early in the process to try and get a presumption passed either through a Governor Executive Order or by statute. The Governor did not issue an Order but the CFO did in late March and it essentially advised state agencies and employers in Florida that they should recognize these claims as presumptively work related. That was not binding but something that a lot of Florida employers recognized and agreed that it essentially was the right thing to do for first responders.

At the same time, federal legislation was moving related to public safety officer benefits which provide for health benefits and some limited disability benefits for first responders who were injured or killed on the job. Congress did pass the legislation and it went into effect in August and recognized COVID as presumptively work related at least with respect to death claims. The language there was something thought to be beneficial for Florida police officers and firefighters. Mr. Bichler stated that separate legislation in Florida was also proposed. Florida has special protections for first responders in Chapter 112 and separate legislation was proposed for some union leaders and a template was created that they can use to try and go find sponsorship to pass legislation that would provide basic coverage for COVID cases with the ability to rebut the presumption in certain circumstances where you could demonstrate that the disease was contracted somewhere else.

Because of the timing of Florida's limited legislative sessions, the session was during the middle of the pandemic and the session ended and there was no opportunity to pass the legislation but there is interest in potentially doing it again this year and with the way things are going in Florida with COVID cases rising it appears this may be a good approach to the issue to make sure that first responders are getting covered under work comp for these types of conditions.

At the same time, there is a Task Force in Florida that is pushing primarily to restrict liability which is similar to what is being seen at the federal level where they want to immunize employers from liability claims related to COVID. That is problematic from a civil liberties standpoint that you would not allow someone to bring a claim regardless of circumstances and that may be where the rub is at in Washington. There is a sense of the need to protect employers that may not be real. If you are looking at the legislation that exists in most states, it is restrictive and it is very difficult to prove these cases anyway. In speaking to others, once the previously discussed Florida appellate case was decided last year, most attorneys that represent injured workers pretty much gave up the idea that you could prove an occupational disease or exposure case as the standard is so difficult as the cases are essentially suicide missions as you are likely to lose the case and not meet the burden.

Mr. Bichler urged the Committee to look at the precise language in state statutes regarding exposure and occupational diseases and then make a determination as to how difficult the standard is and whether anything additional is needed to protect employers from liability. Mr. Bichler stated that he would suggest nothing further is needed as about half the claims in Florida are being accepted. That is shocking as given the legal standard, Mr. Bichler stated he doesn't think any employer would have to recognize COVID-19 as being work related. It is encouraging that roughly half of the cases are being acknowledged and it seems as though employers and carriers are attempting to do the right thing in various circumstances. Mr. Bichler stated that his sense is that this may not be the sort of pressing issue that it seems and individual states will have their own determinations as to the compensability of these types of conditions.

Ya'Sheaka Williams, Esq., Partner at Eraclides Gelman, stated that when she thinks about 2020 and COVID, this has definitely been a year of change and adaptability. We have been thrust into this new world of remote working and having to adapt to the change in the world. Work comp has adapted to the changes that COVID has presented as well. On March 9, 2020, Governor DeSantis issued a state of emergency and

Executive Order 20-52 which essentially limited personal interactions outside of the home. At that time, many businesses closed or worked from home. Ms. Williams stated that all of her insurance defense clients are remote still today with the expectation that they will return to their offices at some time in 2021 on a graduated basis in order to ensure that they are able to socially distance and keep everyone safe.

Another thing that was big with the Executive Order was that it prevented elective surgery. In most instances, that may not make a big difference but when you are thinking about work comp and injured workers who are scheduled for an elective knee or back surgery that was stopped because the Governor wanted to make sure that surgeries could be done safely while not exposing patients and doctors to COVID and at the same time ensuring that if there was an issue as a result of COVID those facilities could quickly respond.

Eventually, that caused a ripple effect in work comp. If you have a person scheduled for surgery on March 15 the expectation is that they would be out of work for two weeks and the expectation is that you are paying them lost wages for that period of time and then you are able to get them back to work. If elective surgeries are delayed, the employer's exposure continues because the injured worker can't return to work and their out of work status is prolonged and quite possible their ability to recover from the surgery, although it's elective, could have a ripple effective from having them recover long erm.

About two months later, some changes were made with another Executive Order being issued on May 4 (20-112). That Order stated that "Local jurisdictions shall ensure that groups of people greater than ten are not permitted to congregate in any public space that does not readily allow for appropriate physical distancing." Also, "Bars, pubs and nightclubs that derive more than 50 percent of gross revenue from the sale of alcoholic beverages shall continue to suspend the sale of alcoholic beverages for on-premises consumption." If you represent a district or an employer that is largely a business they are drastically impacted by that Order. Not only are they losing revenue but you also have a diminished workforce because if you have a business that more than 50% of revenue is from alcohol and that is stopped, and if they don't have sufficient menus to serve food then more than likely they are not going to be open or they are going to be open at such a reduced capacity that it's going to cause significant loss. At that time, capacity at restaurants was limited to 25%.

On June 5, Executive Order 20-139 was issued which took a look at long term care facilities. The Order stated that those people working at such facilities must undergo routine testing. That is excellent because that means the spread of the virus can be prevented and people with the virus can be treated. Also, retail stores and fitness facilities were allowed to reopen as long as they could ensure social distancing and able to sanitize the facilities. Then, restaurants and businesses moved to 50% capacity and businesses really started to reopen. Then, in September the state moved to the right to work phase and that phase is where the Governor really got aggressive in trying to re-open businesses and getting the economy re-started after roughly six months of businesses being somewhat stagnant because of the precautions needed to help cease the spread of COVID.

All of this relates to work comp. In work comp, if you are an employee that is primarily paid in cash or in tips, their IRS filing is heavily relied on to calculate what the average weekly wage is which is used by the carrier and the claimant's counsel to determine how

much weekly cash benefits the workers would be entitled to if they are out of work based on their work restrictions. The tax deadline was delayed from April to July so there was no obligation for the worker to file before July so in that regard there were issues with trying to calculate what a person could be entitled to on a week to week basis.

Regarding unemployment compensation, during the initial state of emergency in phase one, many businesses were closed and operating at a significant reduced capacity. Ms. Williams stated that many of the employers she represents were furloughing their employees at least for the short term. For those employees, they were not fired but were furloughed and allowed to collect unemployment compensation and so the question is how does unemployment compensation directly impact work comp. Under Florida statute 440.15, it addresses a person's entitlement to unemployment compensation benefits and the impact on work comp. First, if a person is on a no-work status but has been furloughed they would be entitled to unemployment compensation which would include the $600 per week additional benefit provided by the CARES Act. If a person receives unemployment compensation at any time during which they are on a temporary total disability work status where their doctor has said you are so injured that you are unable to work at all, you cannot receive unemployment compensation and compensatory total disability benefits at the same time. Temporary total disability benefits are paid at two thirds of the claimant's average earnings during he week. So, the claimant is unable to double dip. For the employer carrier, that reduced the exposure on that particular claim for as long as the person is receiving unemployment compensation.

For someone who is on duty or has work restrictions at the same time they were furloughed, they would also be entitled to unemployment compensation during that time but they would be able to receive the full 64% of their average weekly wage in conjunction with unemployment compensation. Unemployment compensation is primary so the employer carrier will receive a dollar for dollar offset of unemployment benefits received. As an example, if a person would normally receive a temporary partial disability benefit of $200 per week but with unemployment compensation in the CARES Act they were receiving $700 per week – during that week of temporary partial disability they were receiving no money from work comp because they were fully compensated by unemployment compensation and receiving a benefit of the CARES Act. Ms. Williams stated that for her practice, the positive of the unemployment compensation CARES Act was that for injured employees they weren't able to receive unemployment compensation and work comp or the amount of unemployment compensation that they received was so high that they were entitled to receive unemployment compensation throughout temporary partial disability benefits which in turn reduced the file exposure on the claim.

Ms. Williams stated that another thing that had to be dealt with in phase one were doctor's office closures. At the beginning, it was almost a sense of ants scrambling around figuring what was safe and not safe. Many doctor's offices had to close to make sure they could rest and operate in a way that was safe for them and patients. One medical practice in the Tampa area contracted COVID and as a result the office and multiple offices in that practice group closed down for 3 weeks to make sure it was safe and everything was cleaned. That was a big deal because a lot of injured workers were being sent to that practice group.

Then, there was a concern of injured worker fear. For instance, many did not want to leave the house or go to the doctor's office over fear of contracting COVID. That results in delayed care. However, what has been very positive for work comp practice in Florida is that many doctors have become more innovative and there has been an uprising of Teladoc. When Teladoc was first introduced, Ms. Williams stated that she was skeptical, but this year it has become so prevalent and successfully operated for injured workers being treated. It has also resulted in doctors being more efficient and being able to treat more injured worked which has been a silver lining of COVID. Not every doctor agrees, but for those that do, it is a great way to keep cases moving forward and getting injured workers back to pre-accident status. Physical therapists are also providing therapy via Teladoc which is very innovative and a great way to get injured workers back to work. Ms. Williams stated that the only hiccup she has seen with Teladoc has been technology as it almost presupposes that the injured worker has the necessary technology to get the benefit of Teladoc. There are some vendors out there who provide the technology to injured workers to assist them for appointments. It is very important that those issues are addressed and COVID has highlighted the need to work together and use a more collaborative model in treating injured workers.

Going forward, Ms. Williams stated that enhancing cleaning and treatment protocols will be a priority. You are seeing changes in the amount of people that are allowed to come into the examining room which can be an issue if the injured worker needs a translator. Many times, now the translator attends the visits by phone because the doctor is limiting the amount of people in the room. Nurse case examiners who typically would attend an appointment to get information to give the employer carriers are now attending telephonically. Also, doctor's offices are now conducting temperature checks and waivers and questionnaires or requiring the worker to stay in their car prior to the appointment. Ms. Williams stated that she has noticed providers really adapting to COVID at a great rate as she really hasn't seen a significant decline in the treatment injured workers are receiving.

Ms. Williams stated that she had a case that went to trial earlier this year where the injured worker felt uncomfortable seeing a physician in-person and they were offered to provide transportation services. The worker was concerned with whether they would be the only person in the vehicle or whether they had time to disinfect the vehicle. In that case, the judge ordered that accommodations be made to find a doctor closer to the claimant's home because of his concerns with transportation and COVID. Ms. Williams noted that treatment options have been very innovative and there has been a lot of flexibility in practice. Ms. Williams noted that since COVID, there has been less workers and less claims and that the cases she does have are more litigious because more focus is able to be on those cases. With a reduced workforce and businesses closing, there are less claims and the claims that are filed are related to people having pretty significant injuries and not your run-of-the-mill minor work comp claims and they are significant enough for the person to want to file a claim versus dealing with it and keep working.

Ms. Williams stated that one thing that has been key throughout this has been communication. COVID required these work comp cases to be handled on a more collaborative basis – more communication with claimant's counsel, doctor's offices, vendors who are helping move the cases to the system and getting the injured worker back to work. That is a positive, as has also been the case with the expanded use of telemedicine in the work comp system. Ms. Williams stated that this has been a year of

change and adaptability for everyone and if everyone remains collaborative going forward, the results should be positive in the end.

David Langham, Deputy Chief Judge of Compensation Claims at the Florida Office of Judges of Compensation Claims, stated that he has been in this industry for over 30 years and he has never seen anything like COVID. Judge Langham stated that his main advice for anyone legislating or regulating in this system would be that the ancillary and tangential affects are going to be far broader than the direct affects and that is where minds need to be moving forward. The big peak for work comp claims in Florida was in July and since that time even though the state has opened since then the curve has flattened. A lot of folks thought that once the state was re-opened there would be a lot more work comp claims but that has not happened.

There are 22 million people living in Florida and there have been 23,452 loss time claims reported – the people who have claimed they have suffered a work injury. That is exceedingly low in the grand scheme of things and is important to note. The vast majority of those claims fall into a cost that is less than $5,000 to the carrier; they have a mean average cost of $703 each. Some of the blame for that can be put on the federal government as they stepped in and provided a greater unemployment compensation and some of the blame can be attributed to Mr. Bichler's comments about how hard it is to prove an occupational disease in Florida so some folks looked at things and saw how high the hill they had to climb was or they could just take the unemployment compensation which was a good benefit and a lot of those cases probably steered that way. Judge Langham noted that the vast minority of cases did get very expensive and the mean average of the 6 highest cases was almost $800,000 each. Judge Langham stated that cost does not come from indemnity but rather medical care and the cost of medical care for COVID is very expensive and is something that needs to be monitored.

Miami-Dade is by far the most densely populated county in Florida and 31% of the claims are coming from there. Another 8% comes from Broward so almost 40% of the cases come from an area of the state that has almost 22% of the state's population. That supports the notion that population density is important but not critical as this meeting today is in Tampa that has 7% of the state's population and only 3% of the lost time claims which indicates that COVID can be controlled and better treated in urban areas. For some reasons it is not in some places.

Judge Langham stated that the 31% COVID lost time claim number compares to 8% of all lost time claims in Florida this year. That shows that COVID claims are really a big percentage but they are also only 8% of total expenditures, including the very expensive claims of about $800,000 each, so this is a very broad and very important segment of claims but the cost of them today is simply not where you would expect them to be. The word "today" is important because a lot of scientists are saying that there is such as thing as "long COVID" which refers to the fact that some people may have bad health outcomes years down the road due to exposure and we may be talking about some folks about lung transplants and cardiopulmonary disease of a variety of things. So, picking these things up as compensable today may create risks for insurance carriers 5-10 years down the road and that may be part of the cost not seen yet.

Of the almost 25,000 claims, only 45% have been denied. It turns out that a lot of those denials are based on negative test results – employees who have gone to their employer to report they have COVID at work and they say they have symptoms and then they get

a test result back 10 days later that says they tested negative. That is going to be denied and rightly so. Part of the flattening of the curve might be that employees are not so quick to report in today's environment because for the most part there is wide access to rapid test results.

There is a disparity in the way the money shakes out. Florida's Division of Work Comp chose to categorize all the claims into categories: airline; healthcare; office workers; protective services (first responders); and service industry. The numbers are not in parity everywhere. The office numbers are closely tied: 10.6% of the claims and 10.7% of the cost. But, the protective services category is 32.5% versus 44.2% and the service industry category is 29.2% versus 10.2%. Part of that may be due to optimism bias and Judge Langham warned against that as first responders and doctors are trained professionals and they have convinced themselves that they are invincible and that is a psychological occurrence that we know occurs.

Judge Langham stated that the denials are not totaling $0. For compensable claims the number is about $40 million spent and that number is expected to rise but the denial claims total about $500,000 spent. For cases that are denied and they are not moving forward in terms of expenditure it is important to remember that there are still costs associated with that and employers and carriers are paying those costs to get testing and quarantine time and those sorts of things. Judge Langham noted that of the total amount of lost time claims, Mr. Bichler believes that it is in large part to folks doing the right thing and Judge Langham stated that he does not doubt there is some of that but it also occurs to him that some employers are picking up the claims because by doing so they get a healthy dose of work comp immunity and that may be part of this. We do know that there are several cases pending in Circuit court where employees are trying to sue their employers and they are concurrently in the work comp system. So, all of that probably goes into an employer's decision making process in all of this.

Sen. Bob Hackett (OH) stated that he appreciated Ms. Williams' comments and hopes that the American Medical Association (AMA) was listening because with regard to telemedicine, providers are able to see more patients and it is cheaper most of the time to do telemedicine versus in person care.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Asm. Cooley, the Committee adjourned at 10:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
TAMPA, FLORIDA
DECEMBER 10, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Tampa Marriott Water Street Hotel on Thursday, December 10, 2020 at 3:30 P.M. (EST)

Representative Edmond Jordan of Louisiana, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Sen. Matt Lesser (CT)*
Rep. Matt Lehman (IN)
Rep. Derek Lewis (KY)*
Rep. Joe Fischer (KY)
Rep. Jim Gooch (KY)*
Rep. George Keiser (ND)*
Sen. Shawn Vedaa (ND)

Other legislators present were:

Rep. Martin Carbaugh (IN)
Rep. Peggy Mayfield (IN)*
Sen. Andy Zay (IN)
Rep. Michael Webber (MI)
Asm. Kevin Cahill (NY)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Sen. Matt Lesser (CT), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Rep. George Keiser (ND) the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 26, 2020 meeting.

CONTINUED DISCUSSION ON NCOIL INSURER DIVISION MODEL ACT

Sen. Matt Lesser (CT), sponsor of the NCOIL Insurer Division Model Act (Model), stated that the Committee had a good initial discussion on this Model – which starts on page 127 in the legislator binders – at the last meeting in Old Town. Since that time there has

been some discussion about potentially replacing the Model with Colorado HB1091 – which is in the binders on page 141 – to address some concerns from interested parties. Sen. Lesser stated that at this time he would rather make some amendments to the existing Model as opposed to replacing it. For example, Sen. Lesser stated that he thinks the Committee can get to a place where perhaps some drafting notes are included in the Model on issues such as requiring an independent expert and holding a public hearing so that states can have options as to whether or not they want to require those things in their statutes or provide the Commissioner discretion.

Sen. Lesser stated that he looks forward to working on the Model after this meeting and hopefully it will be ready for a vote at either the next meeting in March or the July meeting.

Karen Melchert, Regional VP, State Relations at the American Council of Life Insurers (ACLI), stated that she understands Sen. Lesser's desire to not replace the Model with the CO bill but ACLI believes that going with the CO bill would in fact be a cleaner approach because the CO bill is based on the Illinois bill which was actually based on the CT bill and there have been improvements along the way. ACLI and the Reinsurance Association of America (RAA) worked with interested parties in CO to get the bill to a point where they were supportive and they would like a Model at NCOIL that they can support.

ACLI and RAA recognize that there are differences of opinion on issues such as the use of an independent expert. When the issue of insurer divisions came to light in 2017 when CT adopted their statute, the industry was pretty divided and ACLI was not really able to weigh in on any proposal but it has worked over the past couple of years to get to a point where ACLI developed principles and guidelines and that is what based ACLI's suggested revisions to CO's bill which would have moved forward and been enacted but for COVID ending session prematurely. Accordingly, ACLI would like a strong Model from NCOIL and the CO bill as amended is a great place to start and address some of the issues Sen. Lesser and the CT DOI has raised. ACLI looks forward to continuing to work on this in order to develop a Model that ACLI can support in states as the issue is starting to pop up more and more as an important tool for insurers to use to organize their risk portfolio and create their corporate structure.

Asm. Cooley stated that he believes this is a very important Model and he has had discussions with Sen. Lesser about it. Asm. Cooley stated that he looks at the Model the way he always does when he sits down to draft a bill – I like the way I'm doing it wrong better than the way the other person is doing it not at all. This is a good Model to start with but Asm. Cooley stated that he understands how as ideas get examined over time you start seeing possible issues and go through iterations of knocking the birds off and cleaning it up. Somebody has the burden of getting that going. Asm. Cooley stated that he strongly favors the idea of that NCOIL is a group of state lawmakers and is now taking a position on this issue so what do they think in this area – lawmakers are the ones who safeguard the public trust and interest. Asm. Cooley stated that he feels that these types of divisions are highly technical and it is for the good of the order and good of the public to have a provision for a hearing but not a court or regulatory hearing. It may be de minimus and it may be decided that it is perfunctory but they have to put together a record and analysis and provide the opportunity to speak. That furthers the public interest.

For the same reason, Asm. Cooley stated that he believes that a drafting note that addresses having an expert potentially would be a very good drafting note to put in a Model like this and it could maybe be backfilled to include a little authorization for the regulator to hire that expert talent if they go down that trail. Asm. Cooley stated that in his experience with CA regulators they often have very experienced people in the DOI and it would not be uncommon form CA's standpoint to think they could handle it in-house but it is the legislators' job to lay the framework

Asm. Cooley believes that NCOIL should be producing off this chassis a Model that is embraced throughout the country. Accordingly, Asm. Cooley favors having some allusion to a departmental hearing in the Model because as a public official he wants them to take that step and expose the thinking in the public realm before everyone has to live with it in the headlines of the local paper and acknowledging that they need to make a judgment of whether there is the right talent in house or not is fair in the sense that legislators are pushing regulators on that issue. This is not to be a pest but rather just to say that if the Model is recommended to the 50 states that a good plan is in place.

Paul Martin, VP of State Relations at the RAA, stated that he fully agrees with Asm. Cooley's comments. Mr. Martin stated that as legislators are fully aware, as we get better with a particular issue or concept the legislation tends to get better. The CO bill is a result of trying to take the lessons learned from other states and come up with a Model that becomes a best in class solution for the division issue. The two issues that seem to be causing the most heartburn are the hearing requirement and the expert requirement. When talking about the hearing requirement we are taking about due process and due process basically has two concepts: notice and opportunity to be heard. Right now, under the Model, there is not enough access to information about the potential division or ability to raise concerns form policyholders and policyholders can be insurance policyholders and annuity holders and reinsurers who have ongoing contractual obligations to companies. They may all have questions about capitalization adequacy, proposed leadership of the new entity or the state of domicile. It could be a whole host of reasons why there should be a hearing to flesh the issues out.

Regarding the expert, Mr. Martin stated that he understands that the CT DOI and the CA DOI have a lot of in-house expertise and it can be appreciated that they can say that they know the entities and they are capable of looking at them and determining whether the proposed division is a good idea or not. However, there are some DOI's across the country that may not have those resources so having the expert available to look at those entities and render an opinion as to whether or not the division should go forward is proper. Also, this is one of the few times that industry recommends that the Commissioner should have more authority and more discretion. In this situation, they should. Under the current Model, if a petitioner for a proposed division checks all the boxes the Commissioner must approve the division. RAA believes the Commissioner should have the discretion to review all the evidence and concerns and have a hearing to hear everyone's opinion and then make a decision whether the division should go forward or determine that some changes should be made to the division before it is allowed to proceed. RAA submits that these are not onerous requirements but rather enhance the confidence of the public and industry in the division process. RAA looks forward to working with everyone on this going forward.

Bridget Dunn, Head of Gov't Relations at Talcott Resolution (TR) stated that TR is a privately owned insurance company based in CT that was formed in 2018 after the

purchase of The Hartford's closed block of life and annuity business. Over the past two years, TR has been working to manage that closed runoff block of business while actively looking to grow its platform. One of the mechanisms that it hopes to utilize in order to acquire other runoff blocks of annuity business is insurer divisions. TR is lucky enough to have an existing division law in CT and it believes that more states that have insurer division laws give it a greater opportunity to grow the platform in a more strategic way. It is important to note that a division is essentially a reverse merger and it does need to have robust Form A-like parameters around it in order to be complete. With that said, it is important that each division follows the Form A-like process for each state which can differ from state to state based on their holding company act. TR is encouraged by the conversations taking place at NCOIL on this issue and looks forward to development and adoption of the Model so that it can be introduced in future legislative sessions.

Daniel Lewallen, Esq. at Faegre, Drinker, Biddle & Reath, LLP, and on behalf of the National Conference of Insurance Guaranty Funds (NCIGF) and the National Organization of Life and Health Insurance Guaranty Funds (NOLHGA), stated that both NCIGF and NOLHGA remain neutral on whether or not insurer division statutes should be adopted and both also agree that if such statues are adopted any insurer division approval should ensure that the eligibility of a dividing insurer's policyholders for guaranty system protection must not be disrupted because of a division. NCIGF and NOLHGA also appreciate the efforts that have already been to ensure that a division plan would not result in policyholders losing their eligibility to be covered by the guaranty association or guaranty fund in their state of residence.

NCIGF and NOLHGA believe that as a matter of core principles they are aligned with NCOIL. NCIGF and NOLHGA believe that focusing on addressing two drafting issues can better preserve the principles of guaranty system protection. First, ensuring continuity of guaranty system protection should be mandatory. There needs to be confirmation that there would be no discretionary authority to approve a division plan without satisfying the fundamental policyholder protection concern that none of the dividing insurer's policyholders would lose eligibility for guaranty association or guaranty fund protection as a result of the division. The current draft identifies generally that the continuation of such protection is one of the three requirements that, if satisfied, mandates approval of a division. It does not, however, make it clear the discretionary approval is not permitted where this policyholder protection standard for mandatory approval has not been satisfied.

Second, the division sponsor should demonstrate continuity of guaranty system protection in the plan of division. In order to ensure that this standard is addressed meaningfully in the insurer division review process, it must be incumbent on the sponsor of a division plan to include in the division plan some evidence or basis that the division will not result in any policyholders losing their eligibility for guaranty association or guaranty fund coverage. Following this meeting, NOLHGA and NCIGF will offer specific language suggestions to address these issues including any criteria that should be addressed in the division plan to establish that continuing eligibility for guaranty fund protection will not be jeopardized by an insurer division.

DISCUSSION ON COVID-19 INSURANCE MODERNIZATION INITIATIVES

a.) Update on NAIC's Innovation & Technology Task Force (TF) Initiatives

The Honorable Glen Mulready, Oklahoma Insurance Commissioner, stated that the TF met virtually last Friday during the NAIC"s Fall National meeting. The TF updated the anti-rebating amendments to Section 4(h) of the NAIC's Unfair Trade Practices Model Act – Model #880 – with two minor revisions. The TF appreciates NCOIL President, Indiana Representative Matt Lehman's participation and many contributions to the amendments. The NAIC feels the revisions strike the right balance between allowing companies to utilize new technologies to offer value-added products and services that mitigate risk and better serve consumers while ensuring appropriate consumer protections. The TF also heard an update from Rep. Lehman on NCOIL's insurance modernization activities. The NAIC looks forward to continuing to work with NCOIL and also state legislators on issues and legislation related to insurance innovation and technology.

Cmsr. Mulready stated that the TF also discussed comments from interested parties to its request for information related to continuing specific regulatory relief or regulatory accommodations offered by states related to technology and digitalization as a result of the COVID-19 pandemic. Nine responses were received and the TF summarized them in a document that is available on the NAIC website. The summary includes response tables grouping them into four main categories including which organizations offered a similar or same suggestion. The tables covered the following main areas: electronic commerce; regulatory capabilities; claims facilitation; specific to surplus lines. While most did not include the specific statutes or statutory language they recommend eliminating or revising, the TF did receive the specific recommendations to develop a bulletin to address concerns relating to existing legislation and/or issues related to the state by state implementation of e-signature laws including the Uniform Electronic Transactions Act (UETA) and existing obstacles to moving ecommerce forward.

The TF members are now in the process of determining which issues to prioritize in the 2021 work plan. The TF has also combined the Big Data and Artificial Intelligence Working Groups to create synergy and efficiencies as the use of big data and intelligent algorithms by the industry are so intertwined it just makes sense to combine those two groups. The TF plans to move forward in 2021 with developing a regulatory framework and strategy for reasonably and meaningfully overseeing and monitoring industry's use of big data and intelligent algorithms like AI and machine learning. The TF may start by looking at the development of a corporate governance model or guidance consistent with the intent and expectations of the AI principles. NAIC looks forward to continuing to work with NCOIL on these important initiatives. Rep. Lehman stated that it is always a pleasure to work with the NAIC and that TF and he looks forward to working with them going forward.

b.) Producer Licensing

Wes Bissett, Senior Counsel, Gov't Affairs at the Independent Insurance Agents and Brokers of America (IIABA), stated that he appreciates the opportunity to talk about how the COVID-19 pandemic affected the agent-broker credentialing process at the state level – things like what agents need to do to obtain licenses and what they need to do maintain those by completing continuing education. It is safe to say that the regulatory framework for credentialing and many other things underwent a fairly significant stress test in recent months and at least as it relates to agent licensing and CE issues, the states did very well from IIABA's perspective. Both legislators and regulators deserve a lot of credit for how things played out.

Mr. Bissett stated that he attributes the success to two things. First, there was a very strong statutory framework in place which is based in large part on the NAIC's producer licensing model law which has been broadly adopted by most states. It is flexible and gave regulators the authority that they needed to act on some of these issues. Second, and perhaps more importantly, over the last two decades the industry stakeholders have been working in concert with legislators and regulators to create an online platform that allows agents to satisfy these types of administrative requirements like renewing a license electronically. So, all of that investment of resources and hard work over the last 20 years really paid off during the pandemic.

Mr. Bissett stated that COVID has had an impact on existing licensees and on people trying to get into the industry. IIABA's focus was largely on those existing licensees who already have existing customers and less so on people who were new and trying to get in. If you were an existing insurance agent there were a couple of potential questions that might have come to mind: renewal of license and continuing education requirements which many people do in person. There were 33 states that issued bulletins that provided extension of time for agents to comply with their renewal and CE requirements and that was helpful. In some ways that may not have even been necessary because of the work that has been done over the last 20 years. Agents in most states now can renew licenses online and can comply with most of their CE online so while it was nice to have that flexibility and a little bit of breathing room in a very difficult environment to comply with those requirements they were arguably not necessary. Mr. Bisset stated that his phone was ringing off the hook in the Spring but not from agents and existing members with concerns about renewals of licenses.

