

**TENTATIVE GENERAL SCHEDULE
NCOIL SUMMER MEETING
JULY 10 - 13, 2019**

As of June 28, 2019, and Subject to Change



**The Marriott Newport Beach Hotel and Spa
Newport Beach, California**



NCOIL SUMMER MEETING

Newport Beach, California

July 10 - 13, 2019

TENTATIVE SCHEDULE

WEDNESDAY, JULY 10TH

Audit Committee (Members Only)	5:30 p.m.	-	6:00 p.m.
Budget Committee	6:00 p.m.	-	6:30 p.m.
Welcome Reception	6:30 p.m.	-	7:30 p.m.

THURSDAY, JULY 11TH

Registration <i>Exhibits Open: 8:30 a.m. – 6:15 p.m.</i>	7:00 a.m.	-	6:00 p.m.
Welcome Breakfast	8:30 a.m.	-	10:00 a.m.
Networking Break	10:00 a.m.	-	10:15 a.m.
Workers' Compensation Insurance Committee	10:15 a.m.	-	11:30 a.m.
Health General Session Prior Authorization: An Obstacle to Care or a Needed Cost Saver?	11:30 a.m.	-	12:45 p.m.
The Institutes Griffith Foundation Legislator Luncheon Subrogation: A Primer for Public Policymakers	12:45 p.m.	-	1:45 p.m.

Special Committee on Natural Disaster Recovery	1:45 p.m.	-	3:00 p.m.
General Session A Discussion on the Evaporating Insurance Market For Contact Sports	3:00 p.m.	-	4:15 p.m.
Networking Break	4:15 p.m.	-	4:30 p.m.
Joint State-Federal Relations & International Insurance Issues Committee	4:30 p.m.	-	6:00 p.m.
Adjournment	6:00 p.m.		
CIP Member & Sponsor Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, JULY 12TH

Registration <i>Exhibits Open: 8:30 a.m. – 5:30 p.m.</i>	8:00 a.m.	-	5:00 p.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:45 a.m.
Essential Education for Legislative Staff: Exploring Risk Management & Insurance Regulation Fundamentals “Understanding the Risk Management Process: Exploring Risk Management Techniques, Products and Pricing” (To run concurrent with Financial Services & Multi-Lines Issues Committee)	9:00 a.m.	-	10:00 a.m.
Networking Break	10:45 a.m.	-	11:00 a.m.
Special Discussion on Federal Insurance Office Priorities	11:00 a.m.	-	11:30 a.m.
NCOIL – NAIC Dialogue	11:30 a.m.	-	12:45 p.m.
Luncheon with Keynote Address	12:45 p.m.	-	2:15 p.m.
Legislative Micro Meetings	2:15 p.m.	-	2:45 p.m.
Innovation General Session Driving Rx Drug Costs Down via Biosimilars?	2:45 p.m.	-	4:15 p.m.
Essential Education for Legislative Staff:	2:45 p.m.	-	3:45 p.m.

Exploring Risk Management & Insurance Regulation
Fundamentals

“Analyzing and Evaluating Emerging Trends and Risks:
Viewed Through the Lens of the Risk Management Process”
(to run concurrent with Innovation General Session)

Networking Break	4:15 p.m.	-	4:30 p.m.
Property & Casualty Insurance Committee	4:30 p.m.	-	6:00 p.m.
Adjournment	6:00 p.m.		
IEC Board Meeting	6:00 p.m.	-	6:45 p.m.

SATURDAY, JULY 13TH

Registration <i>Exhibits Open: 8:15 a.m. – 11:30 a.m.</i>	8:00 a.m.	-	10:00 a.m.
Life Insurance & Financial Planning Committee	8:45 a.m.	-	10:00 a.m.
Networking Break	10:00 a.m.	-	10:15 a.m.
Health Insurance & Long Term Care Issues Committee	10:15 a.m.	-	12:00 p.m.
Business Planning Committee and Executive Committee	12:00 p.m.	-	1:00 p.m.
Adjournment	1:00 p.m.		



*****Please note all speakers listed are scheduled to speak as of June 28, 2019. There may be modifications between now and the start of the Meeting.****

WEDNESDAY, JULY 10, 2019

Audit Committee (Members Only)

Wednesday, July 10, 2019

5:30 p.m. – 6:00 p.m.

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

Vice Chair: Asm. Ken Cooley (CA) – NCOIL Treasurer

Budget Committee

Wednesday, July 10, 2019

6:00 p.m. – 6:30 p.m.

Chair: Asm. Ken Cooley (CA) – NCOIL Treasurer

Vice Chair: Sen. Neil Breslin (NY)

- 1.) Call to Order/Roll Call/Approval of December 6, 2018 Committee Meeting Minutes
- 2.) 2020 Budget Planning
- 3.) Any Other Business
- 4.) Adjournment

Welcome Reception

Wednesday, July 10, 2019

6:30 p.m. – 7:30 p.m.

THURSDAY, JULY 11, 2019

Welcome Breakfast

Thursday, July 11, 2019

8:30 a.m. – 10:00 a.m.

- 1.) Welcome to Newport Beach
- 2.) **Senator Dan “Blade” Morrish – NCOIL President**
 - a.) President’s Welcome
 - b.) New Member Welcome and Introduction
- 3.) Comments from NCOIL CEO
The Hon. Tom Considine
- 4.) Any Other Business
- 5.) Adjournment

Networking Break

Thursday, July 11, 2019

10:00 a.m. – 10:15 a.m.

Workers’ Compensation Insurance Committee

Thursday, July 11, 2019

10:15 a.m. – 11:30 a.m.

Chair: Asw. Maggie Carlton (NV)

Vice Chair: Rep. David Santiago (FL)

- 1.) Call to Order/Roll Call/Approval of March 16, 2019 Committee Meeting Minutes
- 2.) Continued Discussion on Development of NCOIL Workers’ Compensation Drug Formulary Model Act
Rep. Matt Lehman (IN) – NCOIL Vice President (Sponsor)
Ken Eichler, Vice President – Gov’t Affairs, ODG by MCG Health
Daniel Blaney-Koen, Senior Legislative Attorney - American Medical Association Advocacy Resource Center
Stacy Jones, Senior Research Associate, California Workers' Compensation Institute (CWCI)
Mitch Steiger, Legislative Advocate – California Labor Federation
Thomas Naughton, President – MAXIMUS Federal Citizen Services
- 3.) “State of the Line” – An Update on the Status of and Trends in the Workers’ Compensation Insurance Marketplace
Jeff Eddinger, Senior Division Executive – Regulatory Business Management, National Council on Compensation Insurance (NCCI)
- 4.) Any Other Business
- 5.) Adjournment

Health General Session

Prior Authorization: An Obstacle to Care or a Needed Cost Saver?

Thursday, July 11, 2019

11:30 a.m. – 12:45 p.m.

Moderator: Asw. Pam Hunter (NY)

*Jack Resneck Jr., M.D.
Immediate Past Chair
AMA Board of Trustees*

*Benjamin Chandhok
Sr. Dir., State Legislative Affairs
Arthritis Foundation*

*Jennifer Covich Bordenick
CEO
eHealth Initiative and Foundation*

*Vincent Nelson, M.D.
Vice President – Clinical Affairs
Blue Cross Blue Shield Association*

The Institutes Griffith Foundation Legislator Luncheon

Thursday, July 11, 2019

12:45 p.m. – 1:45 p.m.

Subrogation: A Primer for Public Policymakers

Lori Medders, Ph.D.

*Joseph F. Freeman Distinguished Professor of Insurance
Appalachian State University*

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

Special Committee on Natural Disaster Recovery

Thursday, July 11, 2019

1:45 p.m. – 3:00 p.m.

Chair: Sen. Vickie Sawyer (NC)

- 1.) Call to Order/Roll Call/Approval of March 15, 2019 and June 3, 2019 Committee Meeting Minutes
- 2.) Continued Discussion of Proposed Amendments to NCOIL State Flood Disaster and Mitigation Relief Model Act

Rep. David Santiago (FL) (Sponsor)

The Hon. Jennifer Hammer, Founder/Principal – JWHammer, LLC, Former Dir. of the Illinois Insurance Department

Paul Martin, Regional VP – Southwestern Region, NAMIC

Lisa Miller, President & CEO – Lisa Miller & Associates

Dennis Burke, VP – State Relations, Reinsurance Ass'n of America

John Ashenfelter, Assoc. General Counsel – State Farm Insurance Company

Jeff Hinesly, National Flood Insurance Program Director, Farmers Insurance Group

3.) Discussion on the Fallout from the California Wildfires

Karen Reimus, Outreach Coordinator – Roadmap to Recovery Program, United Policyholders

Brad Roeper, Executive Director – California Insurance Guarantee Association

Paul Martin, Regional VP – Southwestern Region, NAMIC

4.) Any Other Business

5.) Adjournment

General Session

A Discussion on the Evaporating Insurance Market for Contact Sports

Thursday, July 11, 2019

3:00 p.m. – 4:15 p.m.

Moderator: Sen. Bob Hackett (OH)

*Steve Fainaru
Senior Writer
ESPN*

*William Primps
Of Counsel
Locke Lord LLP*

*Daniel Daneshvar, M.D., Ph.D.
Neuroscientist
Stanford University*

*John Chino, ARM-PE, CSRM
Area Senior Vice President
Arthur J. Gallagher & Co.*

Networking Break

Thursday, July 11, 2019

4:15 p.m. – 4:30 p.m.

Joint State – Federal Relations & International Insurance Issues Committee

Thursday, July 11, 2019

4:30 p.m. – 6:00 p.m.

Chair: Sen. Jerry Klein (ND)

Vice Chair: Sen. Roger Picard (RI)

1.) Call to Order/Roll Call/Approval of March 15, 2019 Committee Meeting Minutes

2.) Continued Discussion on Development of NCOIL Insurance Business Transfer (IBT) Model Law

Asm. Andrew Garbarino (NY); Rep. Lewis Moore (OK) (Sponsors)

Frank O'Brien, VP – State Gov't Relations, APCIA

Richard Newton – CEO, International Solutions Services, Inc., LLC; Luann Petrellis – Insurance Industry Consultant

Roger Schmelzer, President & CEO, Nat'l Conf. of Ins. Guaranty Funds (NCIGF)

Kevin P. Griffith, Faegre Baker Daniels, LLP – Counsel to Nat'l Org. of Life & Health Ins. Guaranty Assocs. (NOLGHA)

Karen Melchert, Regional VP – State Relations, ACLI

- 3.) Discussion on Proposed Amendments to NCOIL Market Conduct Surveillance Model Law
Paul Martin, Regional VP – Southwestern Region, NAMIC
- 4.) Consideration of Amendments to NAIC Credit for Reinsurance Model Law and Regulation (Models) in Conjunction with NCOIL Resolution of July 17, 2016 Endorsing Models
The Hon. Tom Considine, NCOIL CEO
- 5.) Any Other Business
- 6.) Adjournment

CIP Member & Sponsor Reception

Thursday, July 11, 2019

6:00 p.m. – 7:00 p.m.

FRIDAY, JULY 12, 2019

Financial Services & Multi-Lines Issues Committee

Friday, July 12, 2019

9:00 a.m. – 10:45 a.m.

Chair: Sen. Bob Hackett (OH)

Vice Chair: Rep. Bart Rowland (KY)

- 1.) Call to Order/Roll Call/Approval of March 15, 2019 Committee Meeting Minutes
- 2.) Continued Discussion on Development of NCOIL Insurance Modernization Model Legislation
 - a.) Rebate Reform Initiatives
The Honorable Eric Cioppa, Sup't of the Maine Bureau of Insurance and NAIC President
Frank O'Brien, VP – State Gov't Relations, APCIA
 - b.) Discussion on NCOIL Insurance E-Commerce Model Act
Rep. Edmond Jordan (LA) (Sponsor)
Ron Jackson, VP, State Affairs – Southeast Region, APCIA
 - c.) Other Insurance Modernization Initiatives
- 3.) Measuring the Immeasurable? – A Discussion on A.M. Best's Proposal to Score and Assess Insurer Innovation
Steve Irwin, Senior Director, A.M. Best
Erin Collins, Asst. VP – State Affairs, NAMIC
- 4.) Discussion on Kentucky's First-in-the-Nation InsurTech Regulatory Sandbox
Rep. Bart Rowland (KY)
Patrick O'Connor, Deputy Commissioner – Policy, Kentucky Dep't of Insurance
Greg Mitchell, Esq., Frost Brown Todd, LLC
Wes Bissett, Senior Counsel, Gov't Affairs - IIABA
- 5.) Re-adoption of Insurance Fraud Model Act
Sen. Jason Rapert (AR) – NCOIL Immediate Past President (Sponsor)
Matthew Smith, Dir. of Gov't Affairs & General Counsel, Coalition Against Insurance Fraud
- 6.) Any Other Business
- 7.) Adjournment

Essential Education for Legislative Staff: Exploring Risk Management & Insurance Regulation Fundamentals

“Understanding the Risk Management process: Exploring risk management techniques, products and pricing”

Friday, July 12, 2019

9:00 a.m. – 10:00 a.m.

(to run concurrent with Financial Services & Multi-Lines Issues Committee)

Brad Karl, Ph.D.

***Associate Professor of Finance and Risk Management/Insurance
East Carolina University***

Networking Break

Friday, July 12, 2019

10:45 a.m. – 11:00 a.m.

Special Discussion on Federal Insurance Office Priorities

Friday, July 12, 2019

11:00 a.m. – 11:30 a.m.

The Honorable Steven Seitz, Director, Federal Insurance Office

NCOIL – NAIC Dialogue

Friday, July 12, 2019

11:30 a.m. – 12:45 p.m.

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

Vice Chair: Sen. Jim Seward (NY)

- 1.) Call to Order/Roll Call/Approval of March 15, 2019 Committee Meeting Minutes
- 2.) Discussion on Amendments to NAIC Credit for Reinsurance Model Law and Regulation
- 3.) Discussion on Creation of NAIC Long Term Care Insurance Task Force
- 4.) Update on NAIC Pharmacy Benefit Manager Working Group
- 5.) Update on NAIC Annuity Suitability Working Group/SEC Regulation Best Interest
- 6.) Update on Affordable Care Act Litigation: Texas v. U.S.
- 7.) Any Other Business
- 8.) Adjournment

Luncheon with Keynote Address

Friday, July 12, 2019

12:45 p.m. - 2:15 p.m.

Legislative Micro Meetings
Friday, July 12, 2019
2:15 p.m. – 2:45 p.m.

Facilitator: Hon. Tom Conidine, NCOIL CEO

Innovation General Session
Driving Rx Drug Costs Down via Biosimilars?
Friday, July 12, 2019
2:45 p.m. – 4:15 p.m.

Moderator: Rep. Bart Rowland (KY)

Wayne Winegarden, Ph.D.
Sr. Fellow in Business & Econ.
Pacific Research Institute

Sameer V Awsare, M.D., FACP
Associate Executive Director
The Permanente Medical Group

*Joseph P. Fuhr Jr., Ph.D.**
Professor Emeritus
Widener University

**Brought to you by The Institutes Griffith Insurance Education Foundation. In keeping with the non-partisan, non-advocative mission of The Institutes Griffith Foundation, Dr. Fuhr's remarks will be unbiased and purely educational.*

Chad Pettit
Executive Director – Global Value Access and Policy – Biosimilars Unit
Amgen

Essential Education for Legislative Staff: Exploring Risk Management & Insurance Regulation Fundamentals

“Analyzing and Evaluating Emerging Trends and Risks: Viewed through the lens of the risk management process.”

Friday, July 12, 2019

2:45 p.m. – 3:45 p.m.

(to run concurrent with Innovation General Session)

David Pooser, Ph.D.
Assistant Professor of Risk Management and Insurance
St. John's University

Networking Break
Friday, July 12, 2019
4:15 p.m. – 4:30 p.m.

Property & Casualty Insurance Committee
Friday, July 12, 2019
4:30 p.m. – 6:00 p.m.

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

- 1.) Call to Order/Roll Call/Approval of March 17, 2019 Committee Meeting Minutes
- 2.) Consideration of Model Legislation in Response to the American Law Institute's (ALI) Restatement of the Law, Liability Insurance
Rep. Joseph Fischer (KY) (Sponsor)
Sean Kellem, ALI Law Fellow, The American Law Institute
Frank O'Brien, VP – State Gov't Relations, APCIA
Erin Collins, Asst. VP – State Affairs, NAMIC
Laura Foggan, Esq., Partner – Crowell & Moring, LLP
- 3.) Discussion on Insurance Issues Related to the P2P Car Sharing Industry
Ethan Wilson, Gov't Relations Manager and Senior Legislative Counsel, Turo
Brian Rothery, VP – Gov't and Public Affairs, Enterprise Holdings
- 4.) Discussion on Automobile Insurance Reform Efforts
Cameron Mazaherian, EVP – Carrier Development, Gabi
Richard Gibson, MAAA, FCAS, Senior Casualty Fellow, American Academy of Actuaries
Doug Heller, Consumer Advocate/Insurance Expert – Consumer Federation of America
- 5.) Any Other Business
Erin Collins, Asst. VP – State Affairs, NAMIC
- 6.) Adjournment

IEC Board Meeting
Friday, July 12, 2019
6:00 p.m. – 6:45 p.m.

SATURDAY, JULY 13, 2019

Life Insurance & Financial Planning Committee
Saturday, July 13, 2019
8:45 a.m. – 10:00 a.m.

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

- 1.) Call to Order/Roll Call/Approval of March 16, 2019 Committee Meeting Minutes
- 2.) Insurer's Use of Social Media in Underwriting – An Underwriting Revolution?
The Honorable Maria Vullo, Regulator in Residence – FinTech Innovation Lab NYC,
Former Superintendent of the NY Dep't of Financial Services

- 3.) Update on Federal Retirement Security Legislation – The Setting Every Community Up for Retirement Enhancement Act (SECURE) and the Retirement Enhancement and Savings Act (RESA)

Elizabeth Kelly, SVP of Operations, United Income

Bruce Ferguson, Sr. Vice President – State Relations, ACLI

- 4.) Annuities for the 21st Century

Ann Farley, AVP Innovation Management-Retirement Solutions, Pacific Life Insurance

- 5.) Any Other Business

- 6.) Adjournment

Networking Break

Saturday, July 13, 2019

10:00 a.m. – 10:15 a.m.

Health Insurance & Long Term Care Issues Committee

Saturday, July 13, 2019

10:15 a.m. – 12:00 p.m.

Chair: Asw. Pam Hunter (NY)

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

- 1.) Call to Order/Roll Call/Approval of March 15, 2019 Committee Meeting Minutes
- 2.) Continued Discussion on Development of NCOIL Drug Pricing Transparency Model Act
Rep. Tom Oliverson, M.D. (TX); Sen. Dan “Blade” Morrish (LA) – NCOIL President (Sponsors)
Steve Moore, PharmD, Legislative Chair/Incoming President, Pharmacist Society of the State of New York
Carl Schmid, Deputy Exec. Director, The AIDS Institute
Melodie Shrader, Senior Director – State Affairs, PCMA
Saiza Elayda, Director – State Policy, PhRMA
Jim Parker, Senior Advisor to the Secretary of HHS for Health Reform
- 3.) Discussion on Health Care Sharing Ministries
Rep. Martin Carbaugh (IN) (Sponsor)
The Honorable Dave Weldon, Former Congressman, President – The Alliance of Health Care Sharing Ministries
The Honorable Eric Cioppa, Sup’t of the Maine Bureau of Insurance and NAIC President
Joe Guarino, Health Care Sharing Consultant for Nelson Taplin Goldwater Group (NTG)
- 4.) Discussion on Development of Short Term Limited Duration (STLD) Insurance Model Law
Rep. Martin Carbaugh (IN) (Sponsor)
Jan Dubauskas, Vice President, Senior Counsel – Health Insurance Innovations (HII)
Michelle Lilienfeld, Senior Attorney, National Health Law Program
Jeff Smedsrud, President, Pivot Health
The Honorable Eric Cioppa, Sup’t of the Maine Bureau of Insurance and NAIC President
Jim Parker, Senior Advisor to the Secretary of HHS for Health Reform
- 5.) Any Other Business
- 6.) Adjournment

Business Planning Committee & Executive Committee
Saturday, July 13, 2019
12:00 p.m. – 1:00 p.m.

Chair: Sen. Dan “Blade” Morrish (LA) – NCOIL President
Vice Chair: Rep. Matt Lehman (IN) – NCOIL Vice President

- 1.) Call to Order/Roll Call/Approval of March 17, 2019 Committee Meeting Minutes
- 2.) 2021 Annual Meeting Location
- 3.) Administration
 - a.) Meeting Report
 - b.) Receipt of Financials
 - c.) Consideration of Audit
- 4.) Consent Calendar
 - Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
- 5.) Other Sessions
 - a.) The Institutes Griffith Foundation Legislator Luncheon
 - b.) Essential Education for Legislative Staff: Exploring Risk Management & Insurance Regulation Fundamentals
 - c.) 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



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

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

National Council of Insurance Legislators (NCOIL)

Model Workers' Compensation Drug Formulary Act

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

**Discussion Draft as of June 11th, 2019. To be discussed during the Workers' Compensation Insurance Committee on July 11th, 2019.*

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Section 1.	Short Title
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Section 3.	Selection of Drug Formulary
Section 4.	Operation of Formulary
Section 5.	Rules
Section 6.	Effective Date

Section 1. Short Title

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

Section 2. Purpose

The purpose of this Act shall be to require the establishment of a drug formulary for use in a state's workers' compensation system in order to facilitate the safe and appropriate use of prescription drugs in the treatment of work-related injury and occupational disease.