A bigger issue was the universe of people that were not in the industry and were trying to get licenses for the first time. The hurdles that they were facing were an inability to pass an exam which you need to do in order to be licensed for the first time because you couldn't go to an in-person site and take the exam and secondly, their inability to undergo a criminal background check which is another perquisite because they need to give their fingerprints to regulators in order for that to happen. The good news is that the state regulatory framework had already anticipated this and there is a provision in just about every state code that allows for temporary licensing. Under the NAIC model and laws in most jurisdictions, states can issue temporary licenses of up to 180 days. Commissioners have a lot of discretion when they do that and can condition and post special requirements on anyone obtaining such a license and one of the features of that is that if you are getting a temporary license you have to have a sponsor, either a licensed agent or licensed company that is prepared to assume full responsibility for the actions of that temporary licensee. There were some in the industry that were pushing further for states to issue full blown licenses to new applicants during the process but the temporary licensing system in the IIABA's view worked well and there were 30 states that took advantage of that.

One other development is that we are already seeing states obviate the need for temporary licensing because they are already beginning to offer on-line examinations to new applicants. In less than a year since the outbreak of COVID there have been 26 states that now offer online exams that didn't at the beginning of the year and there are more states on the way. States have the legislative authority to do this. The NAIC Model gives regulators the ability to issue rules and contract with vendors and according to the NAIC they are not aware of any state where there is a statutory impediment to online licensing but there may be some regulatory impediments. So, from a legislative

perspective, the IIABA does not see a need for significant or sweeping legislation or a new Model relating to credentialing.

But, the IIABA does think there is an important role for legislators as it relates to oversight. One of the things that COVID has highlighted is the importance of making compliance with simple administrative tasks easy and simple and maybe look at the more substantive issues differently. So, one thing IIABA would urge NCOIL to consider is that there has been an effort over the last few years to create a multi-state system where an agent can go online and renew their license in just about every state electronically in one stop. The impediment to that is that there are a handful of states that the National Insurance Producer Registry (NIPR) calls the NIPR 5 that don't offer the full functionality of the NIPR at the moment so it is really holding down opportunities for a national registry system.

At the risk of alienating legislators in some states such as WA and NY which are in the NPR 5, getting all states onboard with that electronic licensing opportunity would be significantly helpful. The IIABA also urges legislators to monitor the emergence of new online examinations to see if there are hiccups and if there is a need for legislation. But at the moment it has largely been a success story largely due to the stator frameworks enacted. If something changes, the IIABA wont be reluctant to come back to NCOIL with potential legislative recommendations.

Ms. Melchert stated that temporary licenses really were a godsend during the pandemic because when there were shutdowns people couldn't even go to the facilities because they were closed and weren't deemed an essential business although insurance had been; and when lockdowns loosened, social distancing restrictions and indoor limitations were still in place which meant that you had less capacity at these testing centers and you had a backlog of tests that had not been able to be taken for the last couple of months. Also, in Illinois for example, the testing company that does tests for all professional licenses includes insurance licenses so when you add all of those tests together there were obviously problems. Online testing is being worked on but by the ACLI's count there are only 23 states that have implemented online testing and 4 of them have continued to provide temporary licensing.

Ms. Melchert stated that as noted by Mr. Bissett, there is a great framework out there that provides for temporary licenses. No one wants the temporary licenses to go on indefinitely but the industry was faced with the reality of even with the temporary licenses, some of them were for 90 days, some for 120, some for until the end of the emergency which is all well and good but then you run into the problems of the backlog in testing centers so that is why there was an effort made to get more states onboard for online testing. While there is not a need for any legislative action here in terms of a Model law, legislators are encouraged to talk to their DOIs to determine what they need to implement online testing. Sometimes there are contractual issues as you have to get a new contract with a new vendor and that takes time going through the government administrative process.

The other issue the industry is running into now even when we get to the online testing is the processing of fingerprints and background checks. There are states that will not issue the license until they get the fingerprint report back from the FBI and that is being delayed up to 6 weeks. These are folks that have passed the exam and have got a sponsoring insurer. To that end, it may be helpful to look into a provisional license to fill

in that gap and would automatically become a permanent licensing upon completion of the fingerprint submission and background check. Hopefully this never becomes an issue again but these are all things that don't need to happen anymore – we don't need to be in a classroom anymore to take an exam as there are university's that provide degrees without stepping foot in a classroom.

This is not a small issue for the industry as just two members of ACLI had over 2,000 temporary licenses from the start of the pandemic to now. These are people that are trying to get jobs and start a career as an insurance agent and when that is delayed they might not pursue it further in which case they have already spent a lot of money. That can also result in losing out on young talent and losing out on the ability to reach new communities and disseminate insurance products to them. ACLI appreciates all of the help it has received from legislators and regulators to provide for temporary licensing, online testing, and online learning and that is important for legislators to know as they return home to see what, if anything, they can do to make these processes easier and move them along.

c.) Remote Notarization

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that this is one of those issues that was always just dealt with and wasn't an issue until it became an issue. It is something that has always had to be done as every once in awhile we all have to get something notarized. Social distancing requirements and the pandemic in general brought this issue and others to the forefront that should be addressed from an efficiency perspective. Eliminating in-person notarization requirements and giving businesses the ability to remotely notarize certain things was a significant relaxation during the course of the pandemic and about three dozen states passed guidance, orders and bulletins on the issue. As you would expect, however, with so many states doing things different, folks were all over the place.

APCIA believes this is an opportunity for NCOIL to step in, particularly within the insurance space because NCOIL is the insurance legislators association, and take a look at where notarization adds value and where it provides a measure of consumer protection and perhaps where it is a requirement or procedure that has outlived its usefulness. In addition, APCIA believes that it is a good use of NCOIL's time to take a look at whether online notarizations should be utilized. We are able to meet virtually via Zoom and able to get licensed online and obtain degrees in a virtual setting so why cant some of these consumer protections requirements be done virtually as well. One of the things that has happened over the past few months and which both Cmsr. Mulready and Rep. Lehman have noted is the ability of both NCOIL and NAIC to come together and hash out Models and changes that provide a good amount of consumer protection as well as efficiency. APCIA believes that remote notarization is one of those areas and looks forward to having this remain on NCOIL's agenda in 2021 and working with the Committee going forward.

Rep. Jordan stated that he looks forward to working on this issue. Louisiana passed a bill on this issue and there was an Executive Order as well. One of the issues with the bill and the Order is that it requires you to retain the records for 10 years which is longer than the state attorney Bar requires – the Bar requires 7 years after the conclusion of a matter. Rep. Jordan stated that he would hope that whatever Model is passed by NCOIL

would comply with state requirements. If it is 10 years, so be it, but there should be a level of uniformity. Mr. O'Brien agreed with Rep. Jordan.

Rep. Lehman stated that it is interesting that when COVID began a lot of us realized that due to technology, some ways of doing things would be modernized. The two issues of producer licensing and remote notarization are two issues that Rep. Lehman stated he is glad to see moving forward because we should not go back to how we used to do it as the way we are doing things now is much better. Rep. Lehman stated that he looks forward to working on these issues.

Rep. George Keiser (ND) stated that the pandemic provided an opportunity for all industries, especially the insurance industry. The industry was able to respond in amazing ways and temporary licensing is one example. However, we are not where we want to be. We do not want temporary licensing as a standard because there is a great value of going through the full licensing process and protecting consumers. We need to work on all levels towards those things which we had to do out of necessity which we shouldn't really want to do and can be eliminated by action at this time.

Many states have gone to online learning and online testing so that issue has been eliminated for some states. Many states are still having a problem with electronic signatures and state legislators need to look at their legislation related to that and how the laws may be causing some problems with licensing and other issues. The federal government needs to look at this as the FBI has to come up with an anther way for getting fingerprinting done in a more reasonable timeframe than just saying we can't do it because of the pandemic. This meeting is an example of one of the reactions to technology. North Dakota is a very small state but within about two months of the onset of the pandemic, Zoom was the mode of operation in the state and if someone didn't have that capacity the state worked with them to provide such. We need to take the lessons learned from this pandemic and find solutions rather than saying if another pandemic occurs we will go back to temporary licensing, because it is not the best solution for consumers.

Rep. Jordan stated that he agreed with Rep. Keiser's comments. Separate from temporary licensing issues, Louisiana regulated hemp a couple of years ago and you have to go through a background check with fingerprints and there were a lot of delays with that. Accordingly, Rep. Jordan understands Rep. Keiser's concerns. With regard to remote notarization, a lot of Louisiana bankers wanted that as in Louisiana a notary is sort of a dying breed so ways are being looked at to determine whether some things need to be notarized going forward. Rep. Jordan stated that he looks forward to working on these issues and he agrees that temporary licensing shouldn't just be the standard going forward. With any crisis comes opportunity for innovation and this is an example of that so it is important to keep our thinking caps on and keep being innovative in these areas.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Asm. Cooley, the Committee adjourned at 4:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
TAMPA, FLORIDA
DECEMBER 10, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Tampa Marriott Water Street Hotel on Thursday, December 10, 2020 at 1:45 P.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Rep. Martin Carbaugh (IN)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Joe Fischer (KY)
Rep. Jim Gooch (KY)*
Rep. Derek Lewis (KY)*
Rep. Bart Rowland (KY)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)*
Sen. Shawn Vedaa (ND)
Asm. Kevin Cahill (NY)*
Sen. Bob Hackett (OH)*
Rep. Wendi Thomas (PA)*
Rep. Tom Oliverson, M.D. (TX)*
Del. Steve Westfall (WV)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Martin Carbaugh (IN), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES
Upon a motion made by Rep. Matt Carbaugh and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 26, 2020 meeting.

CONSIDERATION OF NCOIL VISION CARE SERVICES MODEL ACT

Sen. Bob Hackett (OH), sponsor of the NCOIL Vision Care Services Model Act (Model), stated that both sides have worked very hard on the Model but the best decision right

now is to table the Model. The Model is based on legislation that was enacted in Ohio but this Committee is not quite there yet in terms of being ready for a vote since both sides remain far apart from reaching a consensus on the Model. Accordingly, Sen. Hackett stated he would like to table the Model for now and perhaps re-introduce it at a later meeting.

CONSIDERATION OF NCOIL TRANSPARENCY IN DENTAL BENEFITS CONTRACTING MODEL ACT

Asw. Hunter thanked Rep. George Keiser (ND) for introducing the Model last year. Since that time, Rep. Deborah Ferguson (AR), Vice Chair of the Committee, has acted as lead sponsor of the Model.

Rep. Ferguson stated that the Model starts on page 106 of the legislative binders and noted that the Committee has come a long way with the Model since it was first introduced. The Model actually started out with five substantive sections but in a great show of compromise among everyone involved, it has been narrowed to three substantive sections: network leasing; prior authorizations; and virtual credit cards.

Rep. Ferguson stated that these issues are very important to her as a dentist and she is confident that the language before the Committee meets the ultimate goal of transparency – transparency in dental insurance and dental care is the ultimate goal which is why that word is in the title of the Model and has been the focal point of discussions. The provisions are important for dentists but ultimately important for patients because they are the ones left absorbing the costs. Rep. Ferguson stated that before final comments on the Model are heard, she would like to announce a few changes she has made to the Model since it was released in the 30 day materials.

First, the definition of “pre-treatment estimate” has been removed since that term is not in statutory language and to underscore that the Model is focused on prior authorizations, not pretreatment estimates – they are two distinct terms. Next, the word “written” has been included in the definition of “prior authorization” as under the current text oral communications could technically be considered prior authorization, which would be an impractical outcome in the real world. Next, in Section 1B. the words “sold” and “leased” are deleted to make that section consistent with the rest of the Model. Next, in the same section the second sentence starting with “A provider…” has been changed to “If a provider opts out of lease arrangements, this shall not permit the contracting entity to cancel or otherwise end a contractual relationship with the provider” – that change is to clarify the intent of that section; also, some of the language in the drafting note below that section making clear that the section doesn’t apply to leasing companies has been moved into the statutory section.

Next, on the same page in Section 1C1. the second sentence starting with “the third party access provision” will be replaced with “If the contracting entity is an insurer, the third party access provision of any provider contract shall also specifically state that the contract grants third-party access to the provider network and, for contracts with dental carriers, that the dentist has the right to choose not to participate in third-party access.” The reason for that change there is mainly that "clearly identified” is open to interpretation which could potentially be an issue if this language is adopted by multiple states and those states enforce different requirements.

Next, the drafting note regarding prior authorizations will be changed to “Dental services are authorized through prior authorizations, not pre-treatment estimates” just to make that language as clear and strong as possible. Next, Section D3 dealing with virtual credit cards will be deleted just to make sure there is no risk of sharing confidential information. Lastly, a Section will be included at the end of the Model providing the Commissioner authority to promulgate rules that are consistent with the provisions of this Act and the laws of this State.

Chad Olson, Director of State Gov’t Affairs at the American Dental Association (ADA), stated that he is glad to see that compromise has been reached on a lot of the issues in the Model. It is also great to see and hear from Rep. Keiser as he is the original sponsor of the Model. Mr. Olson stated that he looks forward to working with the Committee on further dental issues and is happy to answer any questions.

Teresa Cagnolatti, Director of Gov’t & Regulatory Affairs at the National Association of Dental Plans (NADP), thanked Asw. Hunter, Rep. Ferguson, Rep. Keiser, and the Committee for the work on the Model thus far. Ms. Cangolatti also thanked the ADA for being receptive to the NADP’s comments on the Model. What has emerged from those conversations is that there is a common goal of ensuring that folks have access to quality and affordable dental care. That is what makes NCOIL such an important organization since it can provide a forum to discuss these issues and find common ground.

NADP is glad to see that the leasing provisions of the Model have taken a thoughtful approach and recognize that leasing benefits a number of parties including consumers, providers and insurers. The language has been modified significantly and everyone agrees that transparency is the most important thing. Dentists should have choices to be able to opt-out of the leasing network and they should be well informed. The Model accomplishes that although there is one remaining concern with the Model as currently written.

In two sections there are requirements during the contract renewal process. One is that a list be given to providers of all third parties in existence every time a contract renews. The other is that dentists be given the opportunity to opt out every time the contract renews. It is worth noting that the contracts generally renew on an annual basis and that systems have been built up to make things easier for the provider and everyone that is involved in administration by having the process occur in an automated manner. Given that the Model already requires that carriers inform providers of all the third parties in existence through a website that is updated every 90 days and notify the providers of any new third parties that are purchasing the network 30 days in advance the Model is achieving the joint goal of making sure that providers are well informed without the requirement of the extra renewal language. Accordingly, NADP would like to see the renewal language removed because of the redundancy.

Ms. Cagnolatti thanked Rep. Ferguson for the amendments she discussed earlier regarding the distinction between pre-treatment estimates and prior authorizations. That is important as an industry to say that the most important thing from their perspective between prior authorization and pre-treatment estimates is that a pre-treatment estimate is a voluntary process and is not binding. It is not a guarantee of payment and is not a determination of the necessity of medical services. The amendment is therefore

important to make clear that distinction. Ms. Cagnolatti thanked the Committee again and stated that she is happy to answer any questions.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), stated that he echoes Ms. Cagnolatti's comments and thanked the ADA for its work on the Model. AHIP shares the concerns noted by Ms. Cagnolatti. AHIP appreciates all of the work on the Model and it's a tremendously improved Model.

Rep. Matt Lehman (IN), NCOIL President, asked what the reason is for requiring the notification relating to renewals. Mr. Olson stated that redundancy on informing providers of new relationships while the contract itself might not change but new leasing arrangements might have taken place – it would be good to have it both on the website with notification and on renewal. More of these relationships are taking place than ever before. Also, the renewal language is current law in CA, CT, IL, NC, NE and NJ so there is precedent around the country for this.

Upon a Motion made by Asm. Cahill and seconded by Rep. Keiser, the Committee voted without objection to adopt the Model, as amended, by way of a voice vote. Rep. Ferguson thanked Rep. Keiser again for originally introducing the Model.

CONTINUED DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT

Asw. Hunter thanked everyone for their work on the Model thus far and noted that she has had several conversations with insurers, providers, and constituents regarding their concerns about telemedicine. Asw. Hunter stated that she is confident the Model can get to a place where everyone can support it.

JoAnn Volk, Research Professor at the Georgetown University Center on Health Insurance Reforms, thanked the Committee for the opportunity to speak. The use of telehealth has jumped dramatically as one estimate says there have been almost 1 billion visits this year and one insurer stated that they covered more visits in April than all of the previous year. About two dozen states issued temporary bulletins or emergency orders from their department of insurance under their state's public health emergency authority to relax standards that were in place and encourage greater use of telehealth. That was done not just to encourage proper care and reimbursement levels but also to encourage social distancing and keep people safe.

Ms. Volk stated that amidst all of this, it was a great time to look at state laws to see how they operated prior to COVID and how they might operate after. With funding from the Commonwealth Fund, a 50 state survey is being conducted and some preliminary data can be shared. Regulators were part of the conversation in 10 states to get their feedback on the bulletins and how telehealth has been operating. About three dozen states already require coverage of telehealth visits on par with in-person visits generally saying that if it's a covered service and it's provided via telehealth it must be covered or cannot be denied just because it was a telehealth visit. The next most common feature is that about two dozen states require parity and cost-sharing – that the insured cannot be charged more and in some cases they must be charged less for telehealth visits. Less common but still substantial is that about a dozen states require parity in reimbursement to providers – it can be no less than what is provided for an in-person visit. There are a handful of states that have addressed other, smaller issues. For example, you cannot

restrict the medium that is used which is where the audio-only comes in; a requirement to have a prior relationship; or limit the point of origin which can be broadly defined as anywhere a patient is in their home can qualify for a telehealth visit.

The temporary orders or bulletins under the state public health emergency authority vary. Some just remind of the laws on the books; some encourage but don't require greater access to telehealth; and about two dozen states either relaxed standards or suspended standards that were law prior to COVID. The common themes for the latter approach were to limit or entirely eliminate cost-sharing for consumers, limit or eliminate the use of prior authorization for telehealth visits, or to remove other conditions that might limit access to telehealth such as requiring a specific platform or medium. That is where several states allowed audio-only visits as many states had not allowed such prior to COVID. That became a critical piece of state orders in recognizing that not everyone has broadband access or the right devices to do an audio-visual visit. There was also a recognition that there were greater needs for behavioral health during this time and some people felt more comfortable with an audio-only visit for that type of care. Other conditions that were often waived were that you had to have a prior relationship with the provider or some states would limit the requirement to cover telehealth equal to in-person if it was with an in-network doctor or even in some cases was provided through a telemedicine network. Another common feature of the temporary orders was that reimbursement cannot be lower than what is done for in-person visits.

Going forward, studies show so far that where there were temporary measures regarding reimbursement levels, that will need to be addressed by the legislature in terms of making anything permanent. There were a number of states that had it on the books already and it was not an issue but it will be an issue for those states that either implemented something entirely new or different from what was existing law. The audio-only issue also seems to be one that will be made permanent following COVID. There are also a number of ways states are collecting data on these issues to see how they are working out. In a number of states, the legislative efforts that pre-date COVID really were led by state legislators that were often providers in which case there were year to year standing working groups and these updates were included there. One state insurance department reported that they held a data call with insurers to get some data from them about what they are seeing in terms of use. Others tapped into existing working groups whether with primary care providers or coalitions of mental health providers and consumer representatives to hear about the use of telehealth for those communities. The one clear benefit that was heard throughout all reporting was that there were fewer missed appointments with telehealth and it has been a benefit to maintain access for people, particularly those with chronic conditions who need regular visits.

Jennifer DeYoung, Director of Public Policy, Building Blocks of Health Reform at United States of Care (USofCare), stated that USofCare is a non-profit, non-partisan organization with a mission that is both bold and simple – that everyone in the country should have access to affordable healthcare no matter who they are. And specifically, the goal is intentionally twofold: first - expand access to quality, affordable health care in the near term; second - pave a path toward durable, people-centered federal policies that achieve the mission. A key element of strategy is bringing different perspectives to the table to solve problems. USofCare sees its brain trust, its founders council, entrepreneurial council, voices of real life, and bipartisan board of directors as its unique superpower which sets it apart from other organizations working in this

space. USofCare also plays a unique role in focusing first on where people are and what they are experiencing in the healthcare system. USofCare takes time to listen and understand what their experiences have been like and then uses that information to help inform the solutions that are put forward to solving pain points in the healthcare system.

Ms. DeYoung stated that this year, USofCare has launched a new body of work focused on virtual care. As we have all seen, COVID-19 has brought to light the longstanding problems with our healthcare system including equity issues around disparities such as how some people like black or Hispanic Americans get unequal access to care. USofCare sees a window of opportunity to make meaningful lasting changes to the healthcare system to make the system work better for all people for the long term beyond the pandemic. With virtual care, which USofCare is defining as including telehealth, remote monitoring and other remote forms of communication, USofCare is interested in learning about how virtual care is much more than just another shiny new tool that's out there but rather how it's helping closing gaps and getting people the access they need. To get at that, USofCare is understanding the patient's perspective by doing a national listening tour with people, providers and other key stakeholders to learn about their experiences with virtual care. That is going to be paired with what is learned from people and the research evidence that experts know so what's missing with virtual care can be highlighted and what more can be done to ensure virtual care is working for everyone.

Ms. DeYoung stated that if you go to USofCare's website you can see some products that have been offered so far and some that will be offered in the coming months. Ms. DeYoung stated that she is excited to share with the Committee what USofCare is learning from people and from its research all of which is critical to helping inform how to create policy so that we can ensure policy is focused on what people need the most. USofCare recently fielded a national survey at the end of November to 1,000 registered voters where they were asked questions about their experiences with the healthcare system overall and with virtual care specifically. 44% of respondents have received virtual care most doing so as a result of COVID-19. About half of those that received it identified as Republican and half as Democrat. 59% of those with a disability received virtual care. 73% of those who used it said they had a mental health disorder. Overall, it was found that there is wide support for the convenience of virtual care, especially during the pandemic. 87% had something positive to say about the virtual care experience and 72% appreciated the convenience of not having to leave their place of residence to receive care and the ease of scheduling.

However, many respondents have concerns about the accuracy of care and concerns about the technology. That aligns with what was heard in 101 interviews as well. For example, one older adult interviewed said he would not explore virtual care if he had to do it on his computer or any other way than a phone call because then he would need help from other people and he believes healthcare appointments should be private. Additionally, another point that is very insightful is understanding why people are not using virtual care. According to the poll, of the 53% who had not used virtual care, 16% had not done so because they felt it wouldn't be personalized or meet their specific care needs. Focus group participants also questioned whether they would receive subpar or impersonal care if not done in person. Those are important points to consider as virtual care policies are formalized – how can you retain what's working while addressing what isn't.

Ms. DeYoung stated that to compliment its poll, USofCare has also honed the existing research evidence to understand what other researchers are saying about the barriers people are experiencing with using virtual care. Some barriers are shared across populations while some are unique to certain segments. If we are going to take this unique opportunity with virtual care and design it for the long term so that it helps to get people access to care who in the past have struggled to get the care they need then we need to pay attention to these barriers – what's causing problems now so we can address them in permanent policies.

As next steps are considered regarding virtual care including making permanent the existing emergency actions it is critical that policies are evaluated against criteria that places the needs of patients at the center. If we want to see patients get the care when they need it rather than waiting until an emergency, whenever clinically appropriate, patients must have the flexibility to choose how they would like to receive their care whether it is in person or through any of the virtual modalities. Permanent virtual care policies should address barriers people experience in accessing virtual care so that virtual care is viable option for them.

Ms. DeYoung stated that USofCare did submit specific amendments to the NCOIL Model which focus on strengthening the Model to make sure that barriers people experience are addressed. The increased need for virtual care across all populations due to COVID-19 has demonstrated just a baseline of virtual care's potential capabilities to help achieve better care and address longstanding inequities in access. By putting the patient first, permanent virtual care policy measures have the potential to close gaps in healthcare access.

Mr. Peppard stated that as AHIP has previously testified, health insurance providers are supportive of the appropriate use of telehealth to provide access and to reduce costs for necessary medical services. AHIP is supportive of several provisions of the Model, however, there are some provisions that AHIP is concerned with and AHIP has provided a red-line of the Model with recommended changes.

AHIP believes that health insurance providers should have flexibility in the design of benefits. There is language in the Model that limits that flexibility and that is recommended to be modified or removed. AHIP is also specifically concerned with requiring equivalent telehealth and in-person payment rates. That eliminates the cost-saving potential of telehealth and can create disincentives. There was a recent National Governors Association (NGA) report which includes the perspective that there are efficiencies in telehealth making it a lower cost service and requiring payment parity misses an opportunity to lower costs. Mr. Peppard stated that while AHIP reads the Model to require payment parity, it has heard that there are some that suggest that it does not in fact do so. If there is a belief among Committee members that the Model does not require payment parity and there is a reluctance to remove that language identified AHIP would when request an amendment that specifically states that the Model does not require payment parity.

Kimberly Horvath, Senior Legislative Attorney at the American Medical Association (AMA) stated that the AMA continues to support fair and equitable payments for telehealth which will help advance the investments in telehealth by physician practices across the country. Since the Committee last met there have been some results from a telehealth impact survey of healthcare providers which was performed by the COVID-19

healthcare coalition. The survey provided some finings relating to quality of care, patient experience, cost to professionals and certain barriers. Over 75% of clinicians responding to the survey indicate that telehealth enabled them to provide quality care for their patients for both COVID-19 related care and a whole range of care as well. More than 80% of respondents indicated that telehealth improved the timeliness of care for their patients. A similar percentage of respondents stated that their patients reacted favorably to telehealth. Of importance to the discussion on payment, the biggest challenge respondents indicated for having telehealth was low or no reimbursement and that was identified as the biggest challenge or barrier to maintaining telehealth post-COVID – 73% of respondents indicated that was the case.

That is a key reason why the AMA continues to support equitable payment for services provided via telehealth and that really means that when services are comparable and commiserate with the services provided in-person that the payment should be the same. As we continue to promote innovation and as we continue to see value in telehealth moving forward and as physician practices continue to make significant investments in telehealth there needs to be certainty going forward with reimbursement models. Telehealth has become very important during the pandemic and there is a growing recognition that there are potentially long lasting benefits and value to continued use of telehealth in terms of patient outcomes and access to healthcare as well as the patient and provider experience. The AMA continues to do research in those areas and will share that going forward.

Asw. Hunter stated that Section 5 of the Model talks about allowing out-of-state providers access to compete with in-state providers. Asw. Hunter stated that she has had some conversations with providers who have said that is not equitable and asked for comments on that issue from the speakers.

Mr. Peppard stated that AHIP believes that Section allows for expansion of access and AHIP believes that is one of the good things that has come out of the pandemic related to emergency orders. It is important to note that when carriers offer telehealth as a benefit they generally already offer the ability to speak to providers who are in-state. Mr. Peppard stated that he is not sure he understands the concern that there wouldn't be availability to speak to providers instate.

Asw. Hunter stated that the providers are worried that out-of-state practitioners could essentially take in-state physician patients. Mr. Peppard stated that he is not sure AHIP views it that way and that is certainly not AHIP's intent with regard to increasing access. Ms. Horvath stated that the AMA continues to support state-based licensure and the Interstate Medical Licensure Compact as a path forward to helping physicians in particular that are interested in practicing across state lines. There is a really good reason to maintaining state-based licensure such as having various state laws that are already in place continue to be recognized like age of consent so that patients in states are protected and making sure that physicians and other healthcare providers are licensed and have oversight from the board of medicine of the state in which the patient is located.

Asw. Hunter stated that during NCOIL's virtual D.C. fly-in earlier this year, one of the biggest things heard during meetings with telehealth related to infrastructure. Asw. Hunter noted that all broadband access is not the same and presuming that someone has a smartphone doesn't

necessarily mean that they have FaceTime or data in order to make them able to have a substantive telemedicine appointment. Asw. Hunter stated that without that broad infrastructure investment then accessibility for telemedicine will not exist for those people who have the biggest barrier to access to healthcare. Ms. DeYoung stated that those points are being brought to light in the research being done and that is why allowing telemedicine visits over the phone is important because some people simply don't have the smartphone capability and that is a barrier. USofCare is part of a larger coalition called the American Connection Project that is aiming to examine and look for a broader broadband access particularly in rural communities.

Sen. Hackett stated that expanding broadband access is important and that is being worked on in Ohio. Sen. Hackett stated that he has had several telehealth visits and they all have gone very well. It is amazing how much telehealth has been used in Ohio. Sen. Hackett stated that he is for coverage parity but stated that almost ever provider he knows except for certain specialties say that telehealth is cheaper so there is a cost savings. So, why should the consumer not share in those cost savings?

Ms. Horvath stated that there is indeed a value to telehealth and what the AMA is trying to do right now is take advantage of this unique opportunity and look at the data and find out what that value is. It is also important to be cognizant of the fact that there is an investment as well for physicians and other healthcare providers as they are implementing this into their practice. There is an investment in electronic health records and making sure that everything meets the standards that are required and that everything is protected. Certainly, the cost in comparing it to in-person visits is again something that the AMA is looking at as well. The AMA is looking for consistency for healthcare professionals as they are providing and implementing these telehealth services as part of the services they provide to their patients. It is important to make sure that they know moving forward that payment will be commiserate with what they receive for in-person services in helping make sure that they can sustain providing services via telehealth.

Sen. Hackett stated that in Ohio they stated that it is up to the plans and the provider to negotiate. Certain specialties do indeed have an investment and they have to do things a little differently but in a lot of the areas of telehealth investment is minimal. Sen. Hackett stated that some of the visits he had with a specialist were just iPhone to iPhone. Sen. Hackett stated that he does not believe total payment parity should be required and also noted that Ohio is not going to codify the telehealth rules until everything settles and things can be examined after the pandemic. Certain specialists should have payment parity because of investments but others will even tell you that telehealth is cheaper for a provider and Sen. Hackett stated that is why payment should be negotiated between the provider and insurer.