Section 3. Selection of Drug Formulary

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

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

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

- (1) Whether the formulary focuses on medical treatment specific to workers' compensation.
- (2) Whether the basis for the formulary is readily apparent and publicly available.
- (3) Whether the formulary includes measures to aid in management of opioid medications.
- (4) The cost of implementation and post-implementation associated costs of the formulary.

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

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

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

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

Section 4. Operation of Formulary

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

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

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

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

(B) If a prescribing physician submits to an employer a request to permit use of a drug that is included but not recommended in the formulary including the prescribing physician's reason for requesting use of such drug and the employer approves the request, the prescribing physician may prescribe such drug for use by the injured employee.

(C) If the employer does not approve the prescribing physician's request under subsection (B) to permit use of a drug that is included but not recommended in the formulary, the employer shall:

(1) send the request to a third party that is certified by the [Utilization Review Accreditation Commission (URAC) or another Accreditation Organization] to make a determination concerning the request; and

(2) notify the prescribing physician and the injured employee of the third party's determination not more than [five (5)] business days after receiving the request.

(D) If an employer fails to provide the notice required by subsection (C)(2), the prescribing physician's request under subsection (B) is considered approved, and reimbursement of the drug that is included but not recommended and prescribed for use by the injured employee is authorized.

(E) If the third party's determination under subsection (C) is to deny the prescribing physician's request to permit the use of the drug that is included but not recommended on the formulary or not included in the formulary:

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

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

(F) Notwithstanding subsections (A) through (E), during a medical emergency, an employee shall receive a drug prescribed for the employee even if the drug is a drug that is included but not recommended on the formulary.

Section 5. Rules

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

Section 6. Effective Date

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

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



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

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

State Flood Disaster Mitigation and Relief Model Act

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

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

Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018; re-adoption extended by the NCOIL Property & Casualty Insurance Committee on December 7, 2018 and the NCOIL Executive Committee on December 8, 2018; re-adoption extended by the NCOIL Property & Casualty Insurance Committee and the NCOIL Executive Committee on March 15, 2019 (per NCOIL bylaws, 5 year re-adoption is pending while amendments are being considered)

****To be discussed by the Special Committee on Natural Disaster Recovery Committee on July 11th, 2019****

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

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Sec. 2	Definitions
Sec. 3	Regulation of flood hazard areas; prohibited uses
Sec. 4	Minimum standards for ordinances; variances for prohibited uses

- Sec. 5 Acquisition of existing structures
- Sec. 6 Delineation of flood hazard areas and 100-year floodplains; powers of the Agency; powers of local governments and of the Agency
- Sec. 7 Procedures in issuing permits
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- Sec. 1 Zoning restrictions in floodplain
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Section 1. Purpose

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

In order to provide a sustainable system to provide disaster relief, in 1968 the U.S. Congress has established the National Flood Insurance Program (NFIP), to which provides flood insurance in conjunction with the private insurance industry. This NFIP remains in operation, however the program has incurred significant losses and now has substantial debt as a result. While there have been various efforts by Congress to address the issue (Biggert Waters Flood Insurance Reform Act of 2012 and the

Homeowner Flood Insurance Affordability Act of 2014), no permanent solution has been adopted.

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

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

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

Section 2. Short Title

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

PART I. FLOOD INSURANCE COVERAGE AND NOTICE

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

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

(b) Requirement for mortgage loans.

(1) Regulated lending institutions. Each [State entity for lending regulation] shall by regulation direct regulated lending institutions not to make, increase, extend, or renew any loan secured by improved real estate or a mobile home located or to be located in an area that has been identified by the Director as an area having special flood hazards and in which flood insurance has been made available ~~under the National Flood Insurance Act, 42 U.S.C. Chapter 50,~~ unless

the building or mobile home and any personal property securing such loan is covered for the term of the loan by flood insurance in an amount at least equal to the outstanding principal balance of the loan or the maximum limit of coverage made available under the Act with respect to the particular type of property, whichever is less.

(2) Applicability

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

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

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

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

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

(c) Escrow of flood insurance payments.

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

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

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

(d) Placement of flood insurance by lender.

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

expense, an amount of flood insurance for the building or mobile home and such personal property that is not less than the amount under subdivision (b)(1) of this Sec. 1, for the term of the loan.

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

(3) Review of determination regarding required purchase.

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

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

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

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

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

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

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

(A) making, increasing, extending, or renewing loans in violation of:

(i) the regulations issued pursuant to subsection (b) of this Sec. 1;

(ii) the escrow requirements under subsection (c) of this Sec. 1;

or

(iii) the notice requirements under Sec. 2 of this Part (below); or

(B) failure to provide notice or purchase flood insurance coverage in violation of subsection (e) of this section.

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

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

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

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

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

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

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

(f) Other actions to remedy pattern of noncompliance.

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

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

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

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

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

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

- (A) is made pursuant to the making, increasing, extending, or renewing of the loan that is initiated by the borrower;
 - (B) is made pursuant to a revision or updating under 42 U.S.C. 4101(f) of the floodplain areas and flood-risk zones or publication of a notice or compendia under subsection (h) or (i) of 42 U.S.C. 4101(h) or (i) that affects the area in which the improved real estate or mobile home securing the loan is located or that, in the determination of the Director, may reasonably be considered to require a determination under this subsection; or
 - (C) results in the purchase of flood insurance coverage pursuant to the requirement under subdivision (d)(2) of this Sec. 1.
- (2) Purchaser or transferee fee. The purchaser or transferee of such a loan may be charged the fee in the case of sale or transfer of the loan.

Sec. 2. Notice requirements

(a) Notification of special flood hazards.

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

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

- (A) a warning, in a form to be established by the [State entity for lending regulation], stating that the building on the improved real estate securing the loan is located, or the mobile home securing the loan is or is to be located, in an area having special flood hazards;
- (B) a description of the flood insurance purchase requirements under section 102(b) of the Flood Disaster Protection Act, 42 U.S.C. Chapter 50;
- (C) a statement that flood insurance coverage may be purchased under the National Flood Insurance Program and also is available from private insurers; and
- (D) any other information that the [State entity for lending regulation] considers necessary to carry out the purposes of the National Flood Insurance Program.

(b) Notification of change of servicer.

(1) Lending institutions. Each [State entity for lending regulation] shall by regulation require regulated lending institutions, in connection with the making, increasing, extending, renewing, selling, or transferring any loan described in subdivision (b)(1) of this Sec. 1, to notify, in writing, the [State entity for lending regulation] of the servicer of the loan during the term of the loan. Such institutions

shall also notify the [State entity for lending regulation] of any change in the servicer of the loan, not later than 60 days after the effective date of such change. The regulations under this subsection shall provide that, upon any change in the servicing of a loan, the duty to provide notification under this subsection shall transfer to the transferee servicer of the loan.

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

Sec. 3. Rules; report

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

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

PART II. FLOODPLAIN REGULATION

Sec. 1. Purposes

The purposes of this Part are to:

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

Sec. 2. Definitions

(a) As used in this Part:

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

(5) "Flood hazard area" means the area designated by a local government, pursuant to this Part, as an area where development must be regulated to prevent damage from flooding. The flood hazard area must include and may exceed the base floodplain.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Prohibited uses. New solid waste disposal facilities, hazardous waste management

facilities, salvage yards, and chemical storage facilities are prohibited in the 100-year floodplain except as authorized under Sec. 4(b) (below).

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

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

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

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

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

Sec. 5. Acquisition of existing structures

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

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

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

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

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

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

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

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

(1) The 100-year floodplain and base-flood elevations for the area are not identified on a floodplain map prepared pursuant to the National Flood Insurance Program within the previous five years.

(2) The Agency determines that the 100-year floodplain and the base-flood elevations for the area need to be identified and the use of the area regulated in accordance with the requirements of this Part II in order to prevent damage from flooding.

(3) The Agency prepares the floodplain map in accordance with the federal standards required for maps to be accepted for use in administering the National Flood Insurance Program.

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

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

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

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

Sec. 7. Procedures in issuing permits

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

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

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

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

Sec. 8. Violations and penalties

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

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

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

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

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

Sec. 9. Other approvals required

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

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

Sec. 10. Floodplain management

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

PART III. FLOODPLAIN MANAGEMENT AND HAZARD MITIGATION

Sec. 1. Zoning restrictions in floodplain

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

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

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

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

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

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

Sec. 2. Creation of plan by Secretary

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

Sec. 3. Plan of conservation and development

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

Sec. 4. Hazard mitigation and floodplain management account

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

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

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

Sec. 5. Definitions

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

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

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

Sec. 6. Hazard mitigation and floodplain management grant program

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

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

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

Sec. 7. Grants to municipalities for planning

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

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

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

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

Sec. 8. Municipal report

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

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

Sec. 9. Model ordinance

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

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

Sec. 10. Regulations

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

PART IV. MISCELLANEOUS PROVISIONS REGARDING PARTICIPATION

Sec. 1. Insurance producer qualification; continuing education

The [State entity for regulating insurance] shall require:

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

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

Sec. 2. Insurance adjuster qualification; education

The [State entity for regulating insurance] shall require:

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

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

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

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

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

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

Sec. 4. Disclosure of real estate flood propensity

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

PART V. FACILITATING PRIVATE FLOOD INSURANCE

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

Sec. 1. Prior Form Approval

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

Sec. 2. Rates

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

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

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

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

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

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

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

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

Sec. 3. Duties of Insurer

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

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

Sec. 4. Duties of an Agent

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

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

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

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

Sec. 5. Other Provisions

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

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

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

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

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

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

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

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National Council of Insurance Legislators (NCOIL)

Insurance Business Transfer Model Act

**Sponsored by Asm. Andrew Garbarino (NY) and Rep. Lewis Moore (OK)*

Initial Discussion Draft based on Oklahoma SB 1101 – The Insurance Business Transfer Act (enacted on May 7, 2018) – To be discussed during the Joint State-Federal Relations and International Insurance Issues Committee on July 11th, 2019

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Section 1. Title

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

Section 2. Purpose

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

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

Section 3. Definitions

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

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

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

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

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

E. "Department" means the State Insurance Department.

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

F. "Commissioner" means the State Insurance Commissioner.

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

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

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

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

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

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

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

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

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

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

Section 4. Court Authority

Notwithstanding any other provision of law, the court may issue any order, process, or judgment that is necessary or appropriate to carry out the provisions of this act. No provision of this act shall be construed to preclude the court from, on its own motion, taking any action or making any determination necessary or appropriate to enforce or implement court orders or rules, or to prevent an abuse of power.