Rep. Keiser stated that we sometimes talk like telehealth is brand new and it is at least 30 years old. Companies like Nighthawk have done screens on radiology from India and Australia because radiologists don't want to come in at night or on Holidays. As a result, the following Monday when the radiologist goes in they re-read it and that is only because of billing. Rep. Keiser accepts that accessibility and costs are going to increase dramatically because the system is utilized more but what are we going to do in terms of payment parity to a physician such as a dermatologist that looks at you over the phone and then says you need to come in to take a closer look – do they get billed twice at the

same amount? Mr. Peppard stated that such double billing is already being seen in Medicare already.

Rep. Ferguson stated that she is not clear as to why providers say telehealth is cheaper for them. When she talks to providers they are spending the same amount of time for telehealth on all different kinds of office visits. If you look at your EOB they should be charging you at the minimum level for the office visit because they are not able to do exams and tests and those kinds of things that they would do in-person. Rep. Ferguson stated that is why she is for payment parity because they are spending the same amount of time and they should be billing a lower level CPT code. Having said that, going forward everyone needs to not fall in the trap of thinking that everything that was an emergency order during the pandemic is appropriate care going forward. Much of it has been compromised care. Some of it is great but a lot of it is compromised.

Sen. Hackett stated that the percentages of appointments being held are tremendously Higher and if you talk to providers they will tell you that. Primary care providers will tell you that telehealth is cheaper and there are no travel issues and patients will show up for the appointments. Rep. Ferguson stated that the doctor is not traveling as those that are doing telehealth are scheduling a telehealth room just like they do for regular appointments so their time is equal so she is not sure how providers are saying it is less expensive.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that he would like to see this issue marinate a little bit as we continue to make our way through the crisis and see what happens in terms of further emergency regulations being promulgated and other legislation coming down the pipeline. Certainly, we should continue to offer guidance and determine whether a distinction should be made between audio and audio-visual visits and we need to determine the issues of duplicate billing for the same episode like an initial telehealth visit and then a follow-up.

Asm. Cahill stated that he is mostly concerned about getting right the reimbursement issue as that issue will determine the incentivization of delivery of healthcare and that is what we have to remember. When we make a decision about the economic relationship between entities we are actually making a decision about how those services get provided. Lastly, Section 5 of the Model is troubling. New York takes licensure of professionals very seriously and that is done in the Higher Education Committee. Competition between providers for scope of practice and protection of title and those sorts of things is very fierce. Asm. Cahill stated that he is not certain that a practitioner in another state would have the same scope of practice or have a title in that state that would match the title in New York and that is something that has to be reconciled. Asm. Cahill stated that he supports using the existing waiver process with telehealth but nonetheless the Model is very important to take up again soon and would urge other Committee members to consider all points raised today.

Asw. Hunter stated that she looks forward to further discussing the Model at the Committee's next meeting in March. It is unlikely that a vote will be taken then as the Committee needs to see how things play out in the states regarding further emergency orders so a vote in July is more likely.

INTRODUCTION AND DISCUSSION OF MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS

Rep. Tom Oliverson, M.D. (TX), sponsor of the Model Act Regarding Air Ambulance Patient Protections (Model), stated that he is very proud to sponsor the Model along with Delegate Steve Westfall (WV). The Model is very straightforward and the ultimate goal is to regulate these air ambulance subscription membership products as insurance. We all are familiar with the phrase – if it walks like a duck and quacks like a duck, it's a duck. That is really where he is coming from as sponsor of this Model in attempting to regulate these products as insurance.

Del. Westfall stated that he is very proud to sponsor this Model along with Rep. Oliverson and he completely agree with Representative Oliverson's remarks. Del. Westfall stated that he thinks air ambulance membership products were started with a good intention but the landscape has changed and memberships have become less relevant and at this point have become problematic because patients really don't need them. Membership is supposed to cover the balance billing portion that a patient may receive if their insurance doesn't pay. However, that has become less of a problem because of the gains with network participation. Also, there have been some complaints that they are marketed in a way and sold to people who don't need them. Del. Westfall stated that he looks forward to working on the Model with everyone and looks forward to seeing everyone in person soon.

Chris Myers, Executive Vice President, Reimbursement and Strategic Initiatives at Air Methods Corporation (AMC), stated that AMC supports the Model. AMC serves 49 states with over 400 helicopters and fixed wing aircraft representing over 65,000 time sensitive transport a year. When called by an independent physician for first response AMC has an asset deployed with highly trained clinicians and pilots within less than 15 minutes. The most common conditions treated are trauma, cardiac, stroke, and respiratory arrest where minutes matter to the outcome of a patient. During these unique times, AMC has transported over 4,000 COVID patients as well. As rural hospitals continue to close, AMC is the last line of defense to get patients to the trauma center that can best serve their needs.

Mr. Myers stated that over the last 4 years, AMC has deployed multiple strategies to make the patient-billing experience as transparent and as simple as possible. The guiding principle is to approach any billing concerns with what is best for the patient. To that end, AMC has aggressively pursued in-network agreements with any willing payer which has resulted in having 50% of its privately insured patients covered by in-network agreements with great partners like Anthem, Humana and most state Blues plans. That is up from only 5% 4 years ago. United, Aetna, and Cigna remain the final opportunities for AMC to be 100% in-network. Being in- network is the best way to remove the financial burden from patients and ease the reimbursement process. Additionally, AMC has deployed patient advocates that are individually assigned to patients with an out-of-network payer and a robust financial assistance policy so that the average out-of-pocket cost for a patient is $167 and getting lower. AMC does not balance bill patients and only sends patients a bill if they have never provided a payer of record or communicated to AMC to get qualified for financial assistance

AMC support the Model because it aligns with AMC's patient-centric approach and protects patients form unscrupulous insurance and insurance like products and related practices. Many membership sales tactics feel like being both arsonist and firefighter where consumers are scared into thinking they will have a big bill and therefore need to buy a membership to avoid an imminent peril from the same company that is

transporting them. That is the opposite of providers working to truly take the patient out of the middle.

The overwhelming majority of air ambulance transports are from Medicare and Medicaid beneficiaries today who have a defined fee schedule and copay. Medicare patients are disproportionately marketed to with tactics like “senior pricing.” The prevalence of these products being solicited to seniors is cause for question about whether regulation is needed. If only 25% of the 3 million air med care memberships are sold to seniors that would make it the second largest Medicare supplement product in the U.S. The lack of regulation of these membership programs today has created financial opportunists like Helimedic which launched a website selling the product but has no verified operations. It claims to cover the entire country in only minutes with only a few helicopters based out of Texas and California. Additionally, when you attempt to call the posted contact number it connects to no one yet they are still trying to sell ambulance memberships at $500 for an individual or $1,500 for a family even garnering local news coverage.

Mr. Myers stated that from a utilization perspective there are approximately 360,000 air medical transports a year which represents 0.11% of the U.S. population. Given the extremely low utilization of air medical services one wonders why there are millions of memberships sold each year. Additionally, 80% of AMC transports are covered by a set fee schedule. Given that dynamic, AMC has determined to apply resources to mitigate any patient out of pocket expenses to the patients that actually need it versus those that in all likelihood will never need it. Mr. Myers stated that he will leave it to others to conclude whether memberships are insurance products are not but a simple definition from Black’s Law dictionary states “insurance is a contract by which one party, the insurer, undertakes to indemnify another party, the insured, against risk of loss, damage or liability arising from the occurrence of some specified contingency.”

Borrowing from the Guardian Flight vs Godfread opinion, “if it looks like a duck, swims like a duck and quacks like a duck, a reasonable person can conclude that it is a duck.” Montana, New York, Connecticut and Wyoming have all decided to regulate memberships as insurance and Florida requires licensure and regulatory oversight as an insurance product in order to sell to Florida consumers. Patients and consumers should have full transparency in understanding the product they are purchasing and not have their care compromised or face unexpected bills. The arsonist and firefighter sales tactic utilized to sell air ambulance memberships puts undue pressure on patients and doesn’t fully disclosure the financial terms of the insurance product they are purchasing or the fact that it isn’t needed. Patients have sued membership providers for balance billing them when the patient has received a legal settlement and the membership provider has tried to collect those funds. Uninsured patients may not necessarily understand that per the contract terms of some providers they can be billed the Medicare allowable rate which isn’t covering their out of pocket costs. The one point that contract membership terms make abundantly clear is that they only cover the patient in the scenario that a specific provider transports them. This creates unnecessary and dangerous pressure on the patient to delay their care and wait for the free air ambulance transport. That is a risk that patients that need time sensitive air ambulance transport cannot afford to take. AMC has chosen a decidedly different path to memberships: you do not have to pay a membership fee to do what is best for the patient – it is part of the service provided.

The Honorable Glen Mulready, Oklahoma Insurance Commissioner, stated that the primary concern for the NAIC with this issue is consumer protection. Some consumers do not understand the limitations of the product and they are sold to people who do not need it as they have other coverage such as Medicare. The product is also sometimes sold to folks who cannot use it as they either do not live in the proper area and also they do not understand the cancellation policy. Some consumers also don't understand the need for the product. There is also a lack of review of rates and forms. Some states have acted upon this as North Dakota has banned the product pursuant to a federal judge ruling that states do have the authority to regulate subscription plans as insurance. NY and WY regulate the product as insurance. MT requires certification of the product. There was also legislation passed in TX requiring reciprocity in subscription services but that was vetoed. Other options under consideration in states include: banning the duplication of coverage and/or standardize the plans; regulate sales including disclosures and notifications. The Department of Transportation (DOT) is also looking at this issue.

Several reforms around this product have required disclosures that only participating carriers provide services in certain areas; requiring the patient is told they must be insured and the service must be a covered benefit; clarifying who does not need it such as in-network participants and Medicare and Medicaid enrollees; submission of data; and going through a dispute resolution program. The NAIC believes that the Model is on a good path but the overriding issue is the balance billing problem within the air ambulance industry. There is a bipartisan, bicameral bill that was agreed to in Congress in 2019 that would have set some parameters but it stalled out. The NAIC has not been involved in the debate surrounding the amount insurers should be paid. The NAIC has sent letters supporting the extension of protections to air ambulance consumers and preservation of state surprise billing laws.

The DOT also appointed the Air Ambulance Advisory Committee which was required by the FAA Reauthorization Act of 2018 to look at air ambulance costs and transparency. North Dakota Insurance Commissioner Jon Godfread was appointed as the state regulator representative and the report containing findings and recommendations should come out at some point next year. In addition, the DOT has requested comments on the need and ability of the Department to regulate air ambulance carries under current rules which prohibit abusive practices. The NAIC also submitted comments urging the DOT to act to protect consumers from abusive balance billing practices. There is no timeframe on that for further action.

On behalf of Global Medical Response (GMR), The Honorable Eleanor Kitzman, former South Carolina and Texas Insurance Commissioner, stated that GMR's footprint has expanded greatly since it last appeared before the Committee to discuss the NCOIL Model Act Regarding Air Ambulance Insurance Claims. GMR is very disappointed that said Model has not been adopted in any states and that the surprise balance billing issue is still present. There is surprise billing legislation proposed in Congress and the DOT Advisory Committee will be issuing guidance soon that may include some of the NCOIL Model concepts. As welcome as that will be, balance billing and membership programs are two very different things and GMR believes its membership programs represent a good value for many consumers and may be an even better option for many consumers.

GMR operates the AirMedCare Network (AMCN) which is the largest membership program in the U.S. with 3.1 million members in 38 states with 320 locations. Memberships ensure that members have no out of pocket expenses if flown by an AMCN participating provider. AMCN does not market in areas where it is not a first or second call provider which means that it is considered a go-to provider based on its service history with the dispatchers and it receives a significant number of transport dispatches in that area. The website coverage map indicates whether coverage is available based on a consumer's zip code.

AMCN memberships are distributed through three channels: direct to consumer which includes mail, digital and attendance at events by sales reps; employer sponsored programs with payroll deduction; and municipal site plans which counties, cities or other local jurisdictions pay to enroll residents for basic coverage which may have defined geographic or other limitations at the discretion of the local jurisdiction purchasing the plan but residents of that area are offered upgraded coverage at a discounted rate. The municipal site plans are currently in 20 states.

Cmsr. Kitzman then discussed AMCN's product membership application form. First, Section 2 asks for the names of all members of the household because a single membership covers all members of the household for the same price. Second, Section 3 contains membership and payment options. Monthly memberships are only $9 per month and an annual membership is only $85 or $65 for seniors which is anyone over 60 years of age. The terms and conditions also state that the membership ensures a patient will have no out of pocket flight expenses if flown by a company providing pre-paid protection against a company's air ambulance costs that are not covered by a member's insurance or other benefits or third party responsibility.

Further, AMCN provider air ambulance services may not be available when requested. Members who have insurance or other benefits that cover the cost of air ambulance services are financially liable for the cost of AMCN provider services up to the limit of any such available coverage. In return for payment of the membership fee, the AMCN provider will consider its air ambulance costs that are not covered by any insurance to have been fully pre-paid. Neither the company nor AMCN will be responsible for payment for services provided by another ambulance service. Additionally, there is an express provision regarding Medicaid that some state laws prohibit Medicaid beneficiaries from being offered memberships or being accepted into membership programs and by applying, members certify to the company that they are not Medicaid beneficiaries.

Cmsr. Kitzman stated that it is important to point out what is not in the application's terms and conditions: any restriction on the number of transports; request for medical information; request for insurance information. That means that every member of a member's household can receive unlimited life or limb saving air transport for as little as $9 per month whether the member is more likely to require transport based on medical condition or has insurance that could reimburse AMCN for its actual costs of transport. GMR has an average of about 2.5 household members per membership agreement currently.

Cmsr. Kitzman stated that she would like to address some misconceptions and understanding regarding memberships, including the mistaken notion that more in-network agreements with

insurers and/or elimination of balance billing is better for consumers than a membership. Any solution to balance billing or in-network wont solve the high deductibles and copays that consumers face. 81% of health plans contain deductibles and 24% of them are high deductibles. According to Kaiser Family Foundation (KFF) in their 2019 employer health benefits survey, there has been a 36% increase in deductibles in the last 5 years and 100% increase in the last 10 years.

With respect to deductibles and copays there is also an argument that they exist as a means to discourage over utilization and should not be forgiven or waived. Cmsr. Kitzman stated that in her experience that is a concept more common in P&C insurance and is intended by insurers to avoid the administrative expenses of low dollar claims and she is not sure how life and limb saving ambulance services dispatched by a third party could be over utilized by a consumer but she also disagrees with premise. Deductible buy back policies are available for various insurance products. There was also a statement made earlier that many members will delay their care in order to ensure that they are transported by a provider that is covered in their membership agreement. Cmsr. Kitzman stated that she is not aware of any evidence of that.

Often these dispatches are when patients are not even conscious and able to make that decision. There was also a reference to cancellation of policies and while it is not clear exactly what that refers to, once a membership fee is paid, GMR's contracts are not cancellable.

Another misconception is that a Medicare enrollee does not need a membership plan because Medicare covers air ambulance services. That is only true if the enrollee has purchased Medicare part B and there is still a 20% copay which based on Medicare's average payment for air ambulance services averages $1,391 which is 21 times the membership fee for seniors. It is possible that a Medicare supplement policy can cover the copay and AMCN includes a FAQ on its website advising consumers to check their coverage. It is also the case that Medicare has a very strict view of medical necessity and has a higher rate of denial for air ambulance services based on that medical necessity in which event a Medicare supplement policy would not provide coverage.

Additionally, several health and human services offices of inspector general advisory opinions have held that membership subscription agreements are permissible for Medicare enrollees under certain circumstances. GMR believes that AMCN's membership programs provide enormous benefits with little to no downside for consumers. If a consumer is transported by a third party, his or her membership benefit does not apply and he or she is not disadvantaged because of the membership agreement beyond the membership fee. If a member is transported by AMCN and is insured, AMCN pursues payment of the reasonable cost of the transport from the member's insurer only and accepts the ultimate payment by that insurer as full payment of its services. The member will never receive a balance bill. Moreover, AMCN waives payment of the member's deductible or copay which will be far more than the cost of membership. If the member is uninsured, the entire transport is covered by the membership agreement.

The proposed Model seems to categorize air ambulance membership subscription agreements as contracts of insurance and to regulate air ambulance companies that provide service through membership programs as insurers. Returning to the definition of insurance from Black's Law Dictionary, AMCN is not indemnifying the member with

respect to the specified contingency, i.e. that the member will need emergency air ambulance services and that AMCN will be dispatched and is able to provide such services. Rather, it agrees to provide the service through one of its participating providers if available. If AMCN is not dispatched or an AMCN participating provider is not available, AMCN has no further obligation under the agreement and AMCN expressly has no liability whatsoever for services provided through another air ambulance service. In the event that the risk of loss, the damage or liability arises from the occurrence of some specific contingency is interpreted as a protection against the risk of a catastrophic billing for the use of an air ambulance, AMCN would be the entity sending the catastrophic billing which never happens to a member and AMCN would then be indemnifying the member against AMCN.

Cmsr. Kitzman stated that Mr. Myers referenced the Guardian Flight case in which it was ruled that air ambulance subscription membership products were a form of insurance. The judge also stated, however, that it was unclear why ND has chosen to prohibit the practice when there is a clear need to address the affordability of air ambulance services implying that he thought subscription agreements did address the affordability issue. He also noted that MT had taken the opposite approach as had WA, AZ and GA. Several states do regulate air ambulance memberships as insurance and there is range of approaches as to how they do that. AK, NE and CA take a light touch while others have effectively expressly regulated the memberships out of existence.

Cmsr. Kitzman stated that she is not here to argue the legalities of it other than to say that GMR does not believe that the product is insurance and to say that just because a practice may be a form of insurance does not mean that it should be regulated as insurance and the best example of that would be warranty products which seem like insurance since there is a payment in advance for a promise to pay in the future for an event that may or may not occur. FL and a few other states regulate that as insurance but most do not. The goal today is to provide a broader, real world context for membership agreements and illustrate the tremendous value of them and to clear up some misinformation about them. Membership agreements may not be the whole solution to affordability of air ambulance services but they seem to be a good approach until a better complete solution is found which no one seems to have done yet.

Asw. Hunter asked if there have been any cases with state Attorneys General where they have filed suit against any of the companies for falsely selling products that they couldn't deliver on. Cmsr. Mulready said he is not aware of any but is not really qualified to answer that. Mr. Myers stated that he is not aware of any. The Helimed company referenced earlier just popped up in the last couple of weeks so there probably has not been enough time to investigate.

Rep. Derek Lewis (KY) stated that as he is in rural Kentucky in the mountains and accessibility is often an issue, air ambulance membership subscriptions are quite common in his area. Rep. Lewis asked Cmsr. Kitzman if she sees the product closer to an Amazon and should not be regulated as supplemental insurance. Cmsr. Kitzman stated that GMR does not believe that the product is insurance and should not be regulated as such but some states do in fact do so and there is a range of approaches as to how it is regulated. Rep. Lewis then had technical problems with his Zoom connection.

Rep. Jim Gooch (KY) asked Cmsr. Kitzman what percentage of GMR's memberships are Medicaid or Medicare recipients. Cmsr. Kitzman stated that none are Medicaid unless they have not told AMCN that they are. As referenced earlier, in the terms and conditions portion of the application by submitting the application they are representing that they are not a Medicaid recipient. Cmsr. Kitzman stated that she does not know the percentage of Medicare beneficiaries but will get the information and report back.

ADJOURNMENT

Upon a Motion made by Rep. Ferguson and seconded by Asm. Cahill, the Committee Adjourned at 3:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
TAMPA, FLORIDA
DECEMBER 11, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Tampa Marriott Water Street Hotel on Friday, December 11, 2020 at 3:15 P.M. (EST)

Senator Travis Holdman of Indiana, NCOIL Immediate Past President, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Jim Gooch (KY)*
Rep. Michael Webber (MI)
Rep. George Keiser (ND)*
Sen. Shawn Vedaa (ND)
Asw. Pam Hunter (NY)*
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Sen. Andy Zay (IN)
Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Sen. Shawn Vedaa (ND), and seconded by Sen. Jim Seward (NY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Sen. Vedaa, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 26, 2020 meeting.

ACCELERATING LIFE INSURANCE INNOVATION TO CREATE MEANINGFUL CHANGE

Brooks Tingle, President & CEO of John Hancock Insurance (JH), stated that it occurred to John Hancock a few years ago that one's life insurance company should care an awful lot about a customer living a long and healthy life. In the range of people that care about you living a long and heathy life, besides your immediate friends and family, your life insurer probably cares more

than anyone. It stuck JH as fundamentally odd that for hundreds of years we would underwrite the daylights of people and often times you would know more about one's health than that person's doctors but then upon issuing the policy just say "we sure hope they live a long and healthy life" but do absolutely nothing to help achieve that outcome. So, it occurred to JH that it should be doing more to help customers live long and heathy lives. As a historical note, it's not actually a new idea. In the 1930's, JH had such a program. At the time, most deaths were attributable to communicable diseases and things like hygiene were very important. JH had a program where they would send nurses around to customer's homes and teach them proper practices for maintaining hygiene to not spread communicable diseases. The American Medical Association (AMA) got cranky about it and said they were infringing on their territory so the program was shut down.

JH partnered with a company from South Africa called Discover Vitality to bring the program to life and JH has seen phenomenal results in the last five years in terms of offering customer's the education and incentives and rewards for taking steps to live a longer and healthier life. JH is not trying to turn everyone into a marathon runner but it has made a big impact on customer's lives and also the industry in terms of how people see life insurers – they are not just there for one's death but also to help them live a long and healthy life. It has been very apparent during COVID that this is the type of solution we need. During COVID, demand for life insurance has gone up as people are more aware of their own mortality and their own baseline health. JH built on that a year ago by building something called John Hancock Aspire – the first and only life insurance built for people living with diabetes. The population of folks living in the U.S. with diabetes is large and growing – over 30 million with 80 million pre-diabetic.

JH had surveyed those customers and over half of them think that they cannot qualify for life insurance. The reality is that the majority of those people do qualify from underwriting and they get very good rates. So, that program gives those people incentives and rewards and education and support for controlling their diabetes and they get a lower premium if they do. Accordingly, there has been a lot of innovation for JH around the ownership experience for life insurance as JH has gone from interaction with a policyholder once or twice a year with just a bill or annual statement to now 30-40 times a month through the Vitality program. Mr. Tingle stated that he believes the next big wave of innovation for the industry is around the buying process. If you think about life insurance, it is hard to find a product that is less fun to own and harder to buy.

Piece of mind is nice but it does center around the thought of dying so JH has tried to make it more fun with apps and games and rewards. Now we have to make it easier to buy – it is hard to think of a product more difficult to buy in this economy as consumers are used to one click buying on Amazing. People have to go through weeks of underwriting for life insurance. Buying a home is difficult but your realtor generally doesn't ask you for blood and urine.

Sen. Holdman asked if he purchased a policy from JH what are the next steps that he should anticipate would happen with the Vitality program. Mr. Tingle stated that JH made a decision a few years ago when Vitality was first offered that it was an optional benefit. In 2018, JH said every customer that buys a policy is going to get some type of Vitality benefits. There are two types of Vitality: Vitality Plus and Vitality Go. If you select plus you receive your policy and are invited to register into the program. Assuming you register, you are then given the choice of receiving a complimentary wearable device like

a Fitbit or Amazon Halo or you can participate in the Apple watch program. The key thing is that you don't have to do any of that – the program is all about carrots and not sticks. Sticks do work from a behavioral science perspective but if you buy a JH policy and chose not to use Vitality there is no harm as your underwriting doesn't change and your price doesn't change. But if you do, you get to claim a complementary device or participate in the Apple watch program and download the app and start sharing whatever information you are comfortable sharing like how many steps you take, whether you went for a preventative screening, signing up for the healthy food program that offers a 25% discount on healthy food purchases at over 17,000 grocery stores. You can go into the ecosystems and start taking advantage of all of the education and tools and support to live a longer and healthier life.

Sen. Holdman asked how JH measures success and what markers does it use. Mr. Tingle stated that long term the most pure definition of success is whether they are helping people living a longer and healthier life. The true answer for that, given the nature of the business, it wont be known for decades. In the short term, the markers looked at are the indicators of improved future mortality such as physical activity. JH Vitality customers are taking over twice as many steps a day as the average American. Also, preventive screening is a marker. We all know that when we approach different ages as a man or woman there are different screenings we need. Not surprisingly, many Americans don't adhere to those guidelines but Vitality customers do since they get points for doing so to adhere to those guidelines more often than the general public. So, JH is watching those indicators that will correlate to improved morality as that is the economic fuel that drives and supports the various rewards and incentives.

Sen. Holdman asked Mr. Tingle what challenges JH has seen during the pandemic and what responses were put together. Mr. Tingle stated that the pandemic has been a tragedy on its face but as someone who cares passionately about the life insurance industry, it is really dismaying to see how many people are dying from COVID that don't have life insurance. It may seem weird for a life insurance company CEO to say that he wishes they were paying more claims, but Mr. Tingle stated that he does indeed wish that was the case because that would mean more of the people passing away from COVID have life insurance. Mr. Tingle stated that he sits in his home office and sees the ticker of the number of deaths and thinks there should be a certain level of claims but in reality there is a fraction of that amount of claims because so many people dying from COVID simply don't have life insurance so that has created a call to action for the industry to ask itself how it can get Americans to make sure they don't die without life insurance.

As it relates to the Vitality program in particular, some features had to be changed. Vitality works such that you get points for doing things that help you lead a longer and healthier life: taking steps; seeing the doc; buying healthy foods; meditating; getting a good night sleep. It's like a frequent flyer program for doing healthy things. You get points; those point accumulate; that determines a status; that status determines how much of a premium discount you get and the value of those rewards. One way that people get to earn points is through gym visits. JH could see almost overnight in March that gym visits decreased sharply. JH knew who the people were that were going to the gym and they contacted them and offered them an alternative means of earning points such as taking a selfie of yourself working out at home. JH sent everyone a JH Vitality facemask and a number of customers said it makes sense that my life insurance

company sent me a mask to promote living a longer and healthier life. JH also held a virtual 5k. So, JH has had to respond with different elements of the program and it has seen different rewards being used less than in prior years. One of the rewards is a discounted hotel stay through hotel.com but no one is using that right now. Also, the healthy food benefit has gone down a bit as people are probably not going to the grocery store as much.

But, it has been great to react and change elements of the program and be able to serve and provide customers changes of the program through its newsfeed. People are much more interested in the program now as people are getting that the more healthy they are should they get COVID the better outcome they are likely to have. A reinsurance partner of JH did a survey of U.S. consumers which asked what's one thing you will do differently as a result of COVID and 70% of people said exercise more and lose weight which at first might not make sense intuitively but makes sense when you watch COVID outcomes and see the correlation between baseline health and the success of fighting COVID.

Sen. Jim Seward (NY) asked Mr. Tingle if he had heard him correctly when he said that there has been an increase in demand of life insurance since the pandemic as people have thought more about their mortality. Regarding the innovation theme, Sen. Seward stated for years we had heard about a shortage of producers and asked if there is any thought of more innovative ways of not only marketing but reaching potentially new policyholders and getting them signed up for life insurance other than the traditional sitting across the kitchen table with an agent.

Mr. Tingle stated that JH has seen an uptick in the demand for life insurance as applications to JH are up 10% this year versus last year and there has been an uptick in interest industry wide as well. Unfortunately it takes events like a pandemic to see such an uptick as the industry saw something similar after 9/11 as people started to think about their mortality and wonder if they are prepared. There has also been an uptick in people thinking about their overall health which has caused people to be attracted to the Vitality program. Regarding distribution, there are a lot of reasons why people are dying from COVID without life insurance protection. Sadly, a third of the population just has such financial pressures that they can't think about another check for life insurance – they have to worry about putting food on the table and rent. But, for other Americans that know they need life insurance but don't have it, part of the problem is distribution and connecting with customers as the industry doesn't have enough boots on the ground traditional card carrying insurance agents to find everyone and sit across from them at the kitchen table. The industry needs new ways to find them whether it is digital or the worksite or online or associations.

The other big barrier to people not having life insurance is that Mr. Tingle stated he is convinced it is the burdensome buying process. You have to really want it to get it. Mr. Tingle told a story of how he presented at a conference consisting of younger people interested in technology and following the presentations they were all very interested in the Vitality program and asked how they could get involved with the program and get a policy and they all wanted to know how to get it via their phones. Mr. Tingle tried to dress it up the best he could but the reality is that he could only tell them the real process which is very time consuming and burdensome.

Unfortunately, none of the young people followed up with him about the program after hearing about the process. Since life insurance is very difficult to get, Mr. Tingle stated he thinks you will see going forward a whole wave of innovation coming relating to the buying process such as the use of electronic health records. So many of us as patients have on our phones an app with our health records. This whole crazy process we go through today regarding requesting a copy of someone's health records and then waiting and reviewing it is burdensome. JH conducted a survey of U.S. consumers asking if they would be willing to provide a one-time limited use to electronic health records – would you be willing to share health records through an app if it meant getting life insurance in days instead of weeks. Over 60% of people responded yes so you will see a wave of innovation around the buying process.