Section 5. Notice Requirements

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

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

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

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

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

Section 6. Application Procedure

A. Application Procedure.

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

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

h. proposal for Plan implementation and administration, including the form of notice to be provided under the Insurance Business Transfer Plan to any policyholder whose policy is part of the subject business,

i. full description as to how such notice shall be provided,

j. description of any reinsurance arrangements that would pass to the assuming insurer under the Insurance Business Transfer Plan,

k. description of any guarantees or additional reinsurance that will cover the subject business following the transfer and novation,

l. a statement describing the assuming insurer's proposed investment policies and any contemplated third-party claims management and administration arrangements,

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

n. a report from an independent expert, selected by the Commissioner from a list of at least two nominees submitted jointly by the transferring insurer and the assuming insurer, to assist the Commissioner and the court in connection with their review of the proposed transaction. Should the Commissioner, in his or her sole discretion, reject the nominees, he or she may appoint the independent expert. The report shall provide the following:

(1) a statement of the independent expert's professional qualifications and descriptions of the experience that qualifies him or her as an expert suitable for the engagement,

(2) whether the independent expert has, or has had, direct or indirect interest in the transferring or assuming insurer or any of their respective affiliates,

(3) the scope of the report,

(4) a summary of the terms of the Insurance Business Transfer Plan to the extent relevant to the report,

(5) documents, reports and other material information the independent expert has considered in preparing the report and whether any information requested was not provided,

(6) the extent to which the independent expert has relied on information provided by and the judgment of others,

(7) the people on whom the independent expert has relied and why, in his or her opinion, such reliance is reasonable,

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

(a) transferring policyholders and claimants,

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

(c) policyholders and claimants of the assuming insurer,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3. The application shall be in the form of a verified petition for implementation of the Insurance Business Transfer Plan in the court. The petition shall include the Insurance Business Transfer Plan and shall identify any documents and witnesses which the applicant intends to present at a hearing regarding the petition.

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

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

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

7. The notice to policyholders shall state or provide:

a. the date and time of the approval hearing,

b. the name, address and telephone number of the assuming insurer and transferring insurer,

c. that a policyholder may comment on or object to the transfer and novation,

d. the procedures and deadline for submitting comments or objections on the Plan,

e. a summary of any effect that the transfer and novation will have on the policyholder's rights,

f. a statement that the assuming insurer is authorized, as provided in this section, to assume the subject business and that court approval of the Plan shall extinguish all rights of policyholders under policies that are part of the subject business against the transferring insurer,

g. that policyholders shall not have the opportunity to opt out of or otherwise reject the transfer and novation,

h. contact information for the Insurance Department where the policyholder may obtain further information, and

i. information on how an electronic copy of the Insurance Business Transfer Plan may be accessed. In the event policyholders are unable to readily access electronic copies, the applicant shall provide hard copies by first-class mail.

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

C. Approval of the Insurance Business Transfer Plan.

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

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

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

a. order implementation of the Insurance Business Transfer Plan,

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

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

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

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

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

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

a. deny the petition, or

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

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

D. Implementation of Insurance Business Transfer Plan.

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

Section 7. Ongoing oversight by Insurance Commissioner

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

Section 8. Fees and Costs

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

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

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

Section 9. Effective Date

This act shall become effective _____.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

MARKET CONDUCT SURVEILLANCE MODEL LAW

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

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

**Proposed amendments submitted for discussion by the National Association of Mutual Insurance Companies (NAMIC)*

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Section 1. Short Title

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

Section 2. Purpose/Legislative Intent

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

- Processes and systems for identifying, assessing and prioritizing market conduct ~~problems~~ issues and allegations that may have a substantial adverse impact on consumers, policyholders and claimants;
- To ensure that substantive and robust analysis is exhibited by the state regulator to assure all parties that the least intrusive and most cost-effective use of public funds or reimbursements from industry have been utilized to effectuate their statutory authority which benefits all consumers.
- Market conduct actions by a commissioner to substantiate or alleviate such market conduct ~~concerns~~ ~~problems~~ and a means to remedy significant and material market conduct that rises to a level of material violations of state law or regulations and harms consumers ~~problems~~; and
- Procedures to communicate and coordinate market conduct actions among states to foster the most efficient and effective use of resources and knowledge.
- Notwithstanding any provisions in this code to the contrary, nothing in this act shall authorize a market conduct examination of the insurer's cybersecurity protection measures which is otherwise provided for in domiciliary state financial examinations consistent with the NAIC's coordinated approach to examinations.

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

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

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

Section 3. Definitions

(a) "Commissioner" means the chief insurance regulatory official of the state, or his or her designee. Drafting Note: Where the word "commissioner" appears in the Model Act, the appropriate designation for the chief insurance regulatory official of the state, if different, should be substituted.

(b) "Complaint" means a written or documented oral communication to the Insurance Department primarily expressing a grievance, meaning an expression of dissatisfaction.

For health companies, a grievance is a written complaint submitted by or on behalf of a covered person.

(c) “Comprehensive Market Conduct Examination” means a review of one or more lines of business of an insurer domiciled in this state that is not conducted for cause. The term includes a review of rating, tier classification, underwriting, policyholder service, claims, marketing and sales, producer licensing, complaint handling practices, or compliance procedures and policies.

(d) “Insurance Compliance Audit” means a voluntary, internal evaluation, review, assessment, audit, or investigation for the purpose of identifying or preventing noncompliance with, or promoting compliance with laws, regulations, orders, or industry or professional standards, which is conducted by or on behalf of a company licensed or regulated under this Code, or which involves an activity regulated under this Code.

(e) “Insurance Compliance Self-Evaluative Audit Document” means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer generated or electronically recorded information, phone records, maps, charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 4. Domestic Responsibility and Deference to Other States

(a) The Commissioner is responsible for conducting market conduct examinations for [insert state] policyholder protection, which shall be accomplished by comprehensive or targeted examinations of domestic insurers and targeted examinations of foreign insurers as deemed necessary by the Commissioner, based on the results of market analysis. The Commissioner may ~~delegate responsibility for conducting~~ accept findings of an examination of a domestic insurer, foreign insurer, or an affiliate of an insurer to the from an Insurance Commissioner of another state in lieu of conducting their own examination. ~~if that Insurance Commissioner agrees to accept the delegated responsibility for the examination.~~

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

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

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

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

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

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

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

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

~~(e)~~ The Commissioner's determination under Subsection ~~(c)~~ is discretionary with the Commissioner and is not subject to appeal.

~~(f)~~ Subject to a determination under Subsection ~~(c)~~, if a market conduct examination conducted by another state results in a finding that an insurer should modify a specific practice or procedure, the Commissioner shall accept documentation that the insurer has made a similar modification in this state, in lieu of initiating a market conduct action or examination related to that practice or procedure. The Commissioner may require other or additional practice or procedure modifications as are necessary to achieve compliance with specific state laws or regulations, which differ substantially from those of the state that conducted the examination. It is acceptable for the Commissioner and the target of an examination analysis or inquiry to enter into a corrective action plan and close further analysis, examination, or any further action against the entity being reviewed.

Section 5. Market Analysis Procedures

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

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

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

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

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

(C) Consider review of company's self-evaluation or assessment and accept in lieu of any further analysis or other action taken. Any review of the same shall be considered analysis workpapers and kept confidential and privileged and otherwise protected as referenced in Section 8 and subject to [insert state code citation].

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

(1) Correspondence with Insurer

(2) Insurer Interviews

(3) Information Gathering

(4) Policy and Procedure Reviews

(5) Interrogatories

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

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

(c) The Commissioner shall select a market conduct action that is cost effective for the Insurance Department and the insurer, while still protecting the insurance consumer. Analysis should include a weighing of direct actual harm to consumers or others as opposed to *de minimus* non-material violations. The Commissioner shall ensure that there is adequate oversight and no practices in place that incentivize third-party vendors or others to elongate examinations solely to incur additional remuneration for their services.

(d) The Commissioner shall take those steps reasonably necessary to eliminate requests for duplicate information provided as part of an insurer's annual financial statement, the

annual market conduct statement of the National Association of Insurance Commissioners, or other required schedules, surveys, or reports that are regularly submitted to the Commissioner, or with data requests made by other states if that information is available to the Commissioner, unless the information is state specific, and coordinate market conduct actions and findings with other states.

(e) Causes or conditions, if identified through market analysis, that may trigger a targeted examination, are:

(1) Credible information obtained from a market conduct annual statement, market survey or report of financial examination indicating potential fraud, that the insurer is conducting the business of insurance without a license or is engaged in a potential pattern of material unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts].

(2) A number of material and confirmed complaints against the insurer or a confirmed complaint ratio sufficient to indicate potential fraud, conducting the business of insurance without a license, or a potential pattern of unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts]. For the purposes of this section, a confirmed complaint ratio shall be determined for each line of business.

(3) Information obtained from other objective sources, such as credible published advertising materials indicating potential fraud, conducting the business of insurance without a license, or evidencing a potential pattern of unfair trade practice in violation of [cite appropriate statutory reference for the state's Unfair Trade and Claims Practices Acts].

(4) Patterns of material violations of Insurance [Code/Law] and administrative regulations promulgated thereunder that cause consumer harm. Drafting note: It is contemplated that Section 5 (e)(4) would encompass items such as rate filings, form filings and termination requirements.

Drafting note: It is contemplated that Section 5 (e)(4) would encompass items such as rate filings, form filings and termination requirements.

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

Section 6. Protocols for Market Conduct Actions

- (a) Market conduct actions taken as a result of a market analysis shall focus on the general business practices and compliance activities of insurers, rather than identifying infrequent or unintentional random errors that do not cause consumer harm.
- (b) (1) The Commissioner is authorized to determine the frequency and timing of such market conduct actions. The timing shall depend upon the specific market conduct action to be initiated, unless extraordinary circumstances indicating a risk to consumers require immediate action.
- (2) If the Commissioner has information that more than one insurer is engaged in common practices that may violate statute or regulations, he/she may schedule and coordinate multiple examinations simultaneously.
- (c) The insurer shall be notified of any practice or procedure which is to be the subject of a market conduct action and shall be given an opportunity to resolve such matters that arise as a result of a market analysis to the satisfaction of the Commissioner before any additional market conduct actions are taken against the insurer. If the insurer has modified such practice or procedure as a result of a market conduct action taken by the Commissioner of another state, the Commissioner shall accept appropriate documentation that the insurer has satisfactorily modified the practice or procedure and made similar modification to such practice or procedure in this state.