Some things you will have to be careful about as legislators and regulators because there is a lot of data out there and you will hear a lot of talk about the use of big data to predict mortality outcomes and you can do it pretty accurately but for fairness reasons there are concerns. Mr. Tingle stated that he has a team of data scientists that if you give them someone's name and birthdate they can give you with 94% accuracy how a traditional underwriter will underwrite a case with all the traditional inputs. But we are not going to underwrite that way because what do you say to a client? The client will say why didn't you give me your best rate and under the traditional method you can say its because of your blood pressure or something else but under the data method you don't want to say its because our predictive algorithm underwriting model scored you to a 68 – what does that mean? It will be an interesting issue for legislators and regulators when thinking about making sure the industry uses data responsibly because we do have to think about improving the buying process as it should take weeks and months – it should take moments or a day or two with the right information but it has to be done responsibly.

You are going to see actors out there doing things differently because the data can be quite predictive. As an example, years ago there was a company saying that they could predict mortality and morbidity based on your cable tv bill as percentage of your income. It didn't work at all when you got to over $150,000 of income but if you made $35,000 a year and have a $250 per month cable bill the logic was that says a lot about your lifestyle. The model wasn't only the cable tv bill and included other inputs but that stuff actually kind of works but its not stuff we should be using for underwriting in Mr. Tingle's view. In his view, the best path to a more timely experience with a customer is some of the traditional and legitimate medical information as inputs but obtaining it much more efficiently and electronically and acted upon more quickly.

The industry does have to innovate as the growth rate has been extremely small considering inflation and we know the products and solutions are valuable so we have to make it easier to buy and more fun to own but we have to do it the right way.

Rep. George Keiser (ND) stated that regarding quick access via the phone it reminded him of what happened when agents came to him very upset about the time it was taking to get medical records from hospitals and providers. Rep. Keiser stated that he was amazed that the providers arbitrarily expanded the timeframe to almost 4 weeks and that resulted in really significant problems for selling of life insurance. Rep. Keiser asked how big of a problem that was.

Mr. Tingle stated that it has been a particular problem during COVID as the industry's reliance on traditional practices of a paramedical exam or an insurance exam or tracking down files at a doctor's office have persisted and there has been a strain on the healthcare system. Frankly, doctor's offices probably have better things to do right now than ferret out copies of people's records for insurance exams. Anything that slows down the process is bad for the customer, bad for the carrier and bad for the agent as they don't get paid until the sale is complete. That is why JH thinks utilization of electronic versions of those records can be so powerful. Its not like the carrier is getting different information tan what it is entitled to – it is just getting that information much more quickly without the agent having to chase it down or the docs office having to copy it or whatever they do. Its always been an issue and its been a bigger issue with COVID and JH is trying to move toward utilization of electronic health records much more.

Sen. Holdman asked what the level of insurance face value is that someone purchases where they aren't required to do the paramedical screening. Mr. Tingle stated it varies by company. It can get up to about $2 million below 65 years of age. He thinks you are going to see an arms race among carriers as to who can underwrite the highest amount for the oldest person with the least information. That has to be done responsibly but it will be good for consumers if life insurance is easier to get and easier to get the protection they need.

REGULATORY CHALLENGES AND TEMP-TO-PERM EFFORTS IN A TOUCHLESS SOCIETY

Jordan Martell, Vice President, Innovation Counsel at Pacific Life, began with some background information. Homo erectus is a species of human that existed for about 2 million years and we have homo sapiens which is all of us. The reason he is starting here is because there is an interesting parallel. By many estimates, homo erectus was the most successful human being to ever walk the earth. That species lasted for over 2 million years and we have lasted for only 300,000 years and given the way 2020 has gone sometimes its doubtful whether we will make it to 2 million years. There was a time on this planet that some people don't know about where many species of humans walked the earth at the same time and they connected with each other. That was true of homo erectus and homo sapiens as these two species competed and it is fairly obvious who won that competition.

Regarding competition, that is relevant to this discussion regarding innovation. Mr. Martell showed a slide of the first tools used by both homo erectus and homo sapiens which were fairly similar. There was no innovation at all with the tools used by homo erectus but with homo sapiens our current tools are smartphones and are very sophisticated. Accordingly, it is not that surprising why homo erectus is gone and homo sapiens are still here. Mr. Martell put forth to the Committee that innovation is the central thesis of the human homo sapiens survival and of the way our minds work – it is in our genes. Survival requires innovation. This is true not only on the species level but at the corporate level as well. More than half of fortune 500 companies have disappeared since 2000. In 1960, the average lifespan of a company listed on the S&P Index was 60 years. Today, the S&P index is made up of newcomers as the average age companies on that index is 15 years. These newcomers are supplanting the traditional powerhouses in the industries very quickly. McKinsey & Co. estimates that by 2027, 75% of today's S&P 500 will disappear. This speaks to the need of legacy companies that want to continue to

serve consumers to do so and embrace innovation to meet their consumes where they are.

Mr. Martell then discussed innovation in artificial intelligence. Mr. Martell sated that he often gets the question of why am I hearing so much about artificial intelligence right now. There are three reasons. First is the formula for AI. Formula doesn't mean a math formula; there is actually nothing very new about the math that underlies AI as that has been around since the 1950s and 1960s. What is new is the formula of data. The estimate is that over 90% of all human data has been created in the past 2 years. So, if you think back to the Bible and Iliad and Odyssey and Shakespeare and Milton and the burning of the library of Alexandria, all of that amounted to less than 10% of human data created. So, part of the formula for AI is data and a corollary necessary component in the formula is computing power. Moore's Law states that the computing power of a microchip will double every 2 years and so far going back to the 1970s when computer chips were new that has happened. So together, data and computing power are here and fueling the drive in AI.

An important aspect of this other than the formula for AI is funding. We hear a lot more about AI because frankly there is a lot of money there now. In 2019, there was $26 billion invested in startup AI companies. However, if AI was so wonderful and simple as this, we wouldn't be talking about it. We are also talking about AI because it has problems. One of the problems is data breaches. AI needs big data in order to be powerful but with big data comes big responsibility and unfortunately we are seeing a growth in the number of consumers impacted by breaches and the number of actual breaches happening. That is something that we as a society, as an industry, and as legislators and regulators, need to consider seriously. Another problem related to AI is the acknowledgement of the discussion happening today around the way AI can sometimes perpetuate inequalities. If you are relying on big data and that data has bias in it and you put that into a computer it shouldn't surprise anyone that the result of that equation will be a biased equation. Proxy discrimination has been a hot topic and there has been a lot of discussion and that discussion is being teed up again because we have the data and the computer power and the funding and the ability to run AI and now we need to grapple with the way to do it responsibly and to determine what data is acceptable to put unto AI and what data is out of bounds.

Mr. Martell then discussed modernization efforts in regulations. In 1903, about 10% of people had a landline telephone and that got up to 40% at about 1930. It peaked at around 1970. So, it took about 70 years for the landline to peak and it never got to 100%. Regarding the use of electrical power in homes, it took about 60 years to where it peaked and that never reached 100%. We still have homes that don't have electric power. You can contrast this info with consumer adoption of more recent tech such as internet, smartphones and tablets. Tablets started around 2008 and in 2019 there is still a vertical rise. The point is that there is a large trend of consumers that are hastening the adoption of technology in particular communications technology such as the internet, smartphones and tablets. People love these because they want to communicate and they are the technologies they embrace in their everyday life. They take them with them wherever they go. By contrast, if you go back to 2000 the internet is just barely taking off at about 20% of market penetration. In 2000, when e-signature law was enacted the fax machine was still the predominant way of communicating other than US Postal.

E-mail was not really widespread, text messaging was not heard of and smartphones did not really exist. Shortly after 2000 when e-sign came into effect the SEC issued guidance on record retention and that guidance to this date still refers to the use of microfiche. A lot has changed in the world of technology since 2000 and 2004 when the microfiche guidance came out. Very few companies still use microfiche but all of them are using internet and related technologies. So, there is a consumer adoption of technology advancing and that was only hastened acutely in March of this year with COVID. The phrase “times like these” in quarterly earnings calls has increased a lot since March. Since March, we have moved towards a touchless society. The point of this is that in addition to the larger trend of consumers moving into the digital space with great haste, we as a country have almost overnight moved to a work from home touchless society.

This transition has provided us with a proving ground to demonstrate that many of the technologies that we have seen consumers adopting are good for business and good for consumers because they meet consumers where they want to be which is in an online digital world. Related to the touchless society and COVID, there are a number of temporary accommodations that have been issued to the insurance industry that has enabled the industry to continue to serve our customers and to serve the communities where they operate. There is an effort underway to look at some of those temporary accommodations that have proven successful under the test of COVID and use this opportunity to make those permanent.

One of those accommodations has been the electronic delivery of documents. The e-sign act for insurance came into place in 2000 and many of the seminal technologies that transformed the country for the first time and enabled a new wave of growth and industry and connected people across the entire continent – all of the technologies are encapsulated on someone’s smartphone. Mr. Martell stated that in south California where he lives, there are sometimes wildfires and it can be almost virtually guaranteed that if he has to leave his house during a wildfire the entire family will grab their smartphones. Not everyone will have the time to grab important papers and documents. That is an important thing to consider because very early legislation like the e-sign act and some of those that came around 20 years ago before the smartphone was even a twinkle in Steve Jobs eye – they presume that paper has some inherent superiority over digital. There are some advantages to paper but there are also advantages to digital and it is important that consumers have a choice of where they get their documents. If they want them on their smartphone where they can take them everywhere they want to go and interact with people such as the JH Vitality product, we need digital capabilities and we need to enable that.

There are a number of trends looking at e-delivery. At the federal level, the DOL and SEC are both maintaining efforts to begin a dialogue around advancing e-delivery of documents. In the U.S. Senate today, there is an e-sign modernization act put forth by Sen. John Thune. It is not very clear what will happen with that as with many things in Congress things are moving slowly but there are models out there to demonstrate what an e-sign modernization act could look like. The Federal Advisory Committee on Insurance (FACI) also recently provided feedback to FIO asking them to explore barriers to e-delivery and issues of access to e-delivery tools. E-delivery is one space where there is a lot of room for improvement to try and meet consumers where they are.

Related to that is the use of electronic signatures and notarizations. Notarization has been around a long time for hundreds of years. Notaries are meant to ease people's concerns about the security and authentication of wet signatures. Today, to the extent that we have achieved some level in wet signatures, we have technology like an iPad where a person can have an authorization software that uses their IP address, thumbprint and personal pin code to serve as a fairly strong authentication that their signature is in fact there's. So, there is a lot of room for growth between the antiquated in person notary process and what new technology has enabled us to do. A number of states have tackled this issue through executive order and regulatory initiatives as well. Some of the temporary accommodations regarding remote notarization are important things for us to consider as an industry because life insurance is a hard product to buy and if we can make it easier and more digital where consumers are that is a way to expand access. There is a bipartisan bill in the U.S. House called the Secure Notarization Act of 2020.

The path is uncertain but it provides a model of what it could look like to modernize this structure. Also, FACI provided comments to FIO asking them to look at the issue of e signature and enhance the ability of industry to leverage these new technologies.

Mr. Martell then discussed in-person requirements. Not that long ago, we were still doing many forms of examinations in-person. Some genius said lets move from in-person exams to computer exams but that still involves people in a room taking exams on computers together so that didn't solve the social distancing issue. Today, however, there is a great number of technologies that enable us to program things in person as well we would on a computer. Zoom is an example. There are a number of examination technologies that allow the CA Bar for example to shift to online computer exams for would be lawyers. The shift to technology and meeting people where they are has allowed the industry to revisit as an industry in person requirements. There has been as successful trial in 2020 as a number of states have allowed relief from in person market conduct exams and financial exams of regulated industries. We have had a chance to try them in a way never before and as a society and hopefully legislators are getting more comfortable because we now have proven technology that can protect the process of examination and protect the branch exams and licensing exams and do just as well as if it was in person and it could be argued that an online or branch exam has an advantage over in person exams because inherently all of the data has to be digital and if you have digital data there are ways it can be fed into computers to streamline review processes that make exams more dynamic based on the ability of AI.

Asm. Ken Cooley (CA), NCOIL Vice President, asked as you look at this imperative change and evolution of things like e-sign law, are there other places where trends are popping up against legal frameworks that present problems that restrict change. One can go back to the history of change in the 1960s as everyone put their money into banks and banks would pay little interest and then there was high inflation in the 1970s and money market mutual funds appeared and people started moving their money out of the banks to where they could get a little more interest which led to the term disintermediation as the bank as the industry saw all their money get sucked out and eventually that led to all kinds of consequences. But change was afoot and it bumped up against existing structures and it upended and changed whole industries. Are there other areas besides e-sign where we could be bumping into change issues?

Mr. Martell stated yes and disintermediation is still a very real issue and you can ask any taxi cab driver in NY and CA about that although there was CA legislation around that recently. Disintermediation is still very real and the need to continue to innovate for legacy companies that want to continue to serve consumers is more important now than ever because technology is changing but regulations are not changing as quickly. Besides e-sign, remote notarization and e-delivery you can also look at things like Telephone Consumer Protection Act (TCPA) which is federal legislation on texting. That was designed when it used to cost you 15 cents every time you got a text message but that is not true today and it also doesn't contemplate technologies like snapchat and other messaging technologies. Although those technologies present regulatory challenges there are a number of areas with respect to regulatory burdens that impair the ability of legacy corporations like Pacific Life to compete with some startup companies. If you look at app based driving that was illegal in many states and they launched those technologies notwithstanding the laws in place and because consumers wanted that and those companies have been successful and the laws have been forced to shift or in some instance states have had to push back against those corporations.

Sen. Holdman stated that he authorized the no-texting while driving legislation back in 2009 and at the time they were brining that there was maybe less than 20 apps that you could load onto your phone. Indiana just passed hands free legislation this past year because we don't even know what the number is as apps are being developed every day and there are tens of thousands of apps you can download on your phone very day so it is a changing society in everything that we do electronically.

ADJOURNMENT

Upon a Motion made by Sen. Vedaa and seconded by Rep. Michael Webber (MI), the Committee adjourned at 4:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL - NAIC DIALOGUE
TAMPA, FLORIDA
DECEMBER 11, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Tampa Marriott Water Street Hotel on Friday, December 11, 2020 at 10:45 A.M. (EST)

Assemblyman Ken Cooley of California, NCOIL Vice President and Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Martin Carbaugh (IN)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)*
Sen. Shawn Vedaa (ND)
Sen. Bob Hackett (OH)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)*
Rep. Jim Gooch (KY)*
Rep. Kevin Coleman (MI)
Rep. Brandt Iden (MI)
Asm. Kevin Cahill (NY)*
Sen. Jim Seward (NY)*
Rep. Wendi Thomas (PA)*
Rep. Joe Schmick (WA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Sen. Travis Holdman (IN), NCOIL Immediate Past President, and seconded by Rep. Martin Carbaugh (IN), Vice Chair of the Committee, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. George Keiser (ND) and seconded by Rep. Carbaugh, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 25, 2020 meeting.

UPDATE ON STATE ADOPTION OF AMENDED NAIC CREDIT FOR REINSURANCE MODELS

Asm. Ken Cooley (CA), NCOIL Vice President and Chair of the Committee, began with an update on State adoption of the amended National Association of Insurance Commissioners (NAIC) Credit for Reinsurance Models. After much hard work, the NAIC adopted amendments to its Credit for Reinsurance Model Law and Regulation in order to incorporate certain provisions of the Covered Agreement between the U.S. and European Union, and a similar Covered Agreement between the U.S. and United Kingdom. Both NCOIL and NAIC have also been tracking each state's adoption of the Models, as well as listing all states' progress on both organizations' websites. There is also a handout that has been posted on the NCOIL website and on the conference app which shows a map of which states have adopted the Models.

Asm. Cooley stated that at NCOIL's last meeting in September in Alexandria, his home state of California had recently adopted the Model which he sponsored in the Assembly. Other states that have since taken action are New York and South Carolina. This topic has been on this agenda several times because of its importance to upholding the state-based system of insurance regulation. As a reminder, it is extremely important for states to adopt the Reinsurance Models, as amended, because pursuant to the terms of the Covered Agreements, U.S. state regulators risk federal preemption of state reinsurance laws unless the appropriate reinsurance collateral reforms are adopted into state law within 60 months from September 2017 – the date the Covered Agreement with the EU was signed.

Additionally, there is a separate, shorter 42-month deadline at which time the federal government will begin conducting an assessment of remaining non-compliant states. This will occur in February 2021. Both NCOIL and NAIC have been working hard to ensure that states adopt the Models so that there is no risk of federal preemption. Asm. Cooley stated that it will be very important for clerks in legislatures to provide legislators with all the deadlines on the Models and noted that the federal government may very well communicate directly with the NAIC on these issues. Asm. Cooley asked for an update as to how the NAIC's efforts have been progressing in terms of working with state legislatures to introduce and adopt this legislation.

The Honorable Glen Mulready, Oklahoma Insurance Commissioner, stated that before he provides an update on this issue, The Honorable David Altmaier, Florida Insurance Commissioner and incoming NAIC President would like to say a few words. Cmsr. Altmaier stated that he is looking forward to his term as NAIC President and stated that during his time as an NAIC Officer, an Insurance Commissioner, and a state insurance regulator, he has worked to ensure that the state based system of insurance regulation is protected. NCOIL and state legislative chambers across the country are committed to that goal as well and Cmsr. Altmaier stated that he looks forward to fostering and improving the collaborative relationship that NCOIL and NAIC have.

Cmsr. Mulready stated that at this point 16 states have adopted the Model with another 13 states having it under consideration. Many of the 13 states with the Model under consideration, including Oklahoma, had planned to adopt it this past session but that was interrupted due to COVID. The NAIC expects many of those states to adopt the Model during next session. Three states (CA, PA, VA) have adopted the Model regulation while four states (KS, MS, VT, WV) have the regulation under consideration. The NAIC anticipates more states adopting the regulation in 2020 as many states will be playing catchup on things that were paused last year due to COVID.

Cmsr. Mulready stated that the 2019 revisions to the Models implement the reinsurance collateral provisions of the Covered Agreements which require states to eliminate the collateral requirements entirely within five years by September 1, 2022 or be subject to federal preemption. The NAIC has adopted the 2019 revisions as an accreditation standard with the effective date of September 1, 2022 which coincides with the date of when the Federal Insurance Office (FIO) may begin preemption of state laws for any state that is not in compliance with the Covered Agreements. However, the NAIC will not begin enforcement of the new accreditation standard until January 1, 2023. Accordingly, it is very important for state legislatures to take action on the Models.

Cmsr. Mulready stated that so far the NAIC has not had any interaction with either FIO or the EU about extending the deadline but the NAIC has had some preliminary discussions with FIO on the status of state adoption of the Models in order to keep them up to date. The NAIC's best guess is that neither FIO or the EU will agree to extend the deadline and that states will need to adopt the revisions by September 1, 2022 or face the federal preemption by FIO. Continued state action on the Models is the best defense against federal preemption and the NAIC appreciates NCOIL's support. Cmsr. Altmaier stated that this is a very important topic at the NAIC and everyone takes their job as a state insurance regulator very seriously particularly when there is a threat of federal preemption. The NAIC feels good about the progress states have made thus far with adopting the Models and looks forward to a very productive 2021.

Asm. Cooley stated that the point regarding no anticipated flexibility from FIO gets to the issue of state insurance regulators working with various federal Administrations. The Covered Agreements began with the Obama Administration and moved into Trump Administration and now we will be moving to a new Administration. Asm. Cooley asked how the NAIC has viewed working with past Administrations and what its hopes are for a productive relationship going forward. Cmsr. Mulready stated that it really is to be determined but the NAIC is very hopeful for a productive relationship going forward. Cmsr. Altmaier stated that the NAIC is anxious watching the appointments the administration is making in the critical areas related to insurance.

In his experience he always looks to the 2008 Dodd-Frank reforms and as extensive as that was it mainly left intact the state based system and the federal government has mostly recognized that the system works and the NAIC will always work to maintain that. Asm. Cooley stated that it will be interesting to see how it unfolds with the Biden Administration making appointments. As a sidebar, CA had a bill that the CA Attorney General was looking to expand that office's power with health insurance. Asm. Cooley disagreed with the bill and after a long conversation with him the bill was laid aside but the CA AG's litigation background will probably be an asset to expanding health coverage and Asm. Cooley thinks he will do a good job and it will be interesting to see how he evolves in that role.

Cmsr. Mulready stated that the OK Department of Insurance (DOI) just went through its accreditation process and just recently received its 5 year accreditation. That was his first time going through the process and it is very robust to make sure there is prudent financial oversight over its domestics. Cmsr. Altmaier congratulated Cmsr. Mulready as that is indeed a robust process. The accreditation program has really been a testament to the state based system of insurance regulation and that will work to be maintained.

Sen. Bob Hackett (OH) stated that OH passed the Model recently and all is need is the Governor's signature.

Rep. George Keiser (ND) stated that both NCOIL and NAIC of course support the state based system of insurance regulation but when you look at this issue it really is the latest example of the federal government coming in and putting a gun to the state's heads and saying either you do this and create uniformity on this issue or we'll take it away – that is not really traditionally the state based system of regulating as we have had incubators across the states doing different things. Rep. Keiser asked if the revisions are appropriate for a small state like ND as compared to CA. At what point do we say we need to limit this blackmail process relating to regulation as we are starting to gradually lose the state system with such an approach.

Cmsr. Almaier stated that with this issue he believes that the NAIC followed a similar process in striving for consistency of prudential oversight of firms, but this issue was a little unique because it related to the Covered Agreement which had been done for the first time. The NAIC was miffed at first that it wasn't more involved with drafting and negotiations but unfortunately once it was ratified by Congress it had to be dealt with. But the fact that the system was retained, albeit by the process as described by Rep. Keiser, and the Models reflect strong state based principles was an advantage. Certainly, the aspects of future Covered Agreements underscore the need to stay involved in the communications. Again, this was a little unique because of the international situations that led to the need for the Covered Agreement and Cmsr. Altmaier stated that makes him feel a little better rather than the federal government saying there was an outright problem with the state based system, and the Models ultimately were drafted by state insurance regulators in collaboration with state legislatures.

Asm. Cooley stated that the point made by Rep. Keiser is interesting as with the rise of technology we see a more interconnected world and we have seen the formation of the EU and the Basel Accords with imposed privacy requirements. There have been a lot of dramatic things on the global scene and as big as the US is we have had to learn to interact with our partners. This issue of the Covered Agreements relates to the heightened levels of global activity and goes to the strategic issue of having a strong NAIC in place to negotiate in D.C. and lawmakers can support that. From time to time of course state legislators may want to have a sidebar with state regulators but legislators have an interest in presenting a strong partnership to the federal government so they feel that they are working in tandem and they can rely on us to ensure they have a seat at the table and important issues are addressed.

We all have a lot to learn in the current Administration and we have a lot at stake to form relationships that are important to developing sound public policy. To Rep. Keiser's point, it is important to recognize the variation across the 50 states which is the genius of McCarranFerguson and we don't want to lose that. Rep. Keiser stated beware of the camel's nose beneath the tent. This is not the first time this has happened – it's about the fifth. It's time to have an honest discussion about this because it is not state based regulation. NCOIL should be cautioned on this as there will be more instances of this in the future and we need to ready to address them. Asm. Cooley agreed.

UPDATE ON PROPOSED CHANGES TO STATEMENT ON STATUTORY ACCOUNTING PRINCIPLE (SSAP) NO. 71

Asm. Cooley stated that when this Committee last met in September in Alexandria, it had a robust discussion on the NAIC's Statutory Accounting Principles Working Group's efforts to update Statement on Statutory Accounting Principle No. 71 titled "Policy Acquisition Costs and Commissions." For those who did not participate in that discussion, the proposed changes deal with something that is called "commission funding agreements" that some insurance companies enter into with third parties. The issue is generally whether the arrangement should affect the commissions that insurers pay to their agents under statutory accounting principles by deferring recognition of that liability. We heard differing opinions as to whether the proposed changes are substantive as opposed to non-substantive. And, we had discussions on the NAIC's use of "incorporation by reference" as is usually the case when legislators hear of substantive changes being made outside the normal legislative process.

Regardless of whether substantive or not though, it seemed clear to all that this change is more than a clarification and could have a significant impact on companies' financial condition. When we left Alexandria, we were told that the NAIC had received letters from at least one Commissioner raising some concerns with the proposed changes which warranted further discussion. I also note that earlier this week, NCOIL CEO Commissioner Tom Considine sent a letter to the Chair of the NAIC's Working Group noting NCOIL's concerns with the proposed changes. Asm. Cooley asked is an update could be provided as to the status of the proposed changes, and what exactly happened after our discussion in Alexandria.

Cmsr. Altmaier stated that since the Committee has already discussed the specifics of the proposal, he will discuss the developments that have occurred since the Committee's last meeting. The NAIC re-exposed the potential revisions recently. The impact of that exposure most significantly is to move the effective date of the revisions. They were originally intended to be effective at the end of the year and the new effective date is to be determined and the NAIC will continue to go through its robust and transparent process to continue the revisions. Once they are completed the implementation date will be discussed. There will continue to be plenty of opportunities for stakeholders to engage on the revisions. The other development is that NAIC staff has been directed to draft an issue paper on the topic and it will essentially be a document to provide a historical reference on how the discussions have gone.

We have had some discussions among ourselves at the WG and Commissioner level about the substantive/non-substantive issue. The WG continues to feel strongly that they are non-substantive changes. The rationale for that is that the WG and Commissioners believes that the revisions are clarifying what is already the intent of SSAP 71 and the guidelines state that is the characteristic that determines whether or not a change is substantive or non-substantive. The NAIC has been told that some carriers may be impacted more than others. The NAIC is aware of four carriers that are utilizing these types of agreements that would be impacted.

The determination as to whether something is substantive or non-substantive is not necessarily the impact to the balance sheets of the carries but whether or not it represents a substantive change from the intent of the accounting principle so that is why this was designated as non-substantive. It is important to note that the designation of non-substantive versus substantive doesn't change the timing of the work as the revisions were started in 2019 and they have gone through multiple exposures and is currently in another exposure so even though it is designated as non-substantive there

are still plenty of opportunities for dialogue and engagement. In terms of the IBR process, this will be consistent with how the NAIC has done other revisions to SSAP – the NAIC does not view this as changing public policy. Rather, the public policy is already there and this is viewed as an implementation of that.

Rep. Martin Carbaugh (IN), Vice Chair of the Committee, stated that this seems to be a solution for a problem that doesn't exist as he has not heard about it from any constituents or regulators in Indiana. Cmsr. Altmaier stated that the instigating event of the revisions was the result of an examination that was conducted by a state on at least one carrier, perhaps all four. It was discovered that the carriers were not accounting for the arrangements the way the NAIC thought that they should and as a result, the NAIC felt that their financial statements were materially misrepresented. While that may not trickle down to the consumer level, it does speak to the ability of state insurance regulators to be able to review accurate financial statements of carriers to ensure the consumers are protected not only by ensuring the viability of the carriers but also ensuring the level playing field of the market. Through that examination process, that issue was discovered and states were in communication with the carriers to correct it but there were some difficulties so the state regulators that discovered the issue felt that clarifying the guidance would be appropriate to prevent it from happening in the future.

Rep. Carbaugh asked if there has been any thought given to a phase-in period for the revisions so that the financial health of the companies could be taken into consideration. Cmsr. Altmaier stated that the NAIC has discussed at a high level a phase in period but given the small number of companies that are believed to have these agreements it was thought to be more appropriate for those carriers – and it is thought that the carriers are already doing so – to engage with their domestic regulators to work through the issues and perhaps allow that phasing-in. It didn't seem appropriate to allow a phase-in period to be built into the guidance because it doesn't seem to be a large number of carriers that have the agreements and it would therefore be better for the domestic regulators to work with the carriers individually. Rep. Carbaugh stated the revisions seem very substantive and not at all a clarification.

Sen. Travis Holdman (IN), NCOIL Immediate Past President, stated that he agrees with Rep. Carbaugh that the revisions seem to be very substantive and IBR once again rears its ugly ahead so it is important to be forewarned as these issues may once again come back in the future.

Asm. Cooley stated that he believes the issue paper will be very important to document the discussions that have taken place. As a lawyer who has had a lot of work in this area, we only have the words in the statute to work with to find intent. To take a proposal and declare its intent which is itself sort of amorphous and say this fits with that intent ergo it is not new – that is not the matter in which law is generally constructed. State legislatures don't operate that way. The mere fact that someone was an author in fact doesn't make their view definitive on what the statute says – it is what the words are; how are they stated; and how are they construed in ordinary English usage. That is where the intent comes. Lawmakers are concerned with what the state of the law is across the 50 states and how that impacts the private sector and businesses. The law can always be changed but not just because on balance of what is stated the intent was thought to be.

Cmsr. Altmaier stated that there are two SSAP's at play – no. 5 which defines liabilities and no. 71 which speaks to this issue. SSAPs have been clear from the outset that policy acquisition costs have to be incurred by the carries upfront and that has been a fixture of account principles since they were drafted. The reason this was flagged during the examinations is that when state regulators saw these commissioned expenses, they were very clearly policy acquisition expenses that should be incurred by the carriers upfront. While some expenses from carriers can be contracted to third parties, policy acquisition expenses are not such expenses so the state insurance regulators at the time felt that those agreements were working around the statutory accounting requirement for them to be booked upfront so the NAIC believes that clarifying that was consistent with the original intent of the accounting principle which is why the revisions were designated as non-substantive.

Cmsr. Altmaier stated that certainly, the NAIC has had discussions about the non-substantive versus substantive issue so he certainly respects both opinions on the issue. With respect to IBR, every state does that a little different. Florida does so by rule and some states do it via statute and there probably are other mechanisms in other states. Cmsr. Altmaier stated that he will have to take the revisions to his Cabinet and they probably wont look at them specifically but they will be informed that the statutory accounting guidance is being amended. If the NAIC were to ever move away from statutory accounting, something that is not envisioned, certainly that would be considered a policy shift and a substantive change versus just implementing already existing policy. For now, the NAIC remains of the opinion that this isn't a change in policy but just implementing technical aspects of already existing policy.

Cmsr. Altmaier stated that he is hopefully that the removal of the effective date and the issue paper will clarify a lot of things and set the stage for additional discussion going forward.

Rep. Carbaugh stated that if a commission is scheduled at 1% per year for six years, that is 6% so what the revisions are saying is that all 6% should be accounted for in year one. Is that correct? Cmsr. Altmaier stated that is his understanding as well and he would be happy to check with one of the NAIC's technical experts to make sure. One of the key principles of statutory accounting and one of the reasons why it was important to have that type of accounting versus something like Generally Accepted Accounting Principles (GAAP) is to make sure that it had a little bit more conservatism built in as opposed to GAAP in recognition of the fact that when an insurance company sells a product they aren't certain how much that product is ultimately going to cost them so the accounting framework should be reflective of that and give state regulators the ability to quickly identify carries that may run into financial concerns. One of the principles that was established that is consistent with that conservatism principle is that things like those types of expense should be recognized upfront to give state regulators the ability to ascertain how much premium dollars need to be earned and if they start to level off if that becomes a financial issue for the carrier. Rep. Carbaugh stated that he doesn't follow the logic of that because if that's the case in his example, if the contact moves in year three and it moves to another company, they never paid the other 3% that had to be accounted for in year one – do they get a credit back? More generally, after 20 years of this, why now?

With regard to the latter question, Cmsr. Altmaier stated that first off, not many carriers are doing this. The NAIC is aware of four carriers so it wasn't something that become

readily apparent to insurance regulators that was even occurring until a group of carries went through their examination process so that is why the issue has arose now. With regard to the first question, that is a little more dependent on the relationship the carriers have with their agents in terms of what they have determined with respect to commission payments. Cmsr. Altmaier stated that his understanding with the particular arrangements in question is that the third party pays to the agent the commissions upfront – the entire lump sum and then it's the insurance company that reimburses the third party over a period of time. Depending on the specific wording of those contracts, if the insured was to move to a different carrier the third party has still paid the full commission to the agent and as far as he knows the carrier is still obligated to reimburse that third party for the full amount and that is one of thing things that complicates attempting to answer that questions.

Rep. Carbaugh queried whether this pushes companies to pay for it all upfront if they have to account for it all upfront to get rid of the ongoing commission and if that's the case that is a 180 degree turn away from the securities industry that is pushing everything away from commissions upfront and into the fee based ongoing earn the business every year mentality which is better for consumers. Cmsr. Altmaier stated that his gut reaction is that probably not because the majority of carriers are not utilizing these types of agreements so they continue to have the same commission structure and the accounting treatment its always had. Accordingly, given the fact that not many carriers utilize these types of agreements ultimately these changes to no. 71 should not have a material impact on the majority of the marketplace. Cmsr. Altmaier stated he is happy to discuss this further with Rep. Carbaugh.

Asm. Cooley stated that this topic is obviously important to legislators and puts a spotlight on the general issue of what is the basis for law and regulation in the insurance industry and the intertwined nature of statutory adoption and regulatory adoptions and at the end of the day each state regulator derives authority from state statutes – there is no other source of authority and as much as the NAIC has grown in size and significance, it's authority is strictly derived from state law so we must be partners. The change in the implementation date is a good one and leaves the conversation a little more open ended in the background work on the thinking that has underscored the action.

DISCUSSION ON NAIC'S SPECIAL COMMITTEE ON RACE IN INSURANCE

Asm. Cooley stated that NCOIL concluded the first meeting of its Special Committee on Race in Insurance Underwriting on Wednesday. The Committee had very productive discussions on the background on insurance industry ratings regulations; a definition of "proxy discrimination"; and the examination and consideration of various insurance rating factors. Asm. Cooley stated that he thinks we can all agree that the Chair of the Committee, Senator Breslin, and NCOIL President, Representative Lehman, did a great job in facilitating the discussions surrounding topics that are indeed not always easy to discuss.

Cmsr. Considine stated that he would like to briefly address the last issue discussed and comment on IBR. NCOIL holds out Florida's IBR process as the gold standard of how it should be done. If every state conducted the process in that manner NCOIL as an organization and the legislative members almost without exception wouldn't have an issue with it. By taking the items that go through the IBR process and putting them through the official regulatory process, that is considered to be the gold standard.

Rep. Matt Lehman (IN), NCOIL President, stated that he thought yesterday's meeting was very productive with speakers with different perspectives providing data-drive information. Rep. Lehman thanked Sen. Breslin for navigating through the meeting. NCOIL will process everything and then set a course of action. Rep. Lehman stated he is looking forward to continuing to work with NAIC. Rep. Lehman noted that he and NAIC President South Carolina Insurance Director Ray Farmer started their respective terms as NCOIL and NAIC President, they never thought they would have as much communication as they did this year on a wide array of issues. Rep. Lehman thanked him for that and stated that he is looking forward to working with Cmsr. Altmaier. It will be interesting to see where the data takes NCOIL on these issues.

Asm. Cooley asked if an update as to how the NAIC's Special Committee on Race in Insurance is structured, what its goals are, and what it has already accomplished. Cmsr. Altmaier stated that the NAIC's work stream started in the summer and they are in a similar posture in that they didn't expect to have these conversations in the beginning of the year. The Committee invites any Commissioner who would like to participate to do so. Normally, these types of committees have about 15-20 members but this Committee is up to 53 of 56 jurisdictions as members which underscores the importance that members have placed on these issues. The Committee is cochaired by Dir. Farmer and Cmsr. Altmaier and the co-Vice Chairs are NAIC Vice Preisdent and Idaho Insurance Director Dean Cameron and NAIC Secretary Treasurer and Missouri Insurance Director Chlora Lindley-Myers. It is no accident that the two co-Vice Chairs are the other two NAIC officers. It is great to have 53 members of the committee but that also makes things a little more challenging to get work done when you have such a large group of people so that has been broken down into five work streams.

The first two are focused on researching the level of diversity and inclusion within the insurance industry (1). Work stream number two is the same effort except that it focuses on the NAIC and the state insurance regulatory community. The third, fourth and fifth work streams look at what barriers might exist in the insurance sector that potentially disadvantage people of color and historically disadvantaged groups within the P&C industry (3), life and annuities industry (4), and the health insurance industry (5). The work streams have all been working very hard throughout the summer and the full committee has had two public meetings the most recent one being at the NAIC Fall National meeting last week. At that meeting, the Committee heard updates from the five work steams and they have reported some of the work the have been working on. The committee anticipates the work streams providing initial reports by the end of the year that includes their findings and initial recommendations to the committee. The initial recommendations will be more like recommending of things to further explore in 2021 and perhaps new work steams will be developed going forward.

Internally, the NAIC has demonstrated commitment to lead by example in this area and has just hired a director of inclusion and formed an employee based council on these issues that will be working with NAIC mgmt. and members on driving some of these cultural transformation efforts. We are all very encouraged by the discussions taking pace on these issues at NAIC, NCOIL and everywhere else. NAIC is looking to being collaborative and discussing these issues in 2021.

Asm. Cooley stated that his recollection is at the start of each year each Committee would identify its goals for the year. Is it the thought that some of these topics may feed into that

priority setting for the various NAIC committees? Cmsr. Altmaier replied yes and said if 2020 has taught us anything at NAIC you have to be ready to pivot your priorities as they are different now than what they were at the beginning of 2020. The NAIC did specifically note when adopting the charges for the letter committees that they haven't changed the charges for the Special Committee but anticipate revisiting those charges and the changes for the letter committees reflective of the work that the Special Committee does generate in their reports. Updating the charges of committees is a very transparent process and the changes always go through stakeholders so everyone is apprised of the changes as they occur.

Asm. Cooley asked again regarding the timing of the anticipated findings. Cmsr. Altmaier said at the end of the year the work streams report to special committee and then the special committee probably will have a discussion about how to best go about exploring those recommendations whether it be assignments to existing committee structure, or have works streams work on it themselves. That has already been flexible as the original hope was to have stuff ready by the Fall meeting but there was a sense that more time was needed. Quality over timing is more important. Asm. Cooley asked if the Committee meetings are public. Altmaier said when they get to the point of documenting recommendations and determining next steps the anticipation is that there will be transparency. It will most likely be virtual and there have already been a couple of public Zoom meetings.

DISCUSSION ON NAIC MARKET CONDUCT ANNUAL STATEMENT (MCAS) BLANKS (D) WORKING GROUP INITIATIVES

Asm. Cooley stated that an issue that has caught the attention of NCOIL is the work of the NAIC's MCAS Blanks Working Group. For those unfamiliar with the term "market conduct annual statement" (MCAS): the goal of the MCAS project is to provide a uniform system of collecting market-related information to help the states monitor the market conduct of companies. The Working Group has been discussing a MCAS reporting approach submitted for consideration by the Center for Economic Justice that would implement a transactional-level reporting approach for travel insurance as opposed to the historically used summary reporting approach. It appears the move to even more transactional level reporting will make completion of this "statement" more burdensome. Asm. Cooley asked if someone could walk the Committee through the NAIC's process for any changes in MCAS reporting and the status of the Working Group's initiatives.

Cmsr. Mulready stated that the market conduct information that is gathered is typically things that state analysis wouldn't be able to obtain on a financial annual statement or another sources – things like policy renewals; surrenders; replacements; cancellations; claims payments and denials; complaints and lawsuits. This year, the WG is focused on travel insurance and health insurance products such as short term limited duration insurance (STLDI). They are drafting the blanks for those as we speak. The process of creating a blank is a collaborative effort which involves regulators, industry and consumer reps. As mentioned, consumer reps have been pushing for the collection on a transactional basis.

During the drafting of the STLDI blanks, one of the consumer reps suggested that the WG consider piloting the STLDI blank as a transactional level market conduct annual statement. The STLDI drafting group raised the discussion to the blanks WG which considered the suggestion during its September meeting. During its October meeting,

the WG heard a presentation from NAIC IT staff concerning the resources, time and effort needed to collect that information on a transactional basis. After discussion at the November meeting, the MCAS Blanks WG decided against pursuing a transactional pilot for this. The decision was reported to the market regulation and consumer affairs committee during the fall national meeting although they have left it open for further discussion down the road although Cmsr. Mulready stated he is not sure how much energy is behind that. The D Committee adopted the WG report and agreed with the decision to not proceed with the collection of transactional data in the MCAS blanks WG.

Asm. Cooley stated that it's sort of an explanation of the expression laws are ideas that require a following and not every idea gets a head of steam behind it so it sounds like there were internal discussions on this and several things were looked at like resources implications, pros and cons, and at a general level the gains to be had versus the cost of implementing it and resources spent and the idea has been set aside for the time being although you cannot un-ring the bell so at some point it might come back.

Cmsr. Altmaier thanked the Committee for the opportunity and said he is committed to Furthering the NAIC's collaborative relationship with NCOIL.

ADJOURNMENT

Upon a Motion made by Rep. Carbaugh and seconded by Rep. Lehman, the Committee adjourned at 12:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
TAMPA, FLORIDA
DECEMBER 12, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Tampa Marriott Water Street Hotel on Saturday, December 12, 2020 at 9:00 A.M. (EST)

Representative Bart Rowland of Kentucky, Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)*
Sen. Shawn Vedaa (ND)
Sen. Neil Breslin (NY)*
Asm. Kevin Cahill (NY)*
Asw. Pam Hunter (NY)*
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)*
Del. Steve Westfall (WV)*

Other legislators present were:

Sen. Mike Gaskill (IN)
Rep. Jim Gooch (KY)*
Rep. Edmond Jordan (LA)*

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Asm. Ken Cooley (CA) NCOIL Vice President, and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Asw. Pam Hunter (NY), and seconded by Rep. George Keiser (ND), the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's September 24, 2020 meeting.

CONTINUED DISCUSSION ON NCOIL DISTRACTED DRIVING MODEL ACT

Sen. Bob Hackett (OH), Co-sponsor of the NCOIL Distracted Driving Model Act (Model), stated that he would like to say a few words before the Committee begins and note the

changes that he and his colleague and co-sponsor of the Model, Assemblyman Ken Cooley (CA), NCOIL Vice President, have made to the Model since the Committee last met in Alexandria in September. The Model is in the legislative binders on page 231. A few housekeeping items were made in the form of adding a Table of Contents; a Title section; and an Effective Date section. A new Section 2 titled "Purpose" was added which most importantly makes clear that the Model is intended to allow for primary enforcement. Lastly, amendments were made throughout the Model to make clear that it targets handheld electronic devices and not in-vehicle technology systems. In Ohio, total claims are down since the pandemic but serious accidents are up and everyone agrees it is due to distracted driving. Sen. Hackett stated that good progress is being made on the Model and he looks forward to the discussion today and hopefully having the Model ready for a vote by the next meeting or the Summer meeting at the latest.

Asm. Cooley thanked Sen. Hackett for describing the changes that have been made to the Model and stressed the importance of the change that now allows for primary enforcement. When discussing this issue he always recalls early in his career in California when everyone was anxious about a mandatory seatbelt law. There was a time when that seemed like a big hill to climb – enacting a mandatory seatbelt law. It started with secondary enforcement but it was then realized that the law saves lives and provides immediate practical value so the jump to primary enforcement was made. Now, such seatbelt laws are ubiquitous. You can see the parallels here with distracted driving laws. Asm. Cooley also noted the importance of the change to the Model noted by Sen. Hackett regarding distinguishing handheld electronic devices from in-vehicle technology systems. Asm. Cooley thanked everyone who has worked on the Model thus far and stated that he looks forward to shepherding it across the finish line to adoption.

Andrew Kirkner, Regional VP – Ohio/Mid-Atlantic Valley at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC urges the Committee to adopt the Model. The Model presents the Committee with an opportunity to send a message to those states that are considering distracted driving legislation and that message is that NCOIL which is truly the country's leading insurance legislative organization is truly committed to ending distracted driving and saving lives. NAMIC spoke in support of the Model at the Committee's last meeting so there is no need to duplicate remarks but it is important to recognize the importance of the amendment made to the Model regarding primary enforcement. The Model also contains prohibitions on watching media or broadcasting media from a car/vehicle while operating it and those are very positive developments and for some of the sates that adopted early distracted driving legislation – so called texting and driving bills – those provisions were not included so that is an improvement and an opportunity for those states to revisit that legislation. NAMIC would like to thank Sen. Hackett and Asm. Cooley for their work and encourages the Committee to adopt the Model.

Wayne Weikel, Senior Director at the Alliance for Automotive Innovation (Alliance), stated that the Alliance is a D.C. based trade association formed earlier this year representing the manufactures who produce 99% of all light duty vehicles on the road each year as well as tier 1 suppliers and autonomous vehicle technology companies. Members have spent billions of dollars to make safer automobiles and the Alliance and its former iterations have supported bills like the Model in states when they have come up. As noted, when the Model was introduced the Alliance had concerns that it would unintentionally capture in-vehicle electronic systems within its scope. That is important because in-vehicle systems have been designed with engineering specs to increase

roadway safety. We want people to pair their phones with their in-vehicle systems – it makes roadways safer. Things like voice to text or how you can call up a recent address but can't type in a new address from scratch while driving are things that make roadways safer. They are also things that make drivers keep their hands on the wheel and eyes on the road which is the most important thing to avoiding unnecessary crashes. The Alliance is supportive of the sponsor's and NCOIL staff's work on the Model thus far to see the Alliance's concerns addressed and as such the Alliance strongly supports the Model as reflected in the 30 day materials and urges its adoption.

Rep. Matt Lehman (IN), NCOIL President, stated that whenever we have had the discussion about distracted driving we narrowly focus it to the handheld devices used while driving. Where does this lead us in terms of there is an aide in the car, kids in the car, and a lot of things that will distract me beyond hand-held devices? When we go down the path of narrowing it to handheld devices where will this end up long term as it relates to other things that cause distracted driving?

Rep. Edmond Jordan (LA), stated that in Section 4(D)(4), when talking about any form of electronic data retrieval of communication he wonders if we are using Waze or Google maps or Apple maps if that falls under data retrieval. The bigger issue is switching to primary enforcement. The Louisiana Black Caucus had a bill like the Model that came up the past several years and that has been a major impediment because of the impact it could have on communities of color and policing. In light of the fact that we just had a meeting dealing with race in underwiring, although this doesn't deal with underwriting, this may be something to consider moving forward. In response to Rep. Lehman's point, Sen. Hackett pointed to Section 4(C) which says "A driver shall exercise due care in operating a motor vehicle on the highways of this state and shall not engage in any actions which shall distract such driver from the safe operation of such vehicle" and stated that may address his concern. Rep. Lehman stated it does in a way but that also goes to Rep. Jordan's point about primary enforcement so under this law would a police officer be able to stop someone who was distracted by how they are drinking their coffee? This just goes to the issue of where does this have a parameter of I can do this but I cant do that.

Asm. Cooley stated that the state of the law in most jurisdictions is that if a police officer sees someone operating a vehicle in an impaired or unsafe manner they can stop you anyway so the Model doesn't change that. He would expect that if an officer sees a driver who has a car full of kids and is turning and looking and talking to them and creating an unsafe condition the officer would feel compelled to pull the driver over and have a conservation to avoid a tragedy occurring. Asm. Cooley stated that accordingly he does not believe the Model is changing the general law of operating a motor vehicle under due care but is just going into a specific area of a new type of peril that gets introduced into the general operation of operating of a motor vehicle.

Asm. Cooley noted that he thinks we can work with staff on making clear that we are not really trying to create a class of re-stating the law of due diligence of driving a vehicle that extends to all other conduct – we're just saying that is the yardstick currently and we are just writing specialized rules with respect to the use of technology.

Asm. Cooley stated that he is mindful of the concerns expressed by Rep. Jordan. Secondary enforcement is not a perfect solution to that either because then what happens if an officer thinks they have an issue then they are looking for some other

reason to conduct a traffic stop in order to address the issue of electronics. There is a long history of problems with that alleging that a taillight has an issue or suspecting issues for pulling someone over. The stats on distracted driving are awfully darn good and if we haven't adequately established that as part of the record then we can do that. This is a Model that can be well-served by clear legislative findings concerning distracted driving and we can readily partner with the automotive innovators and automotive companies themselves and incorporate that.

Asm. Cooley again spoke of his experience with seatbelt laws in CA in the 1980s. People were very nervous about them but in fact it is such palpable common sense that it became widely embraced and that is similar to the type of issue we are dealing with here and this is a significant class of behavior that builds upon the basics law of tort and the application of everyone's duty not to cause harm to others and it writes the rules of this area of technology that is helpful. Sen. Hackett stated that it is helpful if you look at the number of people now that text and drive and use their phones when they drive. If you use your phone when you are in your car you have to look down at it and when you are doing that you are almost driving blind and the numbers have increased so much of that occurrence and people don't realize the huge increase of that.

Asw. Pam Hunter (NY) stated that she would like to associate her comments with Rep. Jordan. Asw. Hunter definitely thinks that there can be instances where models can create unintended consequences and especially negatively impact communities of color and that should be something the Committee should always be careful of and looking at when creating Models. Asw. Hunter asked Mr. Wiekel when is it a manufacture's responsibility, and the line is narrow, that the new vehicles have so many gadgets and technology that while luxurious and convenient, she cant imagine a convenience where somebody is not touching a screen. She stated that she doesn't know where that line is when we are having convos with manufactures relative to responsibility. This is all great and luxurious but it takes away from the fact that you are supposed to be concentrating on driving and when you can watch TV in your car Asw. Hunter thinks the line has been surpassed in over-creating too much of a distraction in the vehicle.

Mr. Wiekel stated that while new automobiles may have video screens available to passengers there is not a car on the road today that is produced that has a TV screen that is capable of displaying entertainment within the eyesight of the driver. While there may be a video screen of some sort it is displaying other info relative to driving. With regard to the line of responsibility, the way auto makers look at this is the billions of dollars that have been pushed into developing autonomous vehicles and according to the National Highway Traffic Safety Administration (NHTSA), 94% of auto accidents are caused by human error. The pathway that auto makers see is that there will be less and less involvement of the human driver in regular roadway situations. The path forward ultimately leads to somewhere in that area. Part of the reason for pushing this legislation is we want to people to pair their phones with their car because it does create some control and in the absence of that someone could be driving down the road watching YouTube on their phone surreptitiously that they are sitting on their lap or something of that sort. We want consumers to link their phones to the vehicle so that we can block out those sort of things. As for distractions, everything something does that is not the driving task in the vehicle could be distraction. The hope with an automobile centers on repetition. Mr. Wiekel stated that when he got a new automobile recently the first week or so it took him a little bit to answer a phone but now having it awhile his eyes don't leave the road to do that or answer a call or setup voice to text so there is a learning

curve but on balance we keep coming back to that its better to have vehicle systems that are designed with international engineering standards better than the wild west of someone is trying to do things on their phone when there are no controls.

Asm. Kevin Cahill (NY), NCOIL Treasurer, echoed the comments from his colleagues regarding the danger of using any kind of enforcement for racial profiling. It is not something that is a matter of opinion as study after study has indicated that law enforcement against drivers who are people of color is substantially higher than law enforcement against drivers who are white. That is a statistic that has been proven over and over again and with specifically distracted driving laws a study of one police department showed that there were 4 times as many black people pulled over for distracted driving than white people in a community that only had 20% black people in it.

Asm. Cahill stated that he doubts very much that people are using devices more because of their race. It probably speaks to the nature of enforcement and that brings us back to the beginning of the conference earlier this week of the very benign and sometimes passive means by which race impacts insurance. If someone gets arrested or is charged with a traffic motor vehicle violation that puts them in a higher risk category and results in their insurance going up. The points are well taken and we should continue to consider those aspects when considering all Models.

That being said, staying with statistics, distracted driving is more dangerous than drunk driving and is killing and causing more accidents than drink driving. If you are one of the many legislators who had the benefit of going to the Griffith Institutes session several years ago on distracted driving where everyone participated with a screen in front of them and participants missed pedestrians because they were intentionally made to distract ourselves you would understand that this is a serious road hazard that has to be addressed. There is no evidence, maybe it hasn't been studied, that drinking coffee while driving or shaving while driving would cause any kind of accident. It is the distraction of your concentration that is at stake here and when you are using a device that causes you to be hung up on or dial a wrong number you lose your focus and you forget momentarily that you are driving.

It is important to step as close as we can to a uniform standard across the country because without laws people make their own judgments as if it's a matter of opinion. When we make these laws we do it to encourage behavior and it certainly has worked as Asm. Cooley pointed out looking at seatbelts. We all wear them now. Look at smoking indoors. There was a time when we didn't do that. Behaviors change because we as legislators make rules and this is an opportunity to makes rules that make the roads safer. That said, Asm. Cahill would like to go back and revisit the topics that Sen. Breslin led earlier in the week and we should be cognizant of those facts going forward and Asm. Cahill supports this Model and the direction of it.

In response to Rep. Jordan, Asw. Hunter, and Asm. Cahill's comments, Mr. Kirkner stated that they all raise an important topic and it was one seen played out at the state level and that is the effectiveness of primary enforcement as weighed against its potential impacts on minority groups. As it relates to the Model before the Committee, the purpose statement puts forth into the Model a pretty cut and dry statement which is that primary enforcement of laws is an important part of the strategy to reduce traffic deaths and life altering crashes. That statement taken alone is true and is certainly something NCOIL should pursue in NAMIC's opinion. That conversation will not happen

in a vacuum and there is ample opportunity at the state level after passage of the Model for states to balance other concerns with that primary enforcement mechanism. This is a conversation similar to what happened in Virginia that is going to come down to the legislative bodies in individual states. If we look to seatbelts for example the CDC cites an age study that with states that have primary enforcement of seatbelt laws have something like 9% higher use of seatbelt. It is not a 1:1 corollary but we know that primary enforcement is helpful and that distracted driving is dangerous. That is not the entire equation and states should look at priorities in enforcement but the Model would still leave ample flexibility for that process to occur. Lastly, there are states that have considered distracted driving legislation that have included as part of the package instructions for the study of enforcement against certain demographic groups. That may be something that is appropriate if not for this Model then for NCOIL to consider.

Rep. Rowland echoed Mr. Kirkner's statement regarding the distracted driving demographic and asked if it would please the Committee if language was inserted in the Model requiring such a study. Sen. Breslin stated that it is a great idea. Sen. Hackett stated that is had no problem with that. Asm. Cooley stated that it is an outstanding idea. The philosophy of the Model is that everyone owes a duty to exercise due care so as to not subject anyone to unreasonable risks of harm. That is the law and the study aligns with that. To put a spotlight on the concern for its equitable enforcement and application and to setup a reporting system on the use of the statute in a given state is a good idea. Rep. Rowland said NCOIL staff can distribute language before the next meeting. Rep. Rowland stated that there is more work to do on the Model but today has been a healthy and productive discussion and he appreciates everyone's involvement.

INTRODUCTION OF NCOIL CORONAVIRUS LIMITED IMMUNITY MODEL ACT (Model)

Rep. Rowland stated that he is proud to sponsor the Model as it deals with such an important and timely issue. The Model is in the legislator binders on page 237 and is very straightforward. It is primarily based on what was enacted in Idaho this past Summer although several states have passed similar laws. The Model essentially protects businesses by providing them a certain level of immunity from lawsuits relating to COVID-19. Of course, if a business acts in a reckless or willful manner, liability can attach, but the businesses who want to re-open in a safe manner should be provided a certain level of immunity from COVID-related lawsuits. Rep. Rowland noted that Congress is considering enacting similar legislation and if it is indeed enacted this model legislation may become moot, but nonetheless we have to be proactive and be prepared.

Rep. Lehman stated that none of us expected to be dealing with the issues we are dealing with today. When it comes to COVID and business immunity this is timely and we may have issues from a processing standpoint in terms of adopting the Model so we will probably have to hold today. When approaching this issue when you look at our communities right now every business is looking to us for help and one of the things they are looking for help with is that they want to re-open their business and open their doors but they don't want to have to keep looking over their shoulder as to who is on their doorstep looking to put them out of business with a lawsuit. This is very important. From a process standpoint, Rep. Lehman stated that this is either in or already making its way through many general assembly's. It's a top priority in IN and will probably move out the first week there.

For the states that have already pushed the legislation, NCOIL is a great organization to gather data so perhaps we should gather that data and say what are best practices that we have seen with these types of laws. This can become a Model that may not address the issue immediately but we can get out in March to say this is what we have found to be best the practices. Every state is going to deal with and consider this and NCOIL has always been an organization that says we build the foundation and you put up the drapes but that foundation is going to have some structure to it and giving some time to see what states do on this enables NCOIL to create a really solid foundation. Rep. Lehman stated that we have to do something and continue to move forward. Rep. Lehman stated that he looks forward to working with Chair Rowland on where we go and with this and also hearing the engagement of the Committee and states. This is a situation where we need all hands on deck from all states to hear everything. Rep. Lehman stated that he looks forward to the discussion today of all perspectives.

Mr. Kirkner stated that if we boil this Model down to its simplest form, it is attempting to accomplish something that is really important. Businesses and individuals alike need to be protected from frivolous lawsuits stemming from the global pandemic currently facing the country and world. While the outbreak and more recent spikes in cases are troubling, for the first time in several months there is a light at the end of the tunnel regarding vaccine distribution and the business world reopening in large part. Whether that is the spring or fall of next year, we do sort of have a perspective on when will things will open back up. That said, when things open back up and consumers return to stores NAMIC thinks its more important than ever to make sure these businesses aren't faced with rising litigation costs relating to frivolous lawsuits.

One of the ways to do that as Rep. Lehman pointed out regarding what states are already doing is limited immunity. We have seen bills in OH, MI, and a number of other states such as IN, WV and other sates considering such legislation as we head into spring sessions. NAMIC thinks the Model is a really good start and step in the right direction and has a few specific comments. In terms of improvement or suggested modifications, NAMIC and its members believe a few things are important. From a threshold standpoint, one of the hot topics in the immunity space right now is the idea of take home liability. The Model specifically exempts work comp law and the impact on it and in the take home liability space one of the concerns raised by NAMIC members is that there will be individuals who contract COVID from individuals who bring it home from work.

The bill extends immunity to persons from liability for exposure but it may not go far enough in extending that immunity to businesses and other persons for exposure to third parties – take home liability. There can be improvements made and NAMIC will certainly offer language to do that. The Model also contains a broad grant of immunity except where there are intentional acts. Many states across the country would require a higher threshold of evidence when referencing an intentional act i.e. clear and convincing standard. It may not be appropriate for NCOIL to list what each state's standard of evidence of intentional acts is but a drafting note on that point cold be important to note the instance that there are differences among the states regarding evidentiary standards for intentional acts.