Section 7. Protocols for Targeted Market Conduct Examinations

- (a) When market analysis identifies a pattern of conduct or practice by an insurer which requires further investigation, and less intrusive market conduct actions identified in section 5 (b) are not appropriate, the Commissioner has the discretion to conduct targeted, market conduct examinations in accordance with the NAIC Market Conduct Uniform Examination Procedures and the Market Regulation Handbook (or procedures, adopted by regulation, that are substantially similar to the foregoing NAIC products).
- (b) If the insurer to be examined is not a domestic insurer, the Commissioner shall communicate with and may coordinate the examination with the insurance Commissioner of the state in which the insurer is organized.
- (c) Concomitant with the notification requirements established in subsection (f) of this section, the commissioner shall post notification on the NAIC Examination Tracking System, or comparable NAIC product as determined by the Commissioner, that a market conduct examination has been scheduled.
- (d) The Commissioner may not conduct a comprehensive market conduct examination more frequently than once every three years. The Commissioner may waive conducting a comprehensive market conduct examination based on market analysis.

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

(e) (1) Prior to commencement of a targeted on-site market conduct examination, market conduct surveillance personnel shall prepare a work plan and proposed budget. Such proposed budget, which shall be reasonable for the scope of the examination, and work plan shall be provided to the company under examination. Additionally, a summary of all actions taken along the continuum of regulatory response shall be documented and provided to the targeted company. Deviations from estimated budgets should rarely occur and only with substantial documentation as to necessity for the same.

(2) Market conduct examinations shall, to the extent feasible, utilize desk examinations and data requests prior to a targeted on-site examination.

(3) Market conduct examinations shall be conducted in accordance with the provisions set forth in the NAIC Market Regulation Handbook and the NAIC Market Conduct Uniform Examinations Procedures (or procedures, adopted by regulation, that are substantially similar to the foregoing NAIC products).

(4) Prior to the conclusion of a market conduct examination, the individual among the market conduct surveillance personnel who is designated as the examiner-in-charge shall schedule an exit conference with the insurer.

(f) Announcement of the examination shall be sent to the insurer and posted on the NAIC’s Examination Tracking System (or comparable NAIC product, as determined by the commissioner) as soon as possible but in no case later than 60 days before the estimated commencement of the examination. Such announcement shall contain:

(1) The name and address of the insurer(s) being examined;

(2) The name and contact information of the examiner-in-charge;

(3) The reason(s) for and the scope of the targeted examination;

(4) The date the examination is scheduled to begin;

(5) Identification of any non-insurance department personnel who will assist in the examination, if known at the time the notice is prepared;

(6) A time estimate for the examination;

(7) A budget and work plan for the examination and identification of reasonable and necessary costs and fees that will be included in the bill, if the cost of the examination is billed to the company; and

(8) A request for the insurer to name its examination coordinator.

(g) If a targeted examination is expanded beyond the reasons provided to the insurer in the notice of the examination required under this section, the Commissioner shall provide written notice to the insurer, explaining the extent of the expansion and the reasons for the expansion. The department shall provide a revised work plan to the insurer before the beginning of any significantly expanded examination, unless extraordinary circumstances indicating a risk to consumers require immediate action.

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

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

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

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

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

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

(5) A company, except in the most exigent of circumstances, shall be given a reasonable time to comply to such requests.

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

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

(A) The Commissioner shall deliver the draft report to the insurer within 60 days of the completion of the examination. Completion of the examination shall be defined as the date the Commissioner confirms in writing that the examination is completed. Provided that notwithstanding any provisions in this code to the contrary, any comprehensive market conduct examination, targeted market conduct examination, or other market conduct examination or activity shall be completed in its entirety within three (3) months of calling for, issuing a warrant, and notifying the company of the start of the examination regardless when started. Any extensions of time shall be in writing and agreed to by the insurer unless exigent circumstances are demonstrated that reveal the regulator through no delay or fault created or caused by the regulator needs further time to complete. Extensions should be the exception to the normal procedures and used rarely.

~~(B)~~ The insurer must respond with written comments within 30 days of receipt of the draft report. At the insurer's election, any comments provided shall be privileged and confidential, considered workpapers of the analysis or examination, and protected per the provisions of this article and [insert state code provisions for protection of proprietary and confidential information].

~~(B)~~ The department shall make a good faith effort to resolve issues and prepare a final report within 30 days of receipt of the insurer's written comments, unless a mutual agreement is reached to extend the deadline. The commissioner may make corrections and other changes, as appropriate.

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

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

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

(k) (1) Upon adoption of the examination report pursuant to subsection (j), the Commissioner shall continue to hold the content of the examination report as private and confidential for a period of thirty (30) days, except to the extent provided in paragraph 2 of this subsection. During this time, the report shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in any private action, provided no court of competent jurisdiction has ordered production. Thereafter, the Commissioner shall open the report for public inspection, provided no court of competent jurisdiction has stayed its publication. This section may not be construed to limit the Commissioner's authority to use any final or preliminary market conduct examination report, and examiner or company work papers or other documents, or any other information discovered or developed during the course of an examination in the furtherance of any legal or regulatory action that the commissioner, in the Commissioner's sole discretion may deem appropriate. Provided that for those Commissioners who publicize or place examinations on their website, any type of market conduct examination or activity that has findings against an insurer and that requires corrective action plans, fines, and penalties or other punitive measures shall be removed no later than three (3) years after the conduct which gave rise to the examination findings has been published. This provision is not intended to prevent responses to Freedom of Information requests or other legal requests for the document.

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

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

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

(A) Clearly identify the types of functions to be subject to outsourcing;

(B) Provide specific timelines for completion of the outsourced review;

(C) Require disclosure of contract examiners' recommendations;

(D) Establish and utilize a dispute resolution or arbitration mechanism to resolve conflicts with insurers regarding examination costs and fees; ~~and~~

(E) Require disclosure of the terms of the contracts with the outside consultants that will be used, specifically the costs and fees and/or hourly rates that can be charged; and

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

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

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

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

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

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

Section 8. Confidentiality Requirements

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

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

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

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

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

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

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

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

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

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

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

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

Section 9. Market Conduct Surveillance Personnel

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

(b) Market conduct surveillance personnel have a conflict of interest, either directly or indirectly, if they are affiliated with the management, have been employed by, or own a pecuniary interest in the insurer subject to any examination under this Act within the most recent five years prior to the use of the personnel. Market conduct surveillance personnel have a conflict of interest, either directly or indirectly if they have contracted with competitors of the insurer subject to any examination within two years of the start date for the examination. As part of any contract or employment arrangement, the market conduct surveillance personnel must agree not to perform any work for or on behalf of competitors of the insurer facing an existing examination while that examination is pending. Additionally, employment requests from regulators to vendors and vice versa should be disclosed in determining conflicts of interest as well. Sufficient parameters to vendor selection per [state law] should be adhered to and documented as to remove any appearance of favoritism to a particular vendor. This section shall not be construed to automatically preclude an individual from being:

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

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

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

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

(c) Any market conduct surveillance personnel having the aforementioned conflict of interest must disclose it to the Commissioner prior to the examination and may request a waiver of the conflict of interest. If the waiver is not granted, the market conduct surveillance personnel cannot proceed with an examination of that insurer until the waiver period is cleared. If the waiver is granted, the Commissioner shall notify both the market conduct surveillance personnel and the insurer under examination.

Section 10. Immunity for Market Conduct Surveillance Personnel

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

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

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

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

Section 11. Fines and Penalties

(a) Fines and penalties levied pursuant to this Act or other provisions of the state Insurance Law shall be consistent, reasonable and justified but not automatic. Appropriate analysis and review of each action taken shall occur and be adequately documented in the workpapers and to the insurer in each insurance of conduct.

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

(c) Self-reporting of violations by an insurer shall be considered in levying fines or penalties and shall in no instance be a cause to more severely punish an insurer but shall be utilized to mitigate anticipated regulator response to the issue.

(d) Analysis shall be performed by the department to ascertain whether if in lieu of fines and penalties, demonstrated prospective compliance thresholds will suffice such as in corrective action plans or other memorandums of understanding where permissible.

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

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

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

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

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

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

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

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

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

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

Section 13. Coordination with Other States Through the NAIC

The Commissioner shall share information and coordinate the Insurance Department's market analysis and examination efforts with other states through the NAIC. Provided that Commissioners shall not participate in MAWG or any multi-state coordinated actions that continue in length over a twelve (12) month period unless there is adequate and specific documentation provided as to exigent circumstances for continuation not caused by the insurance department, lead states, or hired vendors working on the project. Insurance Commissioners should encourage prompt resolution of coordinated actions for all stakeholders involved including consumers and insurers. Resolution of disputes with insurers where original motivation for analysis and review of conduct on a multistate basis does not materialize should not result in payments for costs and expenses of the examination by the insurer.

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

Section 14. Additional Duties of the Commissioner

(a) At least once per year, or more frequently if deemed necessary, the Commissioner shall make available in an appropriate manner to insurers and other entities subject to the scope of [cite Insurance Code citation] information on new laws and regulations, enforcement actions and other information the Commissioner deems pertinent to ensure compliance with market conduct requirements.

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

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

(d) Commissioners shall endeavor on each examination to discuss with insurers who are the target of the regulatory action, statistical and other methodologies that will be used to extrapolate results and whether there is adequate data to have confidence in the results on a going-forward basis.

(e) Commissioner shall provide to insurers prior to any examination the scope, standards, parameters and other criteria for determining violations thereof.

(f) Questions, queries and other input requested from insurers by insurance departments and/or third-party vendors shall be detailed in writing and provide adequate time period to respond.

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

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

Section 15. Effective Date

This Act shall take effect [insert chosen date].

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO BOX 325
TRENTON, NJ 08625-0325
TEL (609) 292-7272

*****Note: All material regarding rebates/anti-rebating laws to be discussed during the Financial Services & Multi-Lines Issues Committee on July 12th, 2019*****

BULLETIN NO. 11-22

TO: ALL INSURERS AUTHORIZED OR ADMITTED TO TRANSACT BUSINESS IN THIS STATE AND ALL PRODUCERS LICENSED IN THIS STATE

FROM: THOMAS B. CONSIDINE, COMMISSIONER

RE: REBATES AND INDUCEMENTS

New Jersey statutes and rules generally prohibit any person from paying or offering, directly or indirectly, as an inducement to make any contract of insurance, any rebate of premiums or commissions or any valuable consideration or thing of value which is not specified in the insurance contract or insurer's rating system. See N.J.S.A. 17:29A15; 17:29AA-14; and 17B:30-13; and N.J.A.C. 11:17A-2.3 and 2.4. Things of value offered with a cost or redeemable value of not more than \$25 are not prohibited.

Questions have arisen regarding whether providing particular services and/or monetary benefits would constitute a prohibited rebate or inducement under these statutes and rules. The purpose of this Bulletin is to clarify the intent of these legal authorities. The Department of Banking and Insurance ("Department") does not construe the intent of these statutes and rules as prohibiting the delivery by producers or insurers of services or other offerings for free or at a discounted price and in a fair and non-discriminatory way, so long as the services or other offerings relate to or enhance the value of the insurance product being purchased.

Examples of services that the Department does not construe as prohibited rebates or inducements under applicable law include:

- Discounts on gym memberships or wellness programs.
- Claims filing assistance, including group health insurance assistance services.
- COBRA, Health Reimbursement Arrangement ("HRA"), Health Savings Account ("HSA") and Flexible Spending Account ("FSA") administration.

- Risk management services, including loss control.
- Product audits to assist policyholders to evaluate their current policies.

Services or monetary benefits provided for free or at a discounted price that inure to the personal benefit of the purchaser and are largely extraneous to the coverage being purchased or the insurance services being provided by an insurer or a producer, or services offered in a discriminatory manner as an inducement to write or move business are prohibited. Examples of such services or benefits that the Department would consider prohibited rebates or inducements include:

- Payments of cash or cash equivalents of greater than \$25.
- Provision of tickets to a concert or event with a value greater than \$25.
- COBRA, HRA, HSA, and FSA administration services offered only to new customers who agree to change producers or insurers, which are not otherwise provided to in-force accounts.

The examples above are not exhaustive.

Services and benefits that are plainly expressed within the contract or rating system are not prohibited rebates or inducements.

NOTE: Authorized title insurers and producers licensed to transact title insurance business are subject to the requirements of the Real Estate Settlement Procedures Act, 12 U.S.C. Sec. 2607, et seq. and the regulations promulgated thereunder. Nothing in this Bulletin should be understood as addressing or interpreting the restrictions imposed upon such insurers and producers by those federal authorities.

Questions regarding this Bulletin may be directed to the Office of the Insurance Ombudsman at 800-446-7467 (Option 3) or by email to: ombudsman@dobi.state.nj.us.

October 21, 2011
Date



Thomas B. Considine
Commissioner

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

Bulletin 426
Rebates – Guidance for Producers
(Replaces Bulletin 384)

This Bulletin replaces Bulletin 384 and provides additional guidance for producers regarding what activities may be conducted under Maine’s amended rebating statutes.

The purpose of Maine’s anti-rebating laws is to protect both insurance consumers and the insurance industry. A consumer’s choice to purchase insurance should not be influenced by inducements that could result in an unsuitable policy choice, and insurance must be provided in a nondiscriminatory manner to like insureds or potential insureds. Anti-rebating statutes are designed to protect insurer solvency and prevent predatory pricing, both of which can hurt market participants and consumers.

The general rule under Maine’s rebating¹ laws is that no person may offer a discount or other inducement to a purchaser or prospective purchaser of insurance unless it is specified in the policy or the insurer’s filings.² A determination whether a given arrangement violates Maine’s rebating statutes is fact-specific and will depend upon the circumstances of the interaction between the parties. Some of the factors that the Bureau will evaluate in determining whether an arrangement violates the general prohibition on rebating will be the timing of the alleged inducement, the prior relationship between the parties, the type of benefit, and the recipient of the benefit. Section 2163-A of the Insurance Code establishes the permitted statutory exceptions to the general prohibition on rebating. Recent changes to this section have expanded the statutory exceptions by increasing the dollar thresholds and addressing the circumstances under which value-added services may be provided for free or at a reduced fee. These changes will go into effect on November 1, 2017.³ The purpose of this Bulletin is to give insurance professionals an overview of the statutory changes and provide guidance regarding how these new exceptions are interpreted by the Bureau.

¹ The subject of this Bulletin is compliance with laws prohibiting improper sales inducements. It does not relate in any way to the health insurance premium rebates that are required by state and federal law when insurers fail to meet minimum medical loss ratio standards.

² The rebate provision concerning life and health insurance is found in the Maine Insurance Code at 24-A M.R.S. § 2160. The corresponding provision for property and casualty insurance is located at 24-A M.R.S. § 2162. The provisions are not identical, but set forth the same basic principles for purposes of this Bulletin.

³ See P.L. 2017, ch. 84 (L.D. 1161).

Gifts and Prizes

As of November 1, 2017, a producer may offer gifts valued up to \$100 per year per person in connection with the marketing of insurance, and conduct raffles or drawings with prizes valued at no more than \$500⁴, so long as there is no participation costs to entrants. These gifts may not be in the form of cash; however, cash equivalents (e.g., pre-paid MasterCard or VISA gift card) are no longer prohibited. For group coverage, the \$100 limit applies on a per-applicant-or-policyholder basis; i.e., \$100 per group, not \$100 per covered life.

“Value-added” services

Maine’s recent statutory changes clarify that in certain circumstances, value-added services may be provided to a customer or potential customer, for free or at a reduced fee, without violating the general prohibition on rebating. Those services or discounts that can be valued at \$100 or less per policy per year are clearly acceptable under 24-A M.R.S. § 2163-A(1). If the services are worth more than \$100, the limitation will depend upon whether the value-added service is offered selectively or to all existing customers or potential customers.

If services valued in excess of \$100 are offered to specific customers, the services must be either included within the insurance policy or “directly related to the firm’s servicing of the insurance contract or offered or undertaken to provide risk control for the benefit of a client.”⁵

In evaluating whether a value-added service is directly related to the servicing of the insurance contract, licensees should look at the type of insurance involved and the nature of the services to be offered. The Bureau appreciates that the marketplace has become more complicated, especially for employers in the group health insurance market, and producers want to be able to use their expertise to provide customer assistance in a number of new areas.

The following examples are not intended as a complete list of acceptable services, but are offered to illustrate the range of services that would **generally** not be considered prohibited rebates:

- Risk management assistance provided by the producer;
- Regulatory and/or legislative updates;
- Enhancements that operate to make the producer’s own services and office operations more efficient and convenient for the insured;
- System improvements, which could include software provided to employers, which make information about group benefits provided through the producer more accessible to employers and employees;

⁴ The dollar limits for gifts and raffles were formerly \$20 and \$100, respectively.

⁵ 24-A M.R.S. § 2163-A(2).

- Services provided for COBRA or HIPAA administration for group health insurance customers;
- Administration of employer-sponsored Section 125 plans, flexible spending accounts (FSAs), and health reimbursement accounts (HRAs) for group health insurance customers.

Producers and insurers should be cautious of providing services for free or at reduced cost for enhancements that provide significant value to the customer but have a relatively limited connection to the customer's insurance program. This is an important factor in determining whether the service has been offered primarily as a gift or inducement.

For example, the connection between the insurance coverage and the provision of assistance with payroll or human resource management is likely to be too attenuated to qualify for the "value-added" exemption. Additionally, services that are purchased by the producer from a third party (as opposed to being provided "in house") may be too far removed from the underlying insurance relationship.

Producers and insurers may offer value-added services for free or at a discount without regard to the underlying insurance relationship only when the receipt of services is not contingent upon the purchase of insurance and when the services are offered on the same terms to all potential insurance customers.⁶

October 25, 2017

Eric A. Cioppa
Superintendent of Insurance

NOTE: This Bulletin is intended solely for informational purposes. It is not intended to set forth legal rights, duties, or privileges, nor is it intended to provide legal advice. Readers should consult applicable statutes and rules and contact the Bureau of Insurance if additional information is needed.

⁶ 24-A M.R.S. § 2163-A(3).

PLEASE NOTE: Legislative Information **cannot** perform research, provide legal advice, or interpret Maine law. For legal assistance, please contact a qualified attorney.

An Act To Amend the Insurance Laws Governing the Provision of Rebates

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24-A MRSA §2163-A, as amended by PL 1999, c. 8, §1, is repealed and the following enacted in its place:

§ 2163-A. Permitted activities

1. Permissible gifts and prizes. Notwithstanding any other provision in sections 2160 to 2163, an insurer, an employee of an insurer or a producer may offer to give gifts in connection with marketing for the sale or retention of contracts of insurance, as long as the cost does not exceed \$100 per year per person, and conduct raffles or drawings, as long as there is no participation cost to entrants and as long as the prizes are not valued in excess of \$500. Nothing in sections 2160 to 2163 may be construed to prohibit an insurance producer from receiving a fee rather than commission on the sale of property and casualty insurance in accordance with section 1450 and rules adopted by the superintendent.

Gifts and prizes given pursuant to this section may not be in the form of cash.

2. Permissible value-added service or activity. An insurer, an employee of an insurer or a producer may offer to provide a value-added service or activity, offered or provided without fee or at a reduced fee, that is related to the coverage provided by an insurance contract if the provision of the value-added service or activity does not violate any other applicable statute or rule and is:

- A. Clearly identified and included within the insurance contract; or
- B. Directly related to the servicing of the insurance contract or offered or undertaken to provide risk control for the benefit of a client.

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

4. Rules. The superintendent may adopt rules as necessary to make reasonable modifications to the standards in this section. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter 2-A.

Effective 90 days following adjournment of the 128th Legislature, First Regular Session,
unless otherwise indicated.

Illinois Department of Insurance

PAT QUINN
Governor

ANDREW BORON
Director

TO: All Insurance Companies and Licensed Insurance Producers

FROM: Andrew Boron, Director of Insurance

DATE: December 19, 2012

RE: COMPANY BULLETIN 2012-11
Rebating, value-added services, charitable contributions, consumer gifts
and referral fees

The Illinois Department of Insurance (the Department) receives inquiries regarding whether various programs and services can be offered to consumers or whether such programs and services constitute impermissible rebates.