Finally, NAMIC believes that there can be a broadening of the exposure language in the Model. At present, Section 3 provides immunity for the exposure to COVID but we think that the language can be expanded to contemplate direct or indirect exposure. That

speaks to the issue of take home liability referenced earlier. Globally speaking the Model is a great start and one of the comments received by NAMIC is that a Model that is concise and clean like the Model has the best chance of success. NAMIC agrees with that principle and believes some small tweaks can improve the Model and allow NCOIL to be a leader on the issue. NAMIC will most likely supplement these comments with written comments and thanks NCOIL for being a leader on this issue.

Wes Bissett, Senior Counsel, Gov't Affairs at the Independent Insurance Agents & Brokers of American (Big I) stated that the Big I supports the efforts of the sponsors to take this issue on and the Model is a narrow and short one that merely creates a higher culpability standard for a plaintiff bringing a COVID exposure lawsuit. We have seen numerous states adopt similar legislation this year and as noted Congress is considering similar legislation but the Big I believes the states are the appropriate forum for action like this as it is states that typically address the assignment of liability so it is very appropriate for state legislators to be considering this issue. Given the interest in this issue in many states we think a Model is very appropriate.

There may be legislators on the Committee who feel that it is not appropriate or warranted for their particular state and it may not be universally adopted but there is certainly sufficient interest in this to warrant Model law. It would be an understatement to say that we live in stressful and traumatic and overwhelming times as we are in a global pandemic after all. The pandemic is especially challenging if you are in a business or employer and whether you run a non profit organization, a hospital, a school, a university, or a small busines you are struggling today to make it through this storm and you are not only worried about your personal situation and the long term viability of your enterprise but you have the extra burden and pressure of knowing that you have employees and patrons relying on you. That is a special burden that the owners and operators of businesses and other orgs have and they take it very seriously.

Profit and non profit orgs are facing more challenges than we can cite as a result of the virus and what this Model would do would be to eliminate one small and unnecessary source of concern. It is no secret that we live in a litigious society and businesses are worried about litigation as a result of COVID. It can be an existential threat for businesses that are already on the brink. Many businesses are on the tipping point and the threat of litigation can be the one thing that forces them to close altogether. Businesses are very vulnerable right now. Some might think that the safest course of action and the path of least resistance and the most reasonable thing to do is in this situation is to shutdown altogether but that would put patrons and employees in an even more vulnerable position than they are today.

The threat of litigation in this environment is very real. A business can take every conceivable action possible to prevent the spread of the virus but it is everywhere. We face community spread and it is not going to be a challenge for a plaintiff to make an allegation against a business or non profit company that they will then have to defend against. That claim may not be successful ultimately but you do have to defend against it in courts without much direction and they will be deciding what constitutes reasonable care in this uncertain environment. The Model encourages business in a manner that is consistent with the guidance and directives of state officials to remain open and to operate in a constructive and safe and responsible good faith way. But it does give some degree of confidence to businesses and precludes the ability of courts to frankly engage in de facto COVID related policy making.

The Model though is not limitless and is not an absolute shield against accountability and liability. It doesn't shield bad or improper acts. It doesn't allow bad actors to operate. It doesn't authorize or permit reckless or willful misconduct and some might suggest if you were to pass this that we are going to see a parade of horribles and bad behavior that will emerge as a result of a state passing this Model. The Big I thinks such concerns are completely misplaced for several reasons. We don't think a business once a bill like this is passed is going to choose to become a bad actor and engage in bad faith action. It flies in the face of a businesses own self interest and reputational concerns and the fact that it is trying to remain open safely and keep its employees employed and its patrons served and perhaps most notably the Model itself would still permit plaintiffs to bring lawsuits in those situations and we have not seen in states that passed laws like the Model the types of horrible behavior breakout that some have suggested might.

The witness list today is insurance heavy and that makes sense at an NCOIL meeting but it does underrepresent the very widespread and significant support from just about every segment of the economy: non profit, for profit, public, private sectors. These bills have broad support form just about every conceivable business or employer you can imagine. As we begin to emerge from this crisis and get back on our feet in a collective sense and hopefully get our economy going again, businesses and employers are going to need all of the support and encouragement and certainty they can find and this Model provides that in this limited and narrow context. Mr. Bissett thanked the Chair and sponsors and commended NCOIL for a successful set of meetings this week under difficult circumstances.

Lauren Pachman, Counsel and Director of Regulatory Affairs at the National Association of Professional Insurance Agents (PIA), stated that PIA represents independent insurance agents in all 50 states Puerto Rico and Guam. Many of the agents are small business owners and many of them serve a clientele of small business owners so we have a vested interest in making sure that small businesses are protected during this difficult economic time. As Mr. Bissett mentioned, small businesses could be easily bankrupted by a single lawsuit even if it's a frivolous one and many small businesses are just getting by if that in our current climate. They also need predictability and are typing to operate in accordance with everchanging federal, state and local guidelines regarding COVID such as openings, closings, curfews, time limitations on when they can be open, etc.

The Model reflects the movement around the country towards protecting small businesses with similar legislative efforts and the Model sends a message to states that haven't enacted anything yet that it is a tool in the toolkit they can use to protect small businesses in their state. As mentioned by Mr. Bissett, Section 3 of the Model provides businesses that are in compliance with those everchanging guidelines to be confident that they can open and they will not be the subject of frivolous lawsuits. They of course could be still subject to a frivolous lawsuit but it would be much easier to dispense with a lawsuit in a more cost effective manner with legislation like this on the books. Many of the businesses that we are talking about are already on the brink and they need all the predictability they can get in the current economic climate. This additional predictability provided by the Model will be the difference for some businesses between solvency and collapse. Ms. Pachman thanked the sponsors for developing the Model and is happy to work with other organizations and NCOIL staff about adding any essential provisions that might be of value including what NAMIC mentioned regarding evidentiary standards and also provisions regarding statute of limitations (SOL).

Prof. David Vladeck, A.B. Chettle Jr. Professor of Law at the Georgetown University Law Center, stated that he is going to be the fly on the ointment because he thinks the Committee is embarking on a misadventure that will not help small businesses and people who are harmed. Starting with facts, we have had 16 million cases of COVID reported, nearly 300,000 deaths and there has nearly been no litigation. The Chamber of Commerce has been tracking this from the beginning. The cases that have been brought are cases that ought to be brought like people injured in meat packing plants because their employer failed to take necessary precautions, some cases involving nursing homes which were very slow to protect the people who were living there – that's about it. When looking at the number of small businesses that have been sued over this, its almost zero.

So, first of all, what is the basis for this legislation – why do you think you need it? The tort system in his view has worked very well. There have been so few cases because causation would be extremely hard to prove in these matters. In order to sue somebody you have to be able to show and you have to plead there is a reasonable connection between somebody's COVID and their injury. Causation here is extraordinarily difficult to prove and lawyers are not stupid – they are not going to bring a case that they don't have a substantial chance in winning because they are fronting the money. You might ask – ok so what does it matter if we have this legislation? The legislation is incredibly overinclusive just the way the federal legislation is. The breadth of immunity here is extraordinarily large and undefined. Like the federal statute which might have all sorts of unintended consequences the breadth of the Model doesn't solve for that.

Further, there is an issue of moral hazard. This is classic moral hazard. Prof. Vladeck stated he understands why the insurance industry wants the Model since it will save them money if there are cases but think about moral hazard. The question here is what can we do to reopen our economy – what are we going to do to get people back to work. Is it really sensible to tell the public you are on your own unless somebody engages in an intentional tort which is essentially a crime in every state. Businesses that act responsibly are already protected from liability. Reasonableness is the cornerstone of our tort system so we don't need legislation to protect the responsible. Immunizing companies form liability when they act unreasonably or irresponsibly would be utterly counterproductive and would impede the ability of states to re open their economies.

Telling people they are on their own and there are no real requirements that your drug store or other place of business is takings sensible precautions – that is not the right signal to send. The right signal to send is that if people act unreasonably they will pay for it because that is the way the system has always worked. There are two disciplines on our marketplace - regulation and tort law. There has so far been no effective regulation and that is where the federal government has really failed terribly. There is no effective regulation but there are guidelines and if a company follows those guidelines that company has essentially an airtight regulatory compliance defense. That is the way it works with the law – if there is a regulation and you adhere to it and bad things happen that is not your fault; it is the regulator's fault.

We either need regulation through law or we don't have a marketplace. Every time you go to the grocery store and buy a pound of flour you know you are getting a pound because the initial regulatory system had to do with weight and measures. Now we have public health measures. There are all sorts of problems with the Model that the Committee has not even begun to think about. What about cases that have arisen prior

to the passage of the Model? There would be a huge constitutional issue if you tried to wipe away those claims. Do you have the constitutional authority to wipe away the property interest someone has in a legal claim retrospectively? A lot of the discussion so far has been on frivolous cases. The courts know how to prevent frivolous cases. If you file a frivolous case as a lawyer you pay a price. The Model has nothing to do with frivolous lawsuits. Another justification is there is a reasonable measure in bounds here because it only involves essentially intentional torts or gross negligence. Well, intentional torts are crimes in every states as is what is called gross negligence so what you're really talking about is the only cases that can move forward on the Model is if somebody goes out and intentionally tries to harm someone or engages in an act that is so reckless it meets a gross negligence standard. So, think about someone firing a gun towards a crowd or driving quickly through a pedestrian area – that is what gross negligence is. If you have any doubts about it, Prof. Vladeck stated that testified before the Senate Judiciary Committee and you can look at his testimony on their website as he talks about state law throughout the country.

With regard to take home liability, it exists in very narrow cases. The only cases so far that have been brought on that grounds are in the meatpacking industry in Green Bay and Iowa. Workers got sick and there were huge outbreaks in facilities and they went home and their spouse and children got sick. Should they bear the liability for that? That's what the Model would say – tough noogies for them. Even though they didn't have any fault. If you want to just protect criminals, that's what this Model does. The Model is only talking about gross negligence and willful conduct. Go look at the laws of more states and you will find that all of those things overlap with criminal law. The liability issue here is much more important in terms of signaling than it is with the actual case law that will follow. We dealt with this for almost a year and there have been almost no cases that the industry is fearful of. Law signals a lot and law that basically says that you are on your own in this marketplace – if someone hurts you but didn't do it intentionally or willfully then tough noogies – that doesn't send the right signal. That is the perfect illustration of the Model and Prof. Vladeck urged the Committee to step back and take a look at the data of cases so far and then move forward.

Rebecca Dixon, Executive Director at the National Employment Law Center (NELP), stated that she is here to provide the worker perspective on this issue. Worker health is really public health and workers' rights to a healthy and safe workplace must come before profits. We simply aren't able to reopen businesses and public institutions if workers and consumers aren't safe and don't have confidence in their safety. Granting employers the immunity that some have long sought would create disincentives for even law abiding employers to protect their workers, produce a race to the bottom for workplace standards and would cause a health and safety disaster with new hot spots across sectors and spread across communities. Ms. Dixon stated that she want to leave the Committee with three points. First, when employers across the country fail to adequately protect their workers, they contribute to the spread of COVID into communities and due to historic inequities, this impact is uneven. Where employers are actually located in the labor market determines who is not able to work safely from home, who is out of work, and who is reporting to work and taking a daily risk. The concentration of women and people of color in low paying occupations ensures that they are the workers who are disproportionally in jobs on the front lines of COVID and they often work in industries that don't have health benefits or sick leave and have few workplace protections already.

Ms. Dixon encouraged the Committee to consider the impact of policymaking. What does the data tell us about this recommendation and who is advantaged most by it and who is disadvantaged by it? Who benefits and who is burdened? History shows us that it is important to consider unequal impacts. For example, without ever considering or mentioning race in this historical record the way people were stratified into the labor market enabled the exclusion of millions of workers from the New Deal programs excluded 90% of black women because they were concentrated in agricultural domestic work. There are many examples of how employers have been slow to follow the basic CDC recommendations. As COVID ripped through a pork processing plant in Waterloo, Iowa in April, Tyson's food supervisors not only kept the facility open but they placed bets on how many workers would catch the virus. One plant manager allegedly organized a cash buy in winner take all betting pool for supervisors and managers to wager on how many employees would get sick and test positive for COVID. Let me be clear, workers are getting sick and dying and these are tragedies that are preventable.

Second, the rule of law versus the honor system. Right now, employers operate on the honor system unless their state has issued enforceable guidance. The CDC guidelines are advisory and not enforceable. The Occupational Safety and Health Administration (OSHA) has failed to protect the health and safety of workers during this pandemic. Workers are already really challenged to enforce any of their rights and get access to the courts because of things like forced arbitration and collective action waivers that they sign when they take their jobs. This is also true for health and safety. OSHA has utterly failed to protect workers as its standards are voluntary and not enforceable and it's not enforcing any of the CDC voluntary guidance either.

Unlike other statutes, workers have no private right of action to sue if an employer is violating OSHA including when their employer retaliates against them for raising safety concerns. They only have an administrative remedy to file a complaint and request an OSHA safety inspection. Workers have filed thousands of complaints but OSHA has conducted few if any on site inspections and issued no citations protecting workers from COVID exposure at work. Workers who speak up are facing retaliations and according to a recent survey black workers are twice as likely to face retaliation.

With regard to work comp, for workers injured on the job work comp is no fault coverage but you give up the right to sue for negligence. It is not really clear how much coverage work comp is going to have for COVID since work comp generally does not cover communicable community spread illnesses like cold or flu. Lastly, immunity is really a solution in search of a problem. There is simply no flood of litigation. According to various COVID lawsuit trackers, somewhere between 116 and 234 lawsuits over issues like lack of PPE, exposure or infections at work or death have been filed to date. That's about 2 or 4 lawsuits per state. That is a trickle, not a flood. Also, it is important to know that while supporters of immunity may claim that they are primarily focused on preventing workers and consumers who may get sick from suing them, we need to be clear that the trade associations who lobby for employers including the Chamber of Commerce, Restaurant Association of America, National Association of Manufacturers and National Association of Independent Business to name a few are pushing for legal immunity from a wide range of core worker protections. The immunity sought by these associations and employers side attorneys would extend to violations of a worker's right to minimum wage, overtime, right to not work when you are off the clock protections and disability discrimination including the right to paid sick leave and paid sick time under the Families First Coronavirus Response Act. Throughout history and moments like these

when we face both a pandemic and a public health crisis our challenges are also opportunities. How employers and policymakers respond during this moment could improve work in the U.S. for the long term or make the existing problems worse.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) stated that Prof. Vladeck and other opponents of this particular proposal would suggest that what it basically says to workers is tough noogies and you are out of luck because of these particular provisions. Mr. O'Brien stated that he would suggest that Prof. Vladeck and others would equally say to business communities and Main Street America tough noogies to you because you followed the rules and now there is the potential to you that you could face some additional liability coming your way. In that regard, this is the quintessential public policy question and state legislators and orgs like NCOIL are well positioned to determine whose nooiges are going to be tougher.

This particular type of issue is a classic public policy question and it is something that a number of legislators in several states have wrestled with. As Rep. Lehman noted, it is also something that more states are going to wrestle with coming on down the pike. One of the points that opponents of this type of proposal would make, will make, and have made this morning is that there are not a lot of lawsuits out there at the present time. Taking them at their word and assuming that stats are correct and there is no reason to doubt otherwise, that is today – what about tomorrow and next week and what happens when main street America begins to reopen and begins to move into an area where we are in regular order and the doors to the court houses are open and trials are beginning to be scheduled and things like that.

Plaintiffs lawyers and their supporters will say see, there are no cases, but with courts shuttered and the SOL on their side, folks are not under any immediate need to file the cases. There may be practical issues, there may be SOL issues, pre judgment interest issues and concerns, tactical and strategic questions, individual lawyers in their offices may be weighing whether or not to take a case and file a case – there are lots of reasons tight now why there may not be an immediate tsunami of cases but there could be. For main street America who has been worried about their survival the potential for litigation coming on down the road is another concern. Imagine yourself as doing everything you can possibly think of and followed the rules of your state and community and all of a sudden you have a suit filed against you. Well, it is true that as we go through the litigation process you may do well on that suit form your perspective and defeat it but sometimes the mere filing of litigation is as damaging as going through the litigation itself. There is a cost perspective, there is an emotional perspective, etc. That is not to say that there will be instances where litigation is warranted – there may very well be and in the Model it is crafted such that if a defendant acted intentionally, willfully or recklessly a claimant could pursue damages. It is not a complete bar and it is going to be up to state legislatures across the country to determine what the bar should be. If there are situations where a business has acted recklessly and has put their workers, customers and general public in danger and not followed the rules and has done so intentionally or recklessly then they should suffer the consequences and that is something that should play out as issues such as this are debated within the state legislatures.

Finally, several states around the country have developed legislation on this and it is a

developing area and it is an area that is ripe for NCOIL to consider and is directly in NCOIL's wheelhouse and APCIA would support NCOIL continuing to look at discuss, debate and consider this very important public policy issue.

Rep. Chad McCoy (KY), who is currently working on similar legislation in Kentucky, stated that he is a Republican plaintiff's lawyer but he has been a defense lawyer for a lot of his career and that this issue presents a big balancing act. He has traveled around Kentucky to hear form businesses and this is a very real fear but as noted by Prof. Vladeck the data is just not there right now and in this organization what we have to do is an important balancing act. Frivolous lawsuits need to be stopped immediately and people need to be punished for that but at the same time we cant allow bad actors to get away.

What's very important for the business community is that we give them something that is real but also constitutional and one of the fears in Kentucky with the Model is that they want to be sure that retroactivity is not allowed. We have to keep in mind that there is a vaccine coming so we are looking at a short window of cases and Rep. McCoy would like to throw out something to chew on that has been in done in the medical malpractice area which is the concept of a certificate of merit. A requirement that as a part of filing a lawsuit, the plaintiff and plaintiff's attorney have to file a certificate that they already have an expert that will testify as an expert not only as to a breach of the standard but also to causation and causation is probably the real hiccup in these cases as it will be almost impossible to prove. With the certificate of merit you would immediately cut away any of the frivolous lawsuits and what you would be left with are those that you would have an arguable (doesn't mean win or loss) breach of standard and causation. Kentucky has signaled to the business community that they are behind them but at the same time a balance needs to be struck and you cant throw the baby out with the bath water so to speak.

Rep. George Keiser (ND) stated that he is from ND which is a super red state and has a lot of people who are strong supporters of the President and not only politically supportive but supportive behaviorally and frequently don't wear masks and don't social distance as a source of freedom. ND has a lot of business owners like that. His question is that it seems to be if that if this was passed in ND it would eliminate any requirement to follow science for any employer in terms of social distancing and masks and tracing because there just isn't a requirement since they are exempt from that as this is not part of that – there is no requirement to follow science or to use reasonably objective responses. Rep. Keiser stated that he is curious from a legal standpoint if that would be true.

Prof. Vladeck stated that is a really good question but he is not sure if he has a really good answer because community standards matter in tort law and if the community standard is that you don't need to wear a mask, a jury of someone's peers is unlikely to ding a small business owner for nor requiring masks. His understanding is that the ND Governor doesn't allow mask requirements in the state and if that is true that would complicate tremendously any effort to bring a tort case. Prof. Vladeck haven't looked state by state in a while but when he last looked there was no tort case involving COVID in ND and maybe that's the reason why.

Prof. Vladeck then responded to Mr. O'Brien's point regarding timing. If you want whatever cases to be filed now rather than later just go to the legislature with this kind of

bill because retroactivity is not on the table – whatever you do is perspective only. So, if you want people to file cases then move this bill through a state legislature and whatever cases there are will be filed. The threat of legislation has been minimal ever since Leader McConnel drew a line in the sand about this so Prof. Vladeck thinks the speculation that people are waiting to bring these cases probably is unfounded largely because of the risk that if you wait too long and there is a liability bill then you may be stuck. But, none of this legislation can be retroactive.

Sen. Hackett stated that OH has law on this issue and the question that came up was how can we ask businesses to be open and stay open if we don't provide protections? Sen. Hackett stated that OH is different than the Dakotas as it is often a red state but the cities are blue and when you look at the situation it is such that the Governor and legislature don't get along and the Governor has to work with the legislature better and is not issuing laws that mandate things but rather issuing guidelines so the scenario is how do you operate in situations like that? When the pandemic first started, it was the city areas that were getting hammered and the rural areas were not so the question is how does this operate in a state like that.

Sen. Hackett stated that he got a bunch of calls saying you cant take away the right to sue and there is no way this business should open but the business had the right to open. So how do you operate in a state where you have political difference of opinion and area differences. Prof. Vladeck stated that this is really the same problem that ND has. The less people who are willing to wear masks and social distance, the more difficult it is to prove causation. One of the reasons there has been so few cases filed is because the causation problem for the plaintiff is almost impossible. In ND where people are not wearing masks or rural areas in OH where not wearing masks, proving causation is essentially impossible. Causation is the foundation of tort law and the plaintiff bears the burden on that and they cant sue unless they can show that it's the defendant that actually caused the injury they are complaining of. That is a practical answer but not a legal answer. Sen. Hackett asked if that is the case then why is OH Bureau of Work Comp (BWC) paying a high number of claims that are filed by essential workers – are they doing it out of the goodness of their heart or because there is causation? Prof. Vladeck stated that he is not sure and is not aware of what is considered a high claims rate. A lot of the essential workers in the U.S. were exposed because they didn't have adequate PPE and no social distancing. You see the outbreaks in prisons and packing plants and nursing homes and that is where the cases are so far.

Prof. Adam Scales of Rutgers Law School stated the causation and fault standards applicable in a work comp context are completely different as the whole point of work comp was to reduce the burden on injured workers in establishing fault. Prof. Vladeck wisely focused on causation as a huge issue here and it often intertwined with the questions of fault. If an employee catches COVID and files a claim Prof. Scales personally thinks that there are quite interesting questions about whether causation can be established there. CA went pretty far and articulated an irrebuttable presumption of causation and that is probably a mistake but almost under any work comp plan the burden is simply going to be lesser for an employee compared to a hypothetical tort claimant who would face substantial hurdles in bringing a claim.

Mr. Kirkner stated that part of the discussion here is work comp but the Model specifically exempts work comp. In response to Prof. Vladeck's comments, Mr. Kirkner noted that he stated that this has been a largely fact free discussion and then proceeded

to make a statement that all of the cases that have been filed so far ought to have been filed. It is very difficult to operate in a framework where every case filed is valid. It would be an interesting conversation to do a deep dive on the number of tort cases filed that actually go to a verdict to a jury or from the bench. In fact, most of these cases settle. The fact that there is not a massive amount of cases in the pipeline right now is the result of a number of things not the least of which being that courts have been closed and there is often a 2 year SOL on many of these clams and that SOL varies across the country. The point is that just because the cases don't exist today and the volume that would in Prof. Vladeck's mind lend credence to a bill like this doesn't necessarily mean that they aren't coming. Insurers see frivolous lawsuits every day and it is certainly reasonable to expect that those lawsuits whether causation is an issue or not would occur here and the bottom line is that litigation drives up the cost of insurance and really this is a time where small businesses and large businesses alike can least afford it.

INTRODUCTION OF AMENDMENTS TO NCOIL POST ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

Asm. Cooley stated that this Model was actually readopted by this Committee at its last meeting in September but at the time he felt that there were some loose ends to address. Within the realm of insurance where people are buying a promise of future performance, the first line of defense for all customers is the rating system which is how rates are set for insurance. That's what protects the public to have adequate funds to pay claims. The second line of defense is guaranty funds so somehow if an insurance company runs aground there is an alternative to just a customer bearing that loss and the loss is then distributed through the guaranty system. That raises the issue on insurance division acts to make sure that in transferring a book of business, there are not any unintended consequences with respect to when the business is transferred people are fully protected with the guaranty funds. To ensure that, it is very important to listen to what the guaranty funds have to say about their technical rules of coverage and how it gets funded and that brings us to the proposed amendments to the Model.

The first proposed amendment is on page 244 of the legislative binders and would adjust the Model to address insurance business that has been "restructured" under recently enacted laws which permit insurance business transfers (IBTs) or divisions to ensure that it remains appropriately covered under the guaranty fund. There are concerns many current guaranty fund laws may not protect claimants on policies that are transferred pursuant to these transactions. The language suggested would reflect the policy position that claims that would have been covered before the transaction would retain coverage after; however such a transaction should not create guaranty fund coverage that was not available before the transaction.

The second amendment is on page 248. Guaranty funds all have assessment provisions and they all have caps on those assessments. The proposed amendment would expressly permit assessments to insurance company guaranty association members to fund various expenses that maintain the guaranty funds in an "always ready" posture even when claims activity is low. This is meant to plan in advance for insurance liquidations. It should be noted that the administrative assessment authority sought with this language, combined with any other assessments made to member insurers, would not exceed the two percent threshold already in place in most states. These are highly technical amendments to reconcile the Model with guaranty associations to make sure that they operate without any unintended consequences and shocking occurrences of

having people who thought they were covered having no coverage. Asm. Cooley stated that he looks forward to working on these amendments with the Committee.

On behalf of the National Conference of Insurance Guaranty Funds (NCIGF), Barbara Cox stated that Asm. Cooley did an excellent job of explaining the amendments. The NCIGF takes no position for or against restructuring transactions. We do believe that if there was coverage before the transaction there should be coverage after the transaction. Conversely, there should not be such coverage created by the transaction. The first amendment clarifies that as there is some concern that in many if not most states under current law there is a real question as to whether transferred plans would be covered by the guaranty associations so this amendment was developed by NCIGF's legal committee and it has been well vetted and it is recommended that it be adopted by NCOIL and included in the Model.

The second amendment concerns special assessments to essentially keep the doors open on guaranty funds. NCIGF had a year long study that included board managers, guaranty fund managers and several industry representatives and the concern was that under current practices, funding of the guaranty funds is very much tied to claims volume and that means that a fund could be sitting in a small state with 10 claims and not really have the wherewithal to assess the industry to keep the doors open. Conversely, they could make a claim against the estate and sometimes that can be objectionable because the claims cost per claim could be so high if that were done. This is an optional provision and states may have many other tools within their plan of operation their law or in their practice to make sure that their doors remain open. The other question is why do we have to keep those doors open. Ms. Cox stated that she has been involved with guaranty fund association systems for 25 years and she can tell you that a fund can go to 3 claims to 3,000 or 30,000 overnight. NCIGF encourages pre-planning for liquidations and it doesn't always happen that way. Hence, we want to make sure that to the realest extent possible that claims against a guaranty fund get coverage. That is not always possible but to the greatest extent possible coverage should not be disrupted due to the liquidation of an insurance company.

Rep. Rowland thanked Asm. Cooley for introducing the amendments and stated the Committee will discuss this further in March.

UPDATE ON NO-PAY NO-PLAY LAWS

Prof. Scales stated that when first approached with this topic he had never heard of it and that was rather embarrassing as he is been teaching insurance law for 23 years. For those who also may be unfamiliar with these types of laws, no pay no play laws substantially restrict or eliminate the ability of auto accident injury victims to sue for negligence where the injured person was uninsured. There are several variations you can find sprinkled across the dozen states that have enacted such legislation. Sometimes, the disability is only up to a threshold amount so if your claim falls below that amount you cant sue but if it goes above that amount you could sue. A common restriction is that the disability applies to non-economic harms of pain and suffering end emotional distress. Not infrequently, the legislation is also written such that it allows for no cause of action at all for the injured but uninsured person. The wording of at least some of the legislation is at least open to the interpretation that the disability might extend to non-motorist defendants as well but that needs to be studied further. There is a frequent carveout in most of these statutes – if the defendant motorist is guilty of DUI

or a felony or something similar then the disability on the injured but uninsured motorist suing does not apply.

This type of legislation has been enacted by about a dozen states since 1996 and there are several justifications offered for the laws which can be reflected in the NCOIL Resolution. Some of them are somewhat interlocking but they also contain some contradiction. One idea is that the legislation will reduce premiums and another is that it will reduce fraud. It is hoped that such laws will reduce uninsured driving by making uninsured driving relatively more expensive for individuals. Also, there is the overarching appeal to fairness. There is some limited evidence to the effectiveness of these measures. RAND and others use models to estimate the impacts and the last round found dates back to around 2012 and the estimates pointed to about a 3% reduction in premium cost per insured driver which is about $5 a month at the time in Texas.

That may be a bit optimistic but lower payouts should show up as lower premiums at some point so lets assume that the projection is accurate. 3% isn't zero and I suppose if one had the opportunity to select multiple low value interventions, they might indeed add up to real money in a family budget. That said, it is important to keep this relatively modest benefit in mind when assessing these proposals. On the issue of reducing uninsured driving that is extremely unlikely that the legislation has an effect on that as it does not meaningfully change the incentives for the types of people who are likely to be currently uninsured. If the average non-consumer, the uninsured driver, is ignorant the incentive potential might be needed even further.