The Illinois Insurance Code at 215 ILCS 5/151 provides in part:

Payment or acceptance of rebates prohibited. (1) No company doing business in this State and no insurance agent or broker shall offer, promise, allow, give, set off or pay, directly or indirectly, any rebate of or part of the premium payable on the policy, or on any policy or agent's commission thereon or earnings, profits, dividends or other benefits founded, arising, accruing or to accrue thereon or therefrom, or any special advantage in date of policy or age of issue, or any paid employment or contract for services of any kind or any other valuable consideration or inducement to or for insurance on any risk in this State, now or hereafter to be written, or for or upon any renewal of any such insurance, which is not specified in the policy contract of insurance, or offer, promise, give, option, sell, purchase any stocks, bonds, securities or property or any dividends or profits accruing or to accrue thereon, or other thing of value whatsoever as inducement to insurance or in connection therewith, or any renewal thereof which is not specified in the policy.

The essence of the above prohibitions concern the giving or offering by the insurance producer, of any rebate or other valuable consideration to the prospective insured as an inducement to purchase insurance or any renewal of coverage.

The purpose of this Bulletin is to provide guidance and clarification to licensed insurance producers as to what kinds of services (often referred to as "value-added" services) and marketing programs may be provided to insureds or potential insureds without running afoul of the rebating and inducement provisions in the Illinois Insurance Law. The DOI recognizes that the nature of services that an insurance producer may provide in connection with sale or service of insurance continue to evolve, but even in changing conditions, certain underlying principles can guide licensees in their conduct.

As a general matter, an insurer or insurance producer may not provide or offer to provide an insured or potential insured with any special benefit or discount, including any rebate from the premium, or any service or other incentive in conjunction with the sale of insurance, that is not specified in the policy or contract for insurance. Conversely, an insurer or insurance producer may not provide "free" insurance or offer to pay part of the insurance premium for an insured or potential insured as an incentive to purchase goods, services or even other insurance. The purpose of Illinois' rebating and inducement provisions is to require insurers and producers to market insurance in a nondiscriminatory manner to like insureds and potential insureds, and to foster competition by leveling the playing field for the small and large insurers and producers that operate in this State.

Value Added Services

Acceptable

An insurer or insurance producer may provide a service not specified in the insurance policy or contract to an insured or potential insured without violating the anti-rebating and inducement provisions of the Insurance Law if:

1. the service directly relates to the sale or servicing of the policy or risk reduction or provides general information about insurance; and
2. the insurer or insurance producer provides the service in a fair and nondiscriminatory manner to like insureds or potential insureds

The following services generally will fall within the scope of services that an insurance producer may lawfully provide in connection with insurance sold by the producer if provided incidental to the insurance and in a fair and nondiscriminatory manner to like insureds or potential insureds.

- Risk assessments, market analysis, benefit analytics, including identifying sources of risk and developing strategies for eliminating or limiting those risks;
- Insurance-related regulatory and legislative compliance,

- Tax preparation on behalf of an employer of Schedule A of the Internal Revenue Service Form 5500 Annual Return/Report of Employee Benefit Plan, which requests information regarding insurance contract coverage, fees and commissions, investment and annuity contracts, and welfare benefit contracts;
- Information to group policy or contract holders and members under group insurance policies currently in place, as well as forms needed for plan administration, enrollment in a plan, ongoing enrollment management, employee benefit and compensation statements, insurer website links, and answers to frequently asked questions related to the insurance (including, for example, access through a website created by the insurance producer, to an employee benefit portal that contains such information);
- Certain services provided pursuant to the federal Consolidated Omnibus Budget Reconciliation Act (COBRA), such as billing former employees, collecting the insurance premiums, and forwarding the aggregate premiums to the employer policy or contract holder or to the insurer when offered in connection with the provision of accident and health insurance; and
- Certain services provided in accordance with the federal Health Insurance Portability and Accountability Act and the federal Patient Protection and Affordable Care Act, such as those pertaining to health care access, portability, and renewability, when offered in connection with the provision of accident and health insurance.
- Wellness Services and Programs
- Loss Control/Safety/Claims

Prohibited

However, because they are too attenuated to the provision of insurance, or would otherwise violate the law because the services are not specified in the policy, the following services, if provided by an insurance producer to an insured or prospective insured for "free" or at a reduced fee, or otherwise offered in conjunction with insurance services, could, in the Department's estimation, run afoul of the rebating and inducement provisions set forth in the Insurance Law. Thus, the following services are prohibited:

- Flexible spending administration services; Paid Legal services;
- Payroll services, such as providing employers with check creation and distribution services for their employees;
- Referrals to non-insurance related third-party service providers through which an insured or prospective insured may receive a discounted rate while the producer is the producer of record;
- Advice regarding compliance with federal and state laws concerning human resource issues not relating to the insurance provided;
- Management of employee benefit programs, such as retirement programs and time-off/leave of absence programs, other than the insurance sold by the producer;

- Development of employee handbooks and training, which are unrelated to the insurance purchased; and
- Services related to employee compensation, discipline, job descriptions, leaves of absence, organizational development, business policies and practices, staffing and recruiting that are unrelated to the insurance purchased.

Promotional Items, Raffles, Charitable Donations

Acceptable

- The Department recognizes that a producer, agency, or carrier will have relationships with existing clients. It is often customary to engage these clients in social settings and activities that may include meals, sporting events, or other non-insurance related activities. These types of activities are allowed.
- The Department recognizes that producers and carriers advertise and market their service and products in a variety of methods. Gifts of minimal value such as pens, pencils, calendars, atlases, or golf balls are often provided to the general public. Marketing of a brand or logo on merchandise that is provided to the general public is generally acceptable. In addition, the sponsorship of events whether charitable or not is not considered a rebate. Educational seminars open to the general public where food may or may not be served are not considered rebates as long as no actual selling of a product or service takes place at the event.
- Contests or raffles in which a consumer receives a free chance to win a prize are acceptable as long as they are open to the public and there is no obligation for the consumer to purchase or renew insurance to enter, win, or claim the prize. This would also include an offer of a gift card to quote a consumer's insurance where there is no obligation to purchase such insurance.
- Insurance producers may donate earned commissions to charities as long as clients or prospective clients have no influence over which charity receives the donation, the donation is not in the client's name, and no client or prospective client becomes eligible for a tax benefit from the donation.

Referral Fees

Under 215 ILCS 5/500-80 a licensed producer may share commissions with another licensed producer for selling, soliciting, or negotiating insurance. In the event only one of the producers has the proper qualification, a commission or referral fee can still be shared as long as the non-qualified producer did not sell, solicit, or negotiate the insurance being sold. In addition, a producer may pay a referral fee to a non-licensed person as long as that person does not sell, solicit, or negotiate insurance as defined by 215 ILCS 5/500-10, or perform any other duty that would require a license as defined by 215 ILCS 5/500-

30. If a producer chooses to pay a referral fee to a non-licensed person, the payment may not be conditioned on the purchase of insurance nor may the purchase or insurance be a factor in determining the amount of the referral fee.

The Department further recognizes that issues will come to our attention that are not addressed in this Bulletin. The Department reserves the right to evaluate any given circumstance independently to determine whether the offer of something of value would constitute an inducement or rebate.



Deploying Beneficial Innovation in the Context of State Anti-Rebating Laws A Proposal to NCOIL Regarding State Anti-Rebating Laws

The American Property Casualty Insurance Association (APCIA) represents more than 1200 insurers and reinsurers that provide critically important insurance protection throughout the U.S. and world. In combination, our members write 60% of the U.S. property casualty market. As insurers seek to provide more value-added services to their customers in the form of technology to reduce risk, there is some uncertainty and even hesitation over how state anti-rebating and inducement laws may apply.

The innovative programs/services at issue often leverage the use of IoT connected devices, e.g. monitors, sensors, communication, telematics, biometric wearables to assist policyholders to mitigate risk, and in the process prevent deaths, injuries and financial loss. It is therefore critically important that we find a way forward so as not to lose this historic opportunity to better serve the public by mitigating risk and preventing loss.

Background

From the beginning of insurance, insurers have partnered with their policyholders and the general public to better understand and reduce the risk of loss. Today, insurers provide loss control services to commercial insureds, catastrophe models enabling communities to be more resilient and public information and advocacy for measures resulting in safer roads, buildings and workplaces. Now, technology offers the opportunity to dramatically increase the scope and value of this partnership through the provision of technology to policyholders as part of the service insurers provide.

Anti-rebating laws, however, originally well intended are a cause of concern, a potential hindrance to socially beneficial innovation. We therefore much appreciate NCOIL's focus on the issue and extensive review of this subject. These laws were introduced more than 100 years ago, after the use of rebates threatened the solvency of life insurance companies and raised questions around unfair discriminatory practices. But they are now acting, as was extensively shown during NCOIL's Innovation Sessions, as a potential hurdle to beneficial innovation through technology.

While increasing attention is devoted to new coverages for cyber risk, flooding, cannabis and other emerging exposures, new technological advances and innovation are providing significant opportunity to enhance the insured consumer experience as it relates to standard homeowner, auto and business policies.

Property casualty insurers are operating in an era of unparalleled disruption and promise. Rapidly changing technology and consumer expectations will continue to present challenges and opportunities. Customer experience is even more than before the battleground for differentiation and competitive success. Consumers expect the ease, convenience and response of an Amazon and Uber in all facets of their life – “there must be an App for that” mentality. But delivering on that experience requires a wide variety of digital capabilities that aren’t found in a typical application architecture. IoT connected devices can benefit consumers. This developing technology holds the promise to more effectively collect and analyze data and inform consumer behavior and the ratemaking and claims process. But it may be unclear whether an insurer’s offering comports with State anti-rebating laws.

The Challenge

The marketplace is demanding simpler and more innovation insurance solutions, including the combination of insurance products with non-insurance products and services in a single offering. These logical, complementary insurance/non-insurance product combinations allow insurers to better tailor products and to address emerging risks to the benefit of consumers. It is critically important to all that state laws and regulations keep pace with these innovative and consumer friendly innovations.

Way Forward—Key Issues and Potential Answers

- *What is the purpose of anti-rebating and inducement laws?*
 - These laws address concerns related to the giving or offering by the insurance producer, of any rebate or other valuable consideration to the prospective insured as an inducement to purchase insurance or any renewal of coverage. As a general matter, an insurer or insurance producer may not provide or offer to provide an insured or potential insured with any special benefit or discount, including any rebate from the premium, or any service or other incentive in conjunction with the sale of insurance, that is not specified in the policy or contract for insurance.
- *What screening criteria may ensure that value-added services or products still provide consumer protections and do not violate unfair discriminatory standards?*
 - States could most effectively and efficiently address the goals of legislators, regulators and industry by adding statutory or regulatory provisions that address the emergence of value-added and risk management services, products and devices that may be offered by, through, or in relationship with the insurance carrier. Principle-based criteria can support the innovations of today with the resilience to adapt to future innovations that continue to respond to the needs of consumers (policyholders). Qualified practices would be clarified as not considered to

be an improper inducement for insurance, a rebate, or other impermissible consideration for purposes of the state anti-rebate law or regulation.