The reduced fraud rationale is also a bit tenuous. This is an extraordinary blunt instrument one that punishes fraudster and legitimate victims alike. Fraud and low value PIP claims is a real problem for the insurance industry but basically this is a concession of failure. Unable to detect fraud when it counts, insurance asks to wipe out legitimate claims that share exactly one indicum of potential fraud – the lack of insurance. This brings us to the fairness rationale. It turns out that there is a long history of interest to shutting the courthouse door to morally questionable plaintiffs and illegitimate claims. This has been known as the outlaw doctrine and at times in our history the law has disabled those who are injured while committing crimes or other bad acts like driving on a Sunday from suing in tort. By definition, this eliminates claims without regard to validity. For most of the past century, such defenses were rejected by American law. By the 1950s two legal scholars disposed of the outlaw doctrine as "a barbarous relic of the worst there was in puritanism." The more things change, the more they stay the same. In some other work Prof. Scales has done he has had occasion to observe that every age fits the practices of the past into the felt necessities of the present – only the rationales change as each successive age discards earlier old fashioned reasoning in favor of enlightened modern reasoning that rather amazingly ends up sounding a lot like the oldened days. This is no different.

With that in mind Prof. Scales talked about the fairness aspects of this type of legislation. In his view, it inappropriately conflates the source of the right to injury compensation with the likely source of the funding of that compensation. Simply put, the moral and legal basis of an injury victims claim stems simply from the commission of a wrong from the defendant against the plaintiff. That's it. We don't ask whether either party is rich or poor. We don't make inquiries into religious habits and we have even discarded by overwhelming consensus the concept that directly relevant negligent behaviors should entirely eliminate his right to recovery. The conflation at work here is to elevate plaintiff's

non-compliance with mandatory insurance requirements beyond any considerations of defendant or plaintiff fault. This appeal is easily seen in the catchy title: no pay no play. But the point of rights including those secured by federal and state constitutions and the common law is that you don't have to pay to enjoy them that is why they care caused rights. Prof. Scales pointed out that the carveouts, while politically understandable, contribute to the conceptual confusion here. Drunken driving is bad but it is difficult to understand why an uninsured claimant with a relatively modest injury claim against a driver is free to sue while someone with a catastrophic injury occasioned by a sober driver is cast out of the law's protection. In a weird way, these carve outs for defendants recreate the all or nothing rule that the law long ago discarded for plaintiffs

Moreover, the carve out has literally nothing to do with the alleged rationale for no pay no play laws. The frequency restriction of the disability to non economic harm is also disingenuous. If someone has failed to play by contributing to the insurance system why should his right to recover turn on the particular pathway his injuries take? Two claims with identical injuries for similar accidents might be differently situated as to their ratio of economic to non economic loss. Nothing is perfect in public policy but the policy of treating non-economic injuries as second tier harms susceptible to waiver by non-payment is one congenial to liability insurers which apparently was enough in 12 states but Prof. Scales doesn't think its really persuasive to anyone else. Prof. Scales closed by saying something nice about no pay no play. We don't have true fault and truth in this country. Low injury thresholds mean that in virtually any case with meaningful injury a plaintiff can resort to the tort system. In theory, one might imagine a no fault system that can truly be thought of as creating a broadly applicable threshold on injury suits as a matter of protection for citizen motorists. We have homestead exemptions and other exemptions across tort law and with some work he could see fitting an auto no fault system into the framework. In this framework motorists would have a legal, not merely practical immunity, from suit below a certain threshold in exchange for participation in the system.

Some of the no pay no play laws seem to work kind of like this such as what is in Louisiana and Prof. Scales argued that this limited disability, threshold disability, might be the basis of a conceptual and coherent public policy. Unfortunately, that is not what we have at present.

Mr. Kirkner thanked the Committee for addressing this important topic which really speaks to the role of affordability of auto insurance and public policy. Mr. Kirkner appreciated Prof. Scales presentation but would dispute a few points in it. Without getting too bogged down in the specifics of the legislation, NAMIC believes there is a more appropriate way to refer to these laws. The phrase no pay no play really puts the wrong context on this discussion. The more appropriate title is something like the Missouri legislation that was tilted fairness for responsible drivers. It may seem like a semantic difference but its not because what we are taking about at the end of the day is insurance and insurance is a system of pooled and shared risk in which individuals participate.

The complicated factor to that system is that at least in this country the vast majority of states with just 1 exception have mandated participation in that system. In 2014, NCOIL took a look at this issue and adopted the Resolution which did 2 things. First, it limited the ability of illegally uninsured drivers to collect non economic damages and second it did maintain rights for those illegally uninsured drivers to recover even those non

economic damages in a very limited set of circumstances including when that person was a pedestrian or was an occupant in a car or where they were injured by an at fault drink driver or fleeing felon. That is an important distinction to be aware of.

What the Resolution mainly did and what NAMIC supports is situations that would prohibit illegally uninsured drivers from collecting the benefits of a system in which they do not participate. The Resolution does not bar the illegally uninsured driver from collecting non economic damages. There is a distinction between economic and non economic damages and it is important to not leave the discussion with the impression that fairness for responsible driver laws prohibit collection of economic damages. In fact, by and large the bills are limited to those non economic damages. That is an important distinction. NAMIC would support NCOIL returning to the discussion around these laws and would support model legislation that closely tracks with the Resolution which would in fact bar recovery of non economic damages while maintaining the rights of those same uninsured drivers to collect non economic damages in certain capacities.

Lastly, it is important to note, outside of fairness, what the point of these laws is. One of the rationales is an attempt is to reduce the number of uninsured persons in a state. Many are well aware of the impact of uninsured drivers on the impact of the overall insurance climate. A 2012 study submitted to the Nevada legislature indicated that here could be and likely was some tie in between these laws and a decreased number of uninsured drivers in a given state. Its very fair to say from an intellectual honesty perspective that the study could be updated and use some additional development which NAMIC would support. That is outside of the fairness rationale but in closing it is important to return to that point. Individuals that do not participate in the system should not be able to use the benefits of that system. This is a fairness perspective and NAMIC encourages to continue the discussion and perhaps works toward model legislation in this space.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Rep. Michael Webber (MI), the Committee adjourned at 10:45 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUSINESS PLANNING COMMITTEE AND EXECUTIVE COMMITTEE
NCOIL ANNUAL MEETING – TAMPA, FL
DECEMBER 12, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning Committee and Executive Committee met at the Tampa Marriot Water Street Hotel on Saturday, December 12, 2020 at 12:30 p.m. (EST)

NCOIL President, Rep. Matt Lehman, IN, Chair of the Committees presided.

Other members of the Committees present (* indicates virtual attendance via Zoom)

Asm. Ken Cooley (CA)*
Sen. Matt Lesser (CT)*
Rep. Martin Carbaugh (IN)
Sen. Travis Holdman (IN)
Rep. Edmond Jordan (LA)*
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. George Keiser (ND)
Sen. Neil Breslin (NY)*
Asm. Kevin Cahill (NY)*
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)*

Other Legislators Present were:

Sen. Mike Gaskill (IN)
Rep. Peggy Mayfield (IN)*
Rep. Jim Gooch (KY)*
Rep. Kevin Coleman (MI)
Sen. Shawn Vedaa (ND)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, General Counsel, NCOIL
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Rep. Martin Carbaugh (IN) and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Carbaugh and seconded by Sen. Neil Breslin (NY), the Committee voted without objection by way of a voice vote to approve the minutes of the September 26th, 2020 Committee Meeting minutes.

RESOLUTION RECOGNIZING NCOIL PAST PRESIDENT SENATOR JAMES L. SEWARD (NY) AS AN HONORARY MEMBER OF NCOIL

Before getting to the other Committee business, Rep. Lehman stated that he would like to offer a Resolution Recognizing NCOIL Past President Senator James L. Seward (NY) as an Honorary Member of NCOIL (Resolution) sponsored by himself, Sen. Jason Rapert (AR), NCOIL Immediate Past President, Asm. Ken Cooley (CA), NCOIL Vice President, Sen. Travis Holdman (IN), NCOIL Immediate Past President, Rep. Joe Fischer (KY), NCOIL Secretary, Sen. Neil Breslin (NY), former NCOIL President, and Asm. Kevin Cahill (NY), NCOIL Treasurer. Rep. Lehman remarked how when he attended his first NCOIL meeting, Sen. Seward was NCOIL President and Rep. Lehman was very impressed by how thoughtful and issue-driven Sen. Seward was. Sen. Seward is a true gentleman and is very deserving of the Resolution. Rep. Lehman then read aloud the Resolution.

Sen. Seward stated that is truly honored by the Resolution and gave remarks expressing his appreciation. Sen. Seward noted that he first got involved with NCOIL in 1999 when he was named Chair of the NY Senate Insurance Committee. Sen. Seward further noted that he is very honored to have served as NCOIL President in 2009 which was a tough year in many respects because of the financial crisis. Even during those difficult times, it was important to continue NCOIL's work in protecting the state-based system of insurance regulation. Sen. Seward noted that NCOIL is a very important organization to adopt Model laws that support the state-based system of insurance regulation, to educate legislators on insurance issues, and to interact at NCOIL national meetings with colleagues from across the country. The real hallmark of NCOIL has always been that when an issue is brought up, all sides of the issue are invited to present their views which is invaluable to producing a good work product. Also, NCOIL is a non-partisan organization and oftentimes you don't know who is a Republican or Democrat and that is how it should be. Sen. Seward closed by noting that he looks forward to attending future NCOIL meetings as an Honorary Member and stated that NY will continue to be well represented at NCOIL with Sen. Breslin, Asm. Cahill, Asw. Pam Hunter, Asm. Will Barclay, and others being involved. Sen. Seward again expressed his deep appreciation of the action taken today and the great association with NCOIL over the years.

Asm. Cahill remarked that it has been a pleasure serving with Sen. Seward over the years and thanked him for his years of service. Asm. Cahill stated that Sen. Seward is a true gentleman and he has learned so much from him over the years. NCOIL is a better organization as a result of Sen. Seward's service.

Sen. Breslin echoed Sen. Seward's comments on how a hallmark of NCOIL is its bipartisan nature. Sen. Breslin noted that while he is a Democrat and Sen. Seward is a Republican, they have found so much common ground on insurance issues throughout the years and they have learned so much from each other. Sen. Breslin noted that he has learned a lot from Sen. Seward not only on insurance issues but as to how to conduct yourself. Sen. Seward is everything that a legislator and elected official should be as he is so knowledgeable on so many issues and is able to get along with colleagues on the other side of the aisle.

Upon a Motion made by Sen. Breslin and seconded by Rep. Carbaugh, the Committee voted without objection to adopt the Resolution by way of a voice vote.

FUTURE MEETING LOCATIONS

The Hon. Tom Considine, NCOIL CEO, stated that the 2021 Spring Meeting as it currently stands is scheduled for March in Washington, DC, but it is important to be aware that Washington DC has a meeting limit of 25. As the vaccine rolls out, NCOIL staff will be in contact with the meeting hotel to see if meeting limits are increased. If Washington DC does not increase meeting size, we will need to look at other alternative meeting locations. Legislators in MD were made aware that if they pay their dues, NCOIL will consider holding its Spring Meeting in Annapolis or the Inner Harbor. New Mexico is another option for the Spring Meeting, although Santa Fe may be difficult to get to during March when people are in session.

For the remainder of the 2021 meetings, the Summer Meeting is in July at the Westin Boston Waterfront, and the November Annual Meeting is in Scottsdale, AZ. Additionally, the 2023 Spring Meeting is scheduled to be in San Diego, CA and the hotel search has been narrowed to the Westin Gaslamp Quarter.

ADMINISTRATION

Cmsr Considine noted that there were 246 attendees and participants at the Annual Meeting: 60 in-person and 186 virtual. There were 37 legislators from 21 different states: 14 in-person, 23 virtual. There were two first time legislators and Commissioners from four states participated, one in-person, three virtual.

Cmsr. Considine gave the 2020 unaudited financial report through November 30, 2020, showing a revenue of $1,227,991.73 and expenses of $912,385.23 for an excess of $315,626.50 heading into this meeting. Cmsr. Considine did remark that we may take a little hit on this meeting.

Upon a Motion made by Rep. Carbaugh and Seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to adopt the administration report.

CONSENT CALENDAR

Rep. Lehman noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers in the time between Executive Committee meetings.

The consent calendar included:

The Joint State-Federal Relations and International Insurance Issues Committee re-adopted the NCOIL Market Conduct Annual Statement Model Act.

The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Transparency in Dental Benefits Contracting Model Act.

The 2021 budget as adopted by the Budget Committee on 9/9/20.

The Budget Committee meeting minutes of 9/9/20.

The Special Committee on Natural Disaster Recovery meeting minutes of 9/24/20.

Rep. Lehman asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a Motion made by Asm. Cooley and seconded by Rep. Carbaugh the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Rep. Lehman began by thanking Congresswoman Carolyn Maloney for Zooming in to discuss the Pandemic Risk Insurance Act (PRIA) and other federal developments surrounding pandemic business interruption insurance coverage issues.

Rep. Lehman also thanked Dr. Lawrence Powell who, during the legislator luncheon, delivered a presentation titled "Examining the Insurability of a Pandemic." Dr. Powell was also a panelist during the meeting of the Special Committee on Race in Insurance Underwriting.

There were three interesting and timely General Sessions – "Bitcoin and Beyond- What is This Stuff And How Do We Insure It?"; "What Next for Federal Healthcare? A New Presidency – SCOTUS Decision Looming"; and "Medical Cannabis: Evaluating the Evidence."

On Wednesday, the Special Committee on Race in Insurance Underwriting met for the first time. Rep. Lehman thanked Sen. Breslin for Chairing the Committee along with everyone who participated.

NOMINATING COMMITTEE REPORT

Sen. Travis Holdman (IN), NCOIL Immediate Past President and Co-Chair of the NCOIL Nominating Committee, remarked that there has been a lot of discussion on filling the Nominating Committee slate for 2021. The consensus of the group was to nominate all of the current Officers to return for another term in 2021, due to the nature of business activity and activity of the state legislatures throughout 2020 it seemed appropriate and not inappropriate to ask the current Officers to serve one more term. Sen. Holdman noted that this model has been adopted by other national organizations and the Nominating Committee feels that it is an appropriate action to take. Sen. Holdman noted that he discussed this again this week with Nominating Co-Chair Sen. Jason Rapert (AR) and he still agrees with the recommendation but unfortunately, he had to leave this meeting early to return home.

Sen. Holdman then moved to adopt the Nominating Committee report which is that all of the current Officers be retained for 2021. Asm. Ken Cooley seconded the motion. Sen. Breslin remarked that it is a great idea. 2020 has been an abbreviated year and current Officers are competent who have not really gone through the full year. 2021 will be another difficult year and Sen. Breslin stated that he trusts the current Officers do again do a phenomenal job pulling NCOIL through the pandemic.

Asm. Cahill stated that he is not in support of the motion. Asm. Cahill stated that he respects the individuals involved for their work this past year during what has been an unprecedented one for NCOIL. However, although nothing in NCOIL's bylaws specify that the leadership of the organization change parties every year, it has been the longstanding tradition of NCOIL to do so. But, for the past three years, there have been

leaders from the same party and as noted earlier, while it is indeed difficult to identify which political party NCOIL members belong to, it does have a subtle impact and it affects the ability to attract members of the public and state legislators to attend and participate at NCOIL meetings. It is also important to note that other legislative organizations have developed reputations as being representative of something other than the 50 states so it is important that NCOIL upholds its bipartisan reputation.

Asm. Cahill stated that he also believes that there is no impediment to advancing the Officers as is usually done. While 2020 was different in many respects, NCOIL was able to hold all of its meetings and conducted business effectively by adopting model legislation and holding educational sessions. Asm. Cahill stated that he does recognize that leadership is balanced but as we all know the tenor and tone of meetings are embodied in the President of the organization and while the motion was supported during the Nominating Committee's previous meeting by the person who was scheduled to serve as NCOIL President in 2021, Asm. Cooley, Asm. Cahill stated that he disagrees with the current plan.

Lastly, Asm. Cahill stated that he does not believe the Nominating Committee is properly empaneled. Asm. Cahill stated that he believes there are standing rules that would prohibit any nominees from participating, yet nominees did participate. All officers were also not invited to the Nominating Committee's meeting. Asm. Cahill stated that he does not believe he would have been persuasive during that meeting but he would have liked to have had an opportunity to raise his concerns, but he was denied that opportunity.

Asm. Cahill stated that he wanted to reiterate that his remarks in no way reflect on Rep. Lehman's leadership which he values greatly.

Hearing no further discussion, the Committee voted to adopt the Nominating Committee report by way of a voice vote. Asm. Cahill and Rep. George Keiser (ND) were the only Committee members to vote against the Motion.

Rep. Lehman thanked his fellow Officers for all of their work this year and said that he looks forward to the future. This year has not been easy for anyone and the organization certainly looks forward to having robust in-person discussions. The future is bright as NCOIL is focused on good insurance public policy and addressing timely issues like the Special Committee on Race in Insurance Underwriting and limited immunity for businesses from COVID-related lawsuits. Rep. Lehman stated that he looks forward to a great 2021 and closed by thanking the NCOIL staff for all of their work.

OTHER BUSINESS

Cmsr. Considine asked the Committee to continue utilizing the services of Collins & Co for 2020 audits. They are a small firm and non-profits are their specialty. They were initially retained because of their work with guaranty associations and insurance associations. As a small firm, they can't really rotate audit partners, but they do rotate the staff that works on the audit.

Upon a Motion made by Rep. Carbaugh and seconded by Asm. Cooley the Committee voted to retain the services of Collins & Co. for 2020 audits without objection by way of a voice vote.

Pursuant to NCOIL bylaws, as Chair of the Committee responsible for insurance regulation from NCOIL Contributing States, Rep. Lehman welcomed, WV Delegate Steve Westfall and IN Sen. Andy Zay as NCOIL Executive Committee members.

Rep. Lehman then introduced Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), to offer suggested topics from the IEC for discussion at upcoming NCOIL meetings. On behalf of the IEC, Mr. O'Brien first congratulated Sen. Seward on being recognized as NCOIL Honorary Member.

Mr. O'Brien then noted that the IEC has one topic to present to NCOIL for consideration as it prepared the agenda for the next meeting. The topic submitted from State Farm and the National Association of Mutual Insurance Companies (NAMIC) relates to some regulations that can slow down claims processing in the wake of a natural disaster. In such situations, both carriers and their policy holders both have the same interest - they want to get claims paid quickly and fairly. The IEC would like to explore with NCOIL some ways to increase efficiency of this process, particularly for smaller claims, while at the same time protecting consumers. This is something that is right in NCOIL's wheelhouse and it is worth pointing to the actions NCOIL has taken recently with the Model Act Concerning Statutory Thresholds for Settlements Involving Minors which balanced flexibility with consumer protection.

ADJOURNMENT

There being no further business, upon a motion made by Rep. Carbaugh and seconded by Asm. Cahill, the Committee adjourned at 1:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING
FEBRUARY 19, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, February 19, 2021 at 12:00 P.M. (EST)

Representative Bart Rowland of Kentucky, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Derek Lewis (KY)
Rep. Chad McCoy (KY)
Rep. Brenda Carter (MI)
Rep. Daire Rendon (MI)
Asm. Ken Blankenbush (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Rachel Roberts (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Edmond Jordan (LA)
Rep. John Wiemann (MO)
Sen. Jim Burgin (NC)
Asm. Steve Hawley (NY)
Asm. Jarett Gandolfo (NY)
Asm. Steve Stern (NY)
Rep. Lois Schmitt (PA)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Asw. Pam Hunter (NY) and seconded by Sen. Bob Hackett (OH), the Committee waived the quorum requirement without objection by way of a voice vote.

CONTINUED DISCUSSION ON NCOIL CORONAVIRUS LIMITED IMMUNITY MODEL ACT, INCLUDING STATE ACTIONS RELATING TO CORONAVIRUS BUSINESS IMMUNITY STATUTES

Rep. Bart Rowland (KY), Chair of the Committee, thanked everyone for joining particularly since everyone is very busy continuing to deal with the pandemic and many are waist-deep in legislative sessions. Rep. Rowland stated that he is proud to sponsor this Model as it deals with such an important and timely issue. Every day it seems that another state has either passed legislation on this issue or is considering it since

Congress has been unable to reach any agreement. Rep. Rowland stated that the last time he checked the number was over 20 states that have either passed or introduced similar legislation.

Rep. Rowland stated that he and his colleagues are actively working on legislation in Kentucky that deals with this issue and they hope to send something to the Governor's desk soon. This Committee had a very good discussion on this issue at its last meeting in December where it heard from a panel of speakers with very different views on this issue. At the December meeting, the Committee discussed the first draft of the Model which was largely based on what Idaho had adopted this past Summer. However, everyone should have the latest version of the Model which was distributed last week. The latest version builds upon the first draft by adding some provisions from legislation that was introduced in Kentucky and in Representative Matt Lehman's, NCOIL President, home state of Indiana.

Specifically, a definition of the phrase "arising from COVID-19" was added along with more provisions to Section 3 relating to a reasonably prudent person standard, and a rebuttable presumption that safety measures adopted were reasonable if they conform to the Centers for Disease Control and Prevention (CDC) guidelines in existence at the time of the alleged exposure. On that last issue, Rep. Rowland stated that he knows that some states have included language that applies the presumption to more than one set of safety measures. Rep. Rowland stated that he thinks this is a good example of where an NCOIL Model provides the framework for an issue for states to further develop and that he likes the idea of the Model including the CDC guidelines for the presumption and then states can add to that if they wish.

Rep. Rowland stated that although those provisions were added, the intent of the Model has not changed at all – we're trying to protect businesses and individuals that operate using the proper standard of care from frivolous lawsuits during a time in which they are extremely vulnerable as a result of the pressures COVID-19 has put on them. Given the litigious society that we live in, handling lawsuits during this time can be an existential threat for businesses that are already on the brink of survival. Relatedly, insurance policies should not have to pay for something that ultimately could be impossible for a litigant to prove in certain instances.

Rep. Rowland stated that even with the continued rollout of vaccines and improved treatment methods, he thinks we all know that the country will unfortunately be living with this virus for quite some time. However, conscientious businesses still must be able to function in this era of our 'new normal' without the cloud of potential litigation hanging over their heads. That is not to say that there won't be instances where litigation is warranted – of course, if a business acts in a reckless or willful manner, liability can and should attach, but the businesses who want to re-open in a safe manner should be provided a certain level of immunity from COVID-related lawsuits.

With regard to the format of today's meeting, the Committee will first hear any comments and questions from legislators. Once all legislators are finished speaking, the Committee will then hear any comments and questions from interested persons. Once all comments and questions are heard, Rep. Rowland stated that he would entertain a Motion to vote on the Model as it is important for NCOIL to adopt the Model today as a form of guidance since more and more states are seeking to enact legislation on this issue.

Rep. Lehman thanked Rep. Rowland and everyone else for joining today. Rep. Lehman stated that he is proud to sponsor the Model alongside Rep. Rowland and he agrees with his remarks that it's important for the Committee to adopt the Model today as more and more states are considering this issue. Rep. Lehman stated that in his home state of Indiana, a bill was sent to the Governor's desk earlier this week and he did indeed sign it. In Indiana, it was ultimately agreed upon that the economy simply cannot function if businesses can't get back to the everyday service of providing a product or service to consumers with a fear of being sued hanging over their heads. Even if there has not been a lot of litigation yet, we have to ask ourselves as legislators – what about tomorrow and next week and next month when America further continues its reopening process and begins to get to a place where we are getting back to normal regular order.

Having a law in place that would provide a certain level of immunity to responsible businesses will encourage them to re-open, and protect them and their insurers from any unnecessary litigation. Our business community can't function if they are looking over their shoulder worrying about who is on their doorstep looking to put them out of business with a lawsuit. Rep. Lehman stated that he is pleased that language was added to the Model to build upon the prior version. States have been and are going to deal with this issue in different ways, but, as he often says, NCOIL has always been an organization that says we build the foundation and you put up the curtains. This Model represents a very solid foundation for states to consider and they can work with it as they wish.

Rep. Chad McCoy (KY) stated that for those who were at the Committee's last meeting in December, they would recall that, as a practicing trial lawyer, he was against the Model. However, Rep. McCoy thanked everyone that has worked on the Model since that time to make changes that have alleviated his concerns. Rep. McCoy stated that he believes this Model is great and strikes a really good compromise as it gives businesses the immunity they need and from a legal standpoint it gives an affirmative defense and presumption. Rep. McCoy stated that he supports the Model and hopes the Committee adopts it today.

Rep. Daire Rendon (MI) stated that she has a unique perspective on this issue because besides being a legislator she has been a business owner for 35 years. Rep. Rendon stated that her business was able to work through the pandemic by implementing safety procedures but even with that there will be things that will pop up going forward that will need to be dealt with so she appreciates the comments from the previous speakers. Rep. Rendon asked if the comments submitted by National Association of Professional Insurance Agents (PIA) were taken into account when drafting the Model. The comments addressed a definition for "testing" for COVID-19 and the emergency which they thought should be specifically named. Rep. Rowland stated that he doesn't see anything wrong with PIA's comments but believes that the Model is solid as-is and can be altered by states if they would like to do so with comments such as those submitted by PIA. Rep. Rendon agreed.

Rep. Derek Lewis (KY) applauded the work done on the Model thus far and stated that it represents a proactive approach. Too often, legislatures are reactive instead of being proactive and Rep. Lewis stated that he supports adoption of the Model.

Rep. John Wiemann (MO) stated that his comments do not represent dissatisfaction with the Model as he believes it is a good piece of Model legislation. Rather, he just wanted to comment on his involvement with this issue in Missouri as they have been actively working on it. The bill there has almost passed out of the Senate and then he will take over on the House side. One of the areas that they had a lot of problems with dealt with the applicable standards. The Model uses the CDC guidelines but the Missouri local health departments had a lot of issues with that.

Rep. Rowland stated that he and his colleagues have had similar conversations in Kentucky regarding the applicable standards. Ultimately, the Model cites the CDC guidelines but states can of course cite different guidelines if they wish. Rep. Lehman stated that one of the concerns he and his colleagues had in Indiana with this issue was that what if local standard go well below the CDC standard. So, for example an area might say we're going to be more lenient but it goes well beyond that would that immunity apply if they want to do things so far below CDC. Indiana had similar discussions and ended up looking at it as the CDC is the footprint and then you can go one way or another. Rep. Lehman stated that he is glad this issue was brought up because it led to robust discussions about what happens when places are more or less lenient.

Rep. Rowland stated that another important point to make is that this is a national Model and the CDC is a national entity. Of course, a state law may want to adopt state health guidelines in their law and they certainly are able to do that.

Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC supports the Model and knows that the intent and practical measure of these laws is to protect small businesses as we emerge from the pandemic and shield against frivolous lawsuits. It's important to note that NAMIC concurs with Rep. Lehman that these are sensible and balanced provisions that help us emerge from the pandemic – they don't as some opponents argue invite bad actors that put the public at risk – that's false. NAMIC supports the Model and urges adoption. NAMIC does have a few suggestions that were forwarded to NCOIL staff that Committee members may want to consider when drafting legislation on this issue in their state. First, NAMIC wants to ensure that the applicability covers businesses that are acting in a volunteer capacity.

Second, NAMIC also contemplated similar concerns as have already been mentioned about CDC guidelines and perhaps conflicting with state or local protocols. NAMIC understands Rep. Rowland's and Rep. Lehman's comments about considering this issue at the state level. Finally, the rebuttable presumption of immunity in the Model should be tied to a person's good faith attempts to comply with the CDC or other guidance. The Model does provide that but then inserts an ordinary and reasonable and prudent standard which might muddy the waters and create confusion so we urge states to look at that and stick with just the good faith standard. NAMIC support the model and agrees that timeliness is important and urges the Committee to adopt it.

Wes Bissett, Senior Counsel of Gov't Affairs at the Independent Insurance Agents & Brokers of America (IIABA) thanked Rep. Rowland and Rep. Lehman for sponsoring the Model and for their work to improve the Model. IIABA supports the Model and urges action today. Mr. Bissett stated that he wont repeat his December comments but believes strongly that providing limited immunity for a small window of time is not only

appropriate but would help to eliminate a lot of the concern that small businesses are facing right now. Along the lines of Ms. Collins' comments, IIABA does not want to make perfect the enemy of the good but one suggestion is to eliminate the references to the good faith standard in Section 3(A) and incorporate that into Section 3(B) but that's not something that should impede the Committee's work today. IIABA urges adoption of the Model.

Lauren Pachman, Counsel and Director of Regulatory Affairs at PIA stated that PIA members are often small business owners so this is an important issue. PIA thanks the sponsors and the Committee for their work. As indicated in PIA's comment letter, PIA supports the Model as it affords small businesses the assurances that they need to reopen confidently and without fear of frivolous litigation. As we all know that kind of threat can derail businesses even in the best of economic times and now it poses a greater threat as business are already on the precipice of closing. PIA does have two small recommendations and Ms. Pachman thanked Rep. Rendon for mentioning them. The comments just add detail around testing in Section 2 and add a bit of detail around the state of emergency just to provide states with a template for filling in the actual state of emergency that's in effect. PIA supports the Model and urge states to adopt it.