- *How should the offer of an IoT connected device comport with the state anti-rebating and inducement laws?*
 - The device (service or product) is intended to prevent or mitigate loss or provide loss control;
 - The device (service or product) can monitor or assess risk, identify sources of risk, or develop strategies for eliminating or reducing those risks; and
 - The device (service or product) may be offered or provided to an insured for free or at a discounted price.

- *Here is an APCIA proposal for model language intended to be added to existing anti-rebating/trade practices statutes:*

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

Conclusion

APCIA appreciates the work of State legislators and the focus of NCOIL on its emerging innovation agenda. APCIA believes NCOIL is well-positioned to be in the forefront of efforts to avoid anti-rebating laws from hindering insurers' offering innovative products and services that will assist their policyholders in reducing their risk of loss. We have suggested a way forward through a series of questions, potential answers and model language. This is a critically important issue for the public we serve, and we are committed to working with you deliver the best possible outcome.

Atlantic Corporate Center
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Sen. Jason Rapert, AR
Sen. Travis Holdman, IN

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

AN ACT CONCERNING PRESCRIPTION DRUG COSTS

**Sponsored by Rep. Tom. Oliverson, M.D. (TX)*

**Co-Sponsored by Sen. Dan "Blade" Morrish (LA)*

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

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

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

"Commissioner" means the Insurance Commissioner.

"Department" means the Insurance Department.

"Director" means the Medicaid Director.

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

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

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

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

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

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

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

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

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

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

Section 4. Disclosure of prescription drug pricing information.

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

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

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

(A) Name of the product;

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

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

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

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

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

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

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

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

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

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

Section 5. Disclosure of pharmacy benefit management information.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 7. Severability

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

Section 8. Effective Date

This Act is effective immediately.

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National Council of Insurance Legislators (NCOIL)

Short Term Limited Duration Insurance Model Act

**Sponsored by Rep. Martin Carbaugh (IN)*

**To be discussed during the NCOIL Health Insurance and Long Term Care Issues Committee on July 13th, 2019. Initial draft as of June 11th, 2019 based on Indiana HB 1631 (signed into law on May 6, 2019)*

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Section 10.	Rules
Section 11.	Effective Date

Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

For purposes of this Act:

- (a) “Covered Individual” means an individual entitled to coverage under a short term insurance plan
- (b) “PPACA” means the federal Patient Protection and Affordable Care Act (P.L. 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)
- (c) “Short Term Insurance Plan” means a policy of health insurance that:
 - (1) may be renewed for the greater of:
 - (i) thirty-six (36) months; or
 - (ii) the maximum period permitted under federal law;
 - (2) has a term of not more than three hundred sixty-four (364) days; and
 - (3) has an annual limit of at least two million dollars (\$2,000,000).

Section 4. Renewal and Underwriting

- (a) An insurer may require an applicant for coverage under a short term insurance plan to specify, before issuance of the short term insurance plan, the number of renewals the applicant elects.
- (b) After issuance of a short term insurance plan, the insurer may not require underwriting of the short term insurance plan until:
 - (1) all renewal periods elected under subsection (a) have ended; and
 - (2) the covered individual renews the short term insurance plan beyond the periods described in subdivision (1).

Section 5. Coverage Requirements

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

- (1) Ambulatory patient services;
- (2) Hospitalization;

(3) Emergency services; and

(4) Laboratory services

Section 6. Preferred Provider Plan Requirements

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

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

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

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

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

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

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

Section 7. Disclosure Requirements

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

(1) That the short term insurance plan is not required to include coverage for all ten (10) of the essential health benefits required under the PPACA.

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

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

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

Section 8. Tiering/Rating

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

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

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

Section 10. Rules

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

Section 11. Effective Date

This Act shall take effect [_____].

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National Council of Insurance Legislators (NCOIL)

Insurance E-Commerce Model Act

**Sponsored by Rep. Edmond Jordan (LA)*

**Discussion draft as of June 11th, 2019. To be discussed during the Financial Services & Multi-Lines Issues Committee on July 12, 2019*

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Section 15.	Effective Date

Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

As used in this Chapter, the following definitions apply:

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

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

(b) Posting on an electronic network or site accessible via the internet, mobile application, computer, mobile device, tablet, or any other electronic device, together with separate notice of the posting provided by electronic mail to the address at which the party has consented to receive notice or by any other delivery method that has been consented to by the party. The separate notice of the posting shall contain the internet address at which the documents are posted.

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

Section 4. Electronic delivery of insurance documents and notices

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

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

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

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

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

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

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

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

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

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

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

Section 5. Change in hardware or software requirements

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

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

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

Section 6. Applicability

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

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

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

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

Section 7. Contracts and policies not affected

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

Section 8. Withdrawal of consent

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

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

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

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

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

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

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

Section 10. Alternative method of delivery required

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

- (1) The insurer attempts to deliver the notice or document by electronic means and has a reasonable basis for believing that the notice or document has not been received by the party.
- (2) The insurer becomes aware that the electronic mail address provided by the party is no longer valid.

Section 11. Limitation of liability

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

Section 12. Posting Policy on Internet

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

- (1). The policy and an endorsement must be accessible to the insured and producer of record and remain that way while the policy is in force;
- (2). After the expiration of the policy, the insurer shall archive the expired policy and endorsement for a period of five years or other period required by law, and make the policy and endorsement available upon request. After expiration of the policy, the insurer shall also keep active the insured's user ID used to access the insurer's website for a period of five years or other period required by law;
- (3). The policy and endorsement must be posted in a manner that enables the insured and producer of record to print and save the policy and endorsement using a program or application that is widely available on the internet and free to use;
- (4). The insurer shall provide the following information in, or simultaneous with, each declaration page provided at the time of issuance of the initial policy and any renewals of the policy:
 - (a). A description of the exact policy and endorsement form purchased by the insured;

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

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

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

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

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

Section 13. Receipt of Claim Payments by Electronic Transfer

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

Section 14. Rules

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

Section 15. Effective Date

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

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Sen. Travis Holdman, IN

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

INSURANCE FRAUD MODEL ACT

**Adopted by the NCOIL Executive Committee on July 28, 1995; amended on February 26, 1998; and readopted on November 16, 2001; November 19, 2004; and November 22, 2009.*

Proposed Amendments sponsored by Senator Jason Rapert (AR) – NCOIL Immediate Past President. To be considered during the Financial Services & Multi-Lines Issues Committee on July 12th, 2019

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF _____

The legislature finds that insurance fraud is pervasive and expensive, costing consumers and the business community of this state millions of dollars each year. Each family ~~spends~~ incurs in excess of several hundreds of dollars ~~each year~~ annually in direct and indirect costs attributable to insurance fraud. Insurance fraud takes innocent lives through stated accidents, arsons and unnecessary medical procedures. Insurance fraud increases premiums, leaves consumers with fewer insurance options, and places businesses at risk ~~and is a leading cause of insurance company insolvencies.~~ Some forms of insurance fraud can also lead to the financial collapse of smaller insurance companies, and negatively impacts all insurers regardless of size. Insurance fraud reduces consumers' ability to raise their standard of living and decreases the economic vitality of our~~this~~ state.

Therefore, the legislature believes that the state of _____ must aggressively confront the problem of insurance fraud by facilitating the detection, reducing the occurrence through stricter enforcement and deterrence, requiring restitution and increasing the partnership among consumers, the insurance industry and the state in coordinating efforts to combat insurance fraud by enacting the following Act.

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Section 9. Cooperation
Section 10. Immunity
Section 11. Regulatory Requirements

Section 1. Definitions

As used in this act, unless the context requires otherwise, the following terms have the meaning ascribed to them in this section.

Actual Malice. “Actual Malice” means knowledge that information is false, or “reckless” disregard of whether it is false.

Conceal. “Conceal” or “Concealment” means to take affirmative action to prevent others from discovering information. Mere inadvertent or unintentional failure to disclose information, by itself, does not constitute concealment. Action by the holder of a legal privilege, or one who has a reasonable belief such that a privilege exists, to prevent discovery of privileged information does not constitute concealment.

Insurance Policy. “Insurance Policy” means the written instrument in which are set forth the terms of any certificate of insurance, binder of coverage or contract of insurance (including a certificate, binder or contract issued by a state-assigned risk plan); benefit plan; nonprofit hospital service plan; motor club service plan; or surety bond, cash bond or any other alternative to insurance authorized by this state’s financial responsibility act. Insurance Policy also is any other instruments authorized or regulated by the department of insurance.

Insurance Professional. “Insurance Professional” means sales agents, managing general agents, brokers, producers, adjusters, investigators, examiners, consultants, and third party administrators. An “Insurance Professional” may be a direct employee, independent contractor or in any other similar status of providing service to the insurance company.

Insurance Transaction. “Insurance Transaction” means a transaction by, between or among: (1) an Insurer or a Person who acts on behalf of an Insurer; and (2) an insured, claimant, applicant for insurance, public adjuster, Insurance Professional, Practitioner, or any Person who acts on behalf of any of the foregoing, for the purpose of obtaining insurance or reinsurance, calculating insurance Premiums, submitting a claim, negotiating or adjusting a claim, or otherwise obtaining insurance, self-insurance, or reinsurance or obtaining the benefits thereof or therefrom.

Insurer. “Insurer” means any Person purporting to engage in the business of insurance or authorized to do business in the state or subject to regulation by the state, who undertakes to indemnify another against loss, damage or liability arising from a contingent or unknown event. “Insurer” includes, but is not limited to, an insurance company; self-

insurer; reinsurer; reciprocal exchange; interinsurer; risk retention group; Lloyd's insurer; fraternal benefit society; surety; medical service, dental, optometric or any other similar health service plan; and any other legal entity engaged or purportedly engaged in the business of insurance, including any Person or entity which falls within the definition of "Insurer" found within the _____ Insurance Code § _____.

Pattern or practice. "Pattern or practice" means repeated, routine or generalized in nature, and not merely isolated or sporadic. Evidence of pattern or practice may include acts in this state or any other jurisdiction.

Person. "Person" means a natural person, company, corporation, unincorporated association, partnership, limited liability company, limited liability partnership, professional corporation, agency of government ~~round~~ any other entity.

Practitioner. "Practitioner" means a licensee of this state authorized to practice medicine, osteopathy, and surgery, psychology, chiropractic, pharmacology, or other healing or treatment professions or arts as may be authorized or licensed by this state or the licensed practitioner of any non-medical treatment rendered in accordance with any other recognized religious method of healing; or law or any other licensee of the state or Person required to be licensed in the state whose services are compensated either in whole or in part, directly