Hearing no other comments or questions, upon a Motion made by Rep. Joe Fischer (KY), NCOIL Secretary and seconded by Rep. Lehman the Committee voted without opposition to adopt the Model by way of a voice vote. NCOIL General Counsel, Will Melofchik, stated that the Model will now be placed on the Executive Committee agenda for final adoption in April. NCOIL CEO, Commissioner Tom Considine, stated that for anyone unfamiliar with the model law adoption process at NCOIL, it would be highly unusual for changes to be made to the Model before then so if any legislators are interested in introducing the Model, the version adopted today would be the form they can be comfortable with.

Asm. Ken Blankenbush (NY) asked whether he had to abstain from voting since he is an insurance agent and owns an agency and is a member of IIABA. Rep. Rowland and Rep. Lehman replied no as they are in the same position as Asm. Blankenbush.

Rep. Rowland stated that he has a couple of more pieces of business before the Committee adjourns. First, registration for the NCOIL Spring Meeting in Charleston, South Carolina is now open. The meeting will again be a hybrid format allowing for both in-person and virtual attendance via Zoom. All registration information can be found on the NCOIL website or by reaching out to NCOIL staff.

Second, in December of 2019, NCOIL adopted the Peer-to-Peer Car Sharing Program Model Act which he was proud to sponsor. The Model has been very successful and has been introduced and adopted in several states across the country. Recently, some amendments to the Model have been agreed upon by both the insurers and peer-to-peer car sharing companies which Rep. Rowland would like to sponsor and include on the Committee's agenda for adoption at the Spring Meeting.

Overall, the amendments aim to provide clarity and standardization of insurance coverage during the peer-to-peer car sharing transaction and deal with amending certain definitions in the Model; clarifying state insurance limit, primary liability, and underwriting issues; and providing additional recordkeeping requirements on the car sharing program.

The specific language of the amendments will be included in the 30 day materials next month. Any questions on this can be directed to Rep. Rowland or NCOIL staff.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Rep. Fischer, the Committee adjourned at 12:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING
INTERIM COMMITTEE MEETING
MARCH 5, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Race in insurance Underwriting held an interim meeting via Zoom on Friday, March 5, 2021 at 1:00 P.M. (EST)

Senator Neil Breslin of New York, Chair of the Committee, presided.

Other members of the Committee present were:

Asm. Ken Cooley (CA)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Asm. Kevin Cahill (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Shawn McPherson (KY)
Sen. Jim Burgin (NC)
Rep. Carl Anderson (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Tess Badenhausen, Assistant Director of Administration, NCOIL Support Services, LLC

INTRODUCTORY REMARKS: CHAIR BRESLIN AND INDIANA REPRESENTATIVE MATT LEHMAN – NCOIL PRESIDENT

Senator Neil Breslin (NY), Chair of the Committee, thanked everyone for joining and then turned things over to NCOIL President, Representative Matt Lehman

Rep. Lehman thanked everyone for joining and stated that he is proud to sponsor the proposed definition of “proxy discrimination” alongside Chair Breslin and he believes the definition represents the best path forward for the organization. Rep. Lehman stated that the Committee had a very good discussion on this issue at its last meeting and he would like to thank everyone that participated. In his discussions with Chair Breslin, Rep. Lehman noted that they feel confident that the proposed definition before the Committee represents a solid work product and is something that should be adopted by the Committee so that NCOIL can fulfill its role in providing guidance to states when developing public policy on this first of the two committee charges.

Rep. Lehman stated that he knows Chair Breslin will touch upon this as well, but they both believe it’s vital that the definition of “proxy discrimination” recognize that there is an

intentional act associated with it. This is necessary because the legal term "proxy discrimination" has the word "proxy" right in it, and "proxy" already has a definition that involves volition. It's important that the definition in statute not be in contradiction with the definition as understood by general society. Such a contradiction would create havoc for essentially everyone involved in the underwriting portion of the insurance industry.

Rep. Lehman stated that he also wants to note that since proxy comes to us with an existing definition, that proxy discrimination needs to remain separate from disparate impact discrimination, which involves no intent. The second charge of this Special Committee is to review individual underwriting factors. The Committee will see that some of those factors have a disparate impact on protected classes, and the Committee may conclude that some of that disparate impact is unfair. That requires separate analysis from the fairly straightforward definition of proxy discrimination. Rep. Lehman then repeated something that he said in December but stated that he thinks it's important to reiterate: having conversations like these is not always easy, but NCOIL cannot sit idly while decisions that can have a huge impact on our constituents and the state-based system of insurance regulation in general are made without input from state insurance legislators. Indeed, state legislators are those that have been vested with the authority to make such decisions pursuant to the McCarran-Ferguson Act enacted 75 years ago. Rep. Lehman stated that he looks forward to the discussions today.

Chair Breslin stated that he is proud to sponsor the proposed definition of "proxy discrimination" as it deals with such an important and timely issue. The Committee had a very good discussion on this issue at its last meeting in December where it heard from several speakers with very different views on this issue. A number of people reached out to Chair Breslin afterwards saying it was great to see so many people come together on such important issues. The driving force behind crafting the definition in the manner in which it appears is the need to explicitly recognize that "proxy discrimination" involves some affirmative decision or volitional act by an individual or entity. This concept of intent is necessary both because the legal term "proxy discrimination" includes the word "proxy" which comes with an existing definition, and in order to separate it from being equated with disparate impact discrimination, which involves no intent.

Chair Breslin stated that while he doesn't want to go too far down a linguistics rabbit hole, he does want to spend a little time reviewing the actual, existing definition of "proxy". One dictionary defines it as: "[o]ne who is authorized to act as a substitute for another." Another definition reads: "[T]he authority that you give to somebody to do something for you, when you cannot do it yourself; a person who has been given the authority to represent somebody else; something that you use to represent something else that you are trying to measure or calculate." The words "authorized" and "authority" involve some level of affirmatively and/or intentionally granting permission to someone. The top Merriam-Webster definition of "authorize" reads: "to endorse, empower, justify, or permit by or as if by some recognized or proper authority (such as custom, evidence, personal right, or regulating power)."

Contrast this intentional discrimination which has always been prohibited, with disparate impact, which has, with certain exceptions, always been legal within the insurance industry and involves no intent. Accordingly, equating "proxy discrimination" and disparate impact would both contort the use of the word "proxy" in the phrase so as to render it inconsistent with its plain meaning, and completely revamp the insurance

ratemaking system. Adopting a prohibited disparate impact standard for insurance ratemaking analysis across-the-board would simply be incompatible with basic insurance principles.

Chair Breslin stated that he strongly believes that NCOIL adopting this definition of "proxy discrimination" will be beneficial to not only the organization by demonstrating leadership on such an important issue, but also to states as they begin to deal with these issues in their legislatures. For example, a bill was introduced earlier this week in Colorado containing the term "proxy discrimination" but the bill does not define the term. Everyone on this call today knows the importance of words being defined in legislation. Undefined terms create problems for the legislators that enacted the law, the regulators that enforce the law, courts that are called upon to interpret the law, and those governed by the law.

However, Chair Breslin noted that the Committee's work does not end with defining the term "proxy discrimination." More attention should be given by the Committee during its April meeting to the issues surrounding rating factors and disparate impact. As referenced earlier, as a general matter, disparate impact has always been legal within the insurance industry and by definition, there is no intent involved. However, based on the Committee's discussions during its December meeting, the Committee should further discuss instances where there is overwhelming evidence that disparate impact amounts to unfair discrimination because of, for example, a rating factor's negative impact on a protected class.

That process recognizes that in insurance, actuarial justification is the one core standard of risk-based pricing that applies to every rating factor. But, from time-to-time state legislators, after extensive debate during which all perspectives all heard, decide that even if certain factors can be actuarially justified, social considerations warrant that they be exempted from the core standard or risk-based pricing. This is what happens across the country in state legislatures when deciding whether or not to prohibit insurers from using certain rating factors in underwriting such credit score, zip code, or gender. That is the proper way to address any social unfairness in the insurance underwriting process rather than imposing a disparate impact standard.

That brings us to the format of today's meeting, the Committee will first hear any comments and questions from legislators regarding the definition of "proxy discrimination." Once all legislators are finished speaking, the Committee will then hear any comments and questions from interested persons. Once all comments and questions are heard, Chair Breslin stated that he would entertain a Motion to vote on the definition. Next, the Committee will follow the same format of hearing from legislators first and then interested persons regarding the next steps for the Committee's April meeting when discussing rating factors and disparate impact.

CONTINUED DISCUSSION AND CONSIDERATION OF "PROXY DISCRIMINATION" DEFINITION, AND AMENDMENTS TO NCOIL PROPERTY/CASUALTY INSURANCE MODERNIZATION MODEL ACT

Asm. Ken Cooley (CA), NCOIL Vice President, thanked Chair Breslin and Rep. Lehman for their work. It is worth noting a very important related concept to the whole point made by Chair Breslin concerning the importance of working within a universe of defined terms of known meaning. The business of insurance is one that if you enact statutes

which are vague in their expression then you can have a lot of liabilities arise during the period of time from when the onset of the statute is until they get clarified. Asm. Cooley stated that he feels that in the area of rating, to introduce uncertainty as to on what are the rates founded on really jeopardizes the capital base of insurers because until that all gets sorted out claims can come in and disputes can arise and it can be a very heavy load to deal with in litigation and claims payouts arising from things not being clear.

Asm. Cooley stated that he feels that there is a special responsibility which only insurance oriented lawmakers would grasp which is that to introduce vagueness into the rating statutes and then passing them in states trusting that its going to get worked out in time actually exposes the capital structure of insurance companies to a very significant legal issue. It runs in favor of being conservative, cautious, and thoughtful in how we pick apart something and examine the importance of language and the extent to which it affords clarity so that we are not opening up the potential for legal problems.

Rep. Brenda Carter (MI) stated that she would like to mention the fact that when she and her colleagues were discussing this in Michigan one of the questions was whether gender orientation could be considered as a rating factor by insurers. NCOIL General Counsel, Will Melofchik stated that question goes more towards the Committee's second charge in terms of discussing specific rating factors. NCOIL CEO, Cmsr. Tom Considine, stated that additionally, if an insurer were to use a neutral factor intentionally as a substitute for gender, that would be unfair discrimination by proxy and would be precluded by this definition. Rep. Carter replied thank you.

Rep. Edmond Jordan (LA) stated that he takes somewhat of a different sentiment to this. He does not see the definition as a move forward but rather backwards. Rep. Jordan stated that he listened to the remarks regarding the definition of certain words and a lot of time was spent on proxy, but not on discrimination. Definitions for discrimination include: bigotry, hatred, inequity, injustice, intolerance, prejudice, and unfairness. If the Committee is not dealing with the disparate impact aspect of these issues, then Rep. Jordan stated he is really not sure of what the purpose of the Committee is.

Definitions are fluid. Rep. Jordan stated that if he said someone was a "bad" man, there is context associated with that – it could mean that you are awful but it also could mean that you may be great. If someone said Patrick Ewing is a "bad" player it could mean that he is good. The truth of the matter is that we can define a word to mean what we want it to mean within an organization or an industry. Rep. Jordan stated that he has a disagreement with that. There is a famous quote which says that if you stick a knife in my back nine inches and pull it out six inches, there's no progress - you have to heal the wound that created the injury. Rep. Jordan stated that he believes folks have been discriminating - not this Committee and not individually, but as an industry there may be some fear on how it got there and how to make a profit without certain factors in place.

Rep. Jordan stated that he believes this Committee is well intended but this is only its second meeting and he does not believe you can fix this in one meeting and then vote the next but if that's the attempt then so be it. Rep. Jordan stated that he understands there are efforts to move forward and he believes everyone in good faith wants to move forward. Rep. Jordan stated that he doesn't think the proposed definition gets the Committee to the place where it needs to be - more work needs to be done. Difficult discussions need to be had and he doesn't think that one leads merely by not wanting to be left behind. Rep. Jordan stated that he understands there are other entities trying to

develop a definition but the fear of being left behind doesn't necessarily mean that you are the leader on the subject. Rep. Jordan stated that he believes that if we want to be leaders we need a more thoughtful approach. That is not to say that this approach is not thoughtful, but the Committee can do better. Rep. Jordan stated that he is willing to work on that and would ask for a commitment from everyone to get there.

Chair Breslin thanked Rep. Jordan for his comments and stated that hopefully that's what the Committee is trying to do - to arrive at a valid insurance industry that does now acknowledge or allow any racism to creep into its rating system. It is not a perfect process because it depends on a lot of people to make sure that it acts that way and along the way mistakes will be made but hopefully if we're all trying to climb the same mountain we'll get to the top together.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that he agrees with some of Rep. Jordan's comments in that we have a proactive responsibility to root out discrimination wherever it is but in particular in the area of insurance where there has been a history unfortunately of discriminatory practices in the past. Asm. Cahill stated that while he wholeheartedly supports Chair Breslin and Rep. Lehman on their work and moving this issue forward, and for taking the initiative Cmsr. Considine deserves credit, he believes that even on this first charge the Committee could do more. Asm. Cahill stated that understands that there is a traditional sense of proxy discrimination of requiring an intentional act. However, there is also a belief that proxy discrimination can occur without an intentional act.

Asm. Cahill referred the Committee to a recent Iowa Law School law review article that discusses this very issue especially in age of artificial intelligence. Asm. Cahill stated that for those reasons he wont support the definition but noted again that is not meant to be a slight on the parties involved because he applauds them for their work.

Asw. Pam Hunter (NY) stated that she would like to add on to Rep. Jordan's comments. Foundationally, she feels that this is not the right direction if we're not talking about systemic longstanding discrimination in the industry. Asw. Hunter stated that if you look at long term decisions that have affected communities like redlining, and we're talking about today how we're not going to take into consideration a person's skin color but we're going to talk about someone's zip code, she knows that there are a couple of census tracts where she lives that are the highest poverty rates in the entire country of people of color so they are going to disproportionately have a negative advantage for loans and insurance.

Asw. Hunter stated that she feels strongly that the Committee can do much better in having a broader conversation. Asw. Hunter stated that she knows that the Committee is going to get more in depth in terms of disparate impact and rating factors but if we don't foundationally start in the right direction it wont go to where we need it to be. Asw. Hunter stated that she agrees that this can be more thought out and take more time. While there are other organizations involved, it's not a race to the finish line, but rather making sure we are taking the appropriate steps to right historic wrongs and make sure we have equity going forward. Asw. Hunter stated that she doesn't think the Committee is there yet and its no disrespect to the people involved or the organization but she believes the Committee can do better.

Chair Breslin stated that anyone who would tell him that there hasn't been racism in the industry is deceiving him and not telling the truth but hopefully everyone learns from mistakes. As the famous saying goes – he who forgets the past is doomed to repeat it. The Committee should continue to talk about the past but sometimes that can also be detrimental if you only focus on the past and Chair Breslin stated that he believes the Committee is looking forward and trying to figure out how to move on to make sure that all classes legally are protected and that the insurance industry is at the forefront of making those changes.

Rep. Lehman stated that the comments made by Rep. Jordan, Asm. Cahill and Asw. Hunter brought up some very good points but they focus more on the second part of the Committee's charges which is the rating factor discussion. The factors will be part of the second charge of the Committee but setting forth a definition is key to setting a bar out there that says "we don't want you playing games if you are moving pieces of the puzzle around." What pieces that are part of that puzzle will be part of the second half of the Committee's discussions. Rep. Lehman stated that he doesn't want to cut anyone off but it seems that the discussions thus far are focused on the second charge and we need to focus on the definition right now that we want to put out there that can go into law so that it cant be used improperly by departments and carriers.

Hearing no other questions or comments from any legislators, Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) first thanked Chair Breslin and the Committee for their work on this important issue. As the comments today show it hasn't been easy and APCIA doesn't think it will get any easier but few things that are important are never easy. Second, with regard to the definition, APCIA joins in urging its adoption. In proposing and debating and hopefully adopting the definition, NCOIL is laying out a marker as an initial statement of public policy. By acting in a space where others have not NCOIL fulfills its essential role in assisting lawmakers and others on issues of importance to the state based system of insurance regulation. That is what this Committee and this organization is doing today and will continue to do in the future. Finally, Mr. O'Brien noted that the definition is entirely consistent with the dominant body of case law – it is what the law is now as opposed to what others may want the law to be. The law is a dynamic force and a dynamic object and it is through debate and discussions such as this that change is achieved. But, change begins with a first step and this definition is the first step.

Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC is supportive of the NCOIL direction and concept of both identifying proxy discrimination as a space for action as well as the connection of the concept of intent as it is applied there. NAMIC absolutely agrees that unfair discrimination includes this definition and is absolutely prohibited and has no place in our industry. Ms. Collins stated that she would like to hit a couple of points to explain why in NAMIC's view connection to intentionality is the only viable path forward for a definition of proxy discrimination. First, there has been quite a lot said about applying a disparate impact analysis to insurance or just looking at outcomes of underwriting and rating and setting aside risk profiles and actuarial science - that's a challenge. That means that applying risk classification based upon scientific evidence would be disallowed if the outcome was disproportionate. Ms. Collins stated that she cant think of a single factor anywhere that can survive that test. It's not out of an aversion to examining and having an honest discussion about underwriting and rating, it's just that an outcome approach just does not work with risk based pricing. Even if individuals only

belong to one protected class instead of multiple there is very little feasibility that outcomes will directly align with demographics.

Ms. Collins stated that for example, take the factor of age of a vehicle which is a good one because it can work both ways – it it's new it has new tech and new safety features, and if it's old maybe it doesn't have safety features and is more susceptible to severity. Ms. Collins stated that she has a car that's two years old and according to a Pew research study, 5% of American women have one of her protected class characteristics and that's a little over 8 million people. Well, what if of those women a disproportionate number drive cars that are two years old compared to the rest of the population. My insurance carrier doesn't know, nor do they want to know, about my 5% characteristic but if you apply a typical disparate impact analysis to the factor of age to the vehicle, two things happen. One, its highly likely that age of the vehicle doesn't survive that test and is disallowed as a factor and now my neighbor driving the average age vehicle is going to have to subsidize my newer car.

The second thing that happens, and this is important to me as an individual, is that because my insurance carrier will have to test all of their underwriting variables and show that test and prove it out to regulators in this way, all of a sudden by carrier is going to have to ask me about my 5% characteristic and will have to track it and store it. Ms. Collins stated that some people are going to say that she is engaging in hyperbole or it's too blunt of an instrument that she is using or that she doesn't understand how a disparate impact standard would really be applied and maybe they're right because regulators probably wouldn't start with going after age of a vehicle as a factor. They would pick and choose where to apply the standard and issue declarations about certain factors or reject filings if they have time and resources to do that.

Ms. Collins stated that she doesn't consider that a fair system but she can certainly see the practicality of that outcome. But, that's not the whole story here. If we divorce intentionality when we're talking about this broad concept of proxy discrimination and use disparate impact as an underwriting standard as some have called for, the insurance companies will be universally pulled into bad faith litigation on very single factor that they use no matter what the regulators do and that is something no one wants. Accordingly, Ms. Collins stated that the proposed definition is a good path forward. We're all trying to engage and discuss what industry's role can be in combating systemic racism in America.

Ms. Collins stated that when she listens to people smarter than her talk about potential solutions what comes up over and over again is access: access to insurance; increased products and coverages due to competition; decreasing risk through mitigation and that resulting in more access; and how we can attract new and diverse talent in the industry. Ms. Collins stated that those are things we can and should focus on and she is looking forward to that conversation with this Committee. But upending decades of actuarial science and applying something that isn't risk based is not going to create access in the market but rather will constrict the market and make it hard to know what insurance to write and how much and for how many people – that's not the answer. Creating a highly competitive market with lots of companies to choose from with the ability to match rate to risk is the path forward and where we should start. For that reason, NAMIC supports the definition and encourages adoption.

Birny Birnbaum Director of the Center for Economic Justice (CEJ) stated that CEJ appreciates NCOIL's efforts to examine the impact of systemic racism on insurer practices and insurance companies. However, the proposed definition reflects a profound misunderstanding of how systemic racism affects insurance. By defining proxy discrimination only as the intentional use of a proxy characteristic for a protected class, the definition if adopted would memorialize insurer practices that discriminate indirectly on the basis of race, would discourage insurers from examining the racial impact of their practices and would restrict current regulatory efforts to address such unfair discrimination. It is fundamentally incorrect to say that proxy discrimination must involve intent. The argument misunderstands how bias affects insurance outcomes. The proposal basically takes the view that unless you intend to discriminate, there can be no discrimination and relieves insurers from any responsibility to test their practices for systemic bias.

The realistic view is that systemic racism and historic discrimination can be reflected and perpetuated in so called neutral factors. Literally everyone outside the insurance industry trade associations understands that big data algorithms can reflect and reproduce historic discrimination and that presence of systemic racism demands proactive examination of insurer practices for unnecessary racial discrimination. It is also factually incorrect that disparate impact analysis harms risk based pricing. Such analysis is completely consistent with actuarial practices.

Mr. Birnbaum stated that he would like to get to the type of disproportionate impact that is tied to the use of proxies for prohibited characteristics and not to the outcomes. In earlier conversations we described one situation where insurers were using age and value of a home for underwriting factors for homeowners insurance with the result that communities of color were systemically denied home insurance because these communities were characterized by older, lower value homes – results directly tied to historic discrimination in housing. When challenged, insurers discovered that the factors they were using, age and value, were more correlated with race than with insurance outcomes. As a result of the disparate impact challenge the insurer moved to more relevant risk factors such as the condition of the home and its systems with the result that insurance became more available in communities of color and there was a better correlation between risk classifications and outcomes.

This second type of impact involves unintentional, unnecessary discrimination on the basis of race. It's unnecessary because the facially neutral factor that is reportedly associated with the insurance income is in whole or in part a proxy for the protected class characteristic and predictive of that class characteristic and not the outcome. Stated differently, the facially neutral factor has a spurious correlation to the insurance outcome and is really correlated to the protected class characteristic. So, CEJ suggests that a better definition of proxy discrimination to really get at that unnecessary racial discrimination would be: "Proxy discrimination is the use of a non-prohibited factor that, due in whole or in part to a significant correlation with a prohibited class characteristic, causes unnecessary, disproportionate outcomes on the basis of prohibited class membership."

Mr. Birnbaum stated that he will finish by saying that that any efforts to address systemic racism and proxy discrimination have to apply to all aspects of insurer's operations, not just pricing and underwriting. For example, insurers could be marketing based on protected class factors directly or indirectly and that would not be prohibited by the

definition. Yet with big data analysis insurers can micro target customers, focusing on those they view as high value and excluding those they view as low value with the result that those who are low value that happen to be in communities of color would never see preferred offers. Similarly, for anti-fraud and claims settlement, companies are using big data algorithms and sources of data such as facial analytics that are known to have a strong bias.

The other two points are that industry admits that the proposed definition adds no new tools or resources to regulators. During the December meeting of this Committee Mr. Birnbaum stated that he asked The Honorable Nat Shapo, former Director of the Illinois Department of Insurance whether it's his position that if a regulator discovered an insurer using a perfect proxy for race could the regulator take action to stop that discriminatory practice. Mr. Birnbaum stated that Dir. Shapo offered the view that regulators have that authority. So, given that view the proposed definition not only fails to add any new tools but actually restricts activities that insurance regulators have long engaged in to stop the use of blank proxies. Now, they somehow have to prove intent where currently regulators work on things they know have an unnecessary and unfairly disproportionate impact.

Mr. Birnbaum stated that, in closing, CEJ urges NCOIL to reject the proposed definition of proxy discrimination and hopes that the Committee's intent is to address impacts of systemic racism in insurance. If that's the case, the proposed definition accomplishes just the opposite and would memorialize such unnecessary proxy discrimination.

Dir. Shapo stated that he would like to speak for a couple of minutes since his prior testimony was just cited. First, Dir. Shapo stated that the description of his testimony from December is inaccurate. Dir. Shapo stated that the idea that Mr. Birnbaum asked him a question about a perfect proxy and that he gave a particular response doesn't conform to his memory and is not reflected in the record of the hearing. Dir. Shapo stated that he doesn't believe he was asked a question by Mr. Birnbaum, nor does he believe he could have been as NCOIL to his knowledge only allows Committee members to question witnesses – not other witnesses to do so. Also, Dir. Shapo stated that he thinks that the testimony he gave about the subject is quite a bit more nuanced than described by Mr. Birnbaum. Dir. Shapo stated that he did offer a view on the general subject that he thought the language in the current prohibition in rating based upon a protected class like race should be understood to cover proxy discrimination. Dir. Shapo stated that he has a longstanding concern about regulators sometimes not using the tools they have before they seek more and that informed his position that he just recited.

Dir. Shapo stated that he was also particularly concerned about moving toward a definition that could have bought in the same kind of disparate impact outcome under the guise of proxy discrimination which is reflected in the CEJ submission. The submission talked about proxy discrimination but it's clearly about disparate impact and the distinctions between the two have been well covered in this meeting and prior meetings. The bottom line as he understands it is that NCOIL felt strongly it was necessary to define proxy discrimination particularly because of the idea that without a definition it could bleed over to disparate impact, and NCOIL has also mentioned that the NAIC has adopted a proxy discrimination standard without defining the term so as a practical matter that is the position that NCOIL has taken and makes perfect sense.

Dir. Shapo stated that another accuracy point is that he believes on this question about the age and value of a house there is a reference to insurers finding that there was a correlation to race and not a correlation to risk. There wasn't a citation to this assertion in the CEJ letter but the best he can guess is that it's probably a reference to some decision in the 1980s under a federal anti-discrimination statute. Dir. Shapo stated that he believes the statement is that when challenged insurers found that the factors they were using, age and value of home, were more correlated to race than with insurance outcomes. Dir. Shapo stated that he is not aware of anything in the record that says insurers found that and concluded that they were using factors that were more correlated with race than insurance outcomes. Dir. Shapo stated that he thinks what you had there was a very specific federal statute under which litigation was brought that only pertains to housing and thus in the insurance world homeowners insurance, and the defendant insurance companies as rational actors will do in litigation entered into settlement agreements that may have affected the types of factors they used. That doesn't mean that they concluded that they were correlating with race and insurance outcome.

Dir. Shapo stated that those factual quibbles sort of funnel into the basic disagreement he and Mr. Birnbaum have on these issues. When looking at this it's a question of do you think disparate impact on every factor is the way to analyze this or is it better to funnel into what Chair Breslin said before which is to conduct an examination of individual factors and a determination of whether there is social unfairness that outweighs the social fairness of their actuarial justification. There was a lot of discussion about that at the last hearing and its brought up again here. Dir. Shapo stated that his view is that he thinks the concerns raised by certain Committee members are very important concerns but charge two of the discussion and the legislator's application of their political judgment is the well-established way that legislators have addressed these problems in the past.

Mr. Birnbaum stated that the record is clear that in the last Committee meeting he did ask Dir. Shapo that question and he did respond as set out in CEJ's letter. The second point is that it was not the 1980s it was 1990s and it was a claim brought under Federal Fair Housing Act (FHA). The fact that it was brought under the FHA doesn't really import a problem with the issue of whether disparate impact analysis is relevant and useful for insurance and whether it promotes better risk-based pricing or whether it harms. The evidence is that disparate impact analysis improves risk-based pricing. Industry has never been able to provide a single example of how its harms risk-based pricing. The fundamental problem here is that the definition is conflating two issues – its conflating the types of historic discrimination that leads to embedded outcomes such as shorter life expectancy for black Americans or certain diseases that black Americans suffer – that type of outcome can't be separated from actuarial analysis. The type of issue that we're talking about here can be separated from the outcomes and that's where the problem lies.

Cmsr. Considine stated that while Mr. Birnbaum and Dir. Shapo disagree on the issue of whether a question was asked at a prior meeting, he does not believe Chair Breslin would have allowed another interested party to ask another interested party a question at an NCOIL hearing. That has never been done and the record does not reflect that happening. Perhaps Mr. Birnbaum is referring to an exchange that happened at an NAIC meeting.

Rep. Jordan stated that his immediate concern is he is not sure what exactly the Committee is accomplishing. It just seems the Committee is creating a definition of proxy discrimination seemingly in response to the NAIC. And then there is the question of whether the definition eliminates or mitigates discrimination. In his opinion, it does not so he goes back to his first question of what is the Committee accomplishing. The Hippocratic oath of "do no harm" applies here and Rep. Jordan stated that he believes that if the definition is adopted the Committee is probably doing more harm than good. Rep. Jordan stated that he will close by saying if we substitute gender for race and you're hearing complaints from the people who it immediately affects and you move forward then are they really being heard.

Hearing no further comments or questions from legislators or interested persons, upon a Motion made by Sen. Travis Holdman (IN), NCOIL Immediate Past President and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted to adopt the definition by a vote of 7-3. Rep. Jordan, Asm. Cahill and Asw. Hunter were "no" votes. Rep. Carter did not record a vote as she left the meeting prior to the vote being taken.

Chair Breslin then mentioned that the Committee will be meeting again during the NCOIL Spring Meeting next month. The Committee will continue its second charge of discussing disparate impact and specific rating factors. Currently, Peter Kochenburger, Executive Director, Insurance Law LL.M. Program, Deputy Director, Insurance Law Center, Associate Clinical Professor of Law at the University of Connecticut School of Law will be delivering a presentation regarding insurer's use of criminal history in underwriting. Chair Breslin offered the opportunity for everyone to offer suggestions for other topics for the Committee to discuss.

ADJOURNMENT

Upon a Motion made by Asm. Cahill and seconded by Sen. Holdman, the Committee adjourned at 2:30 p.m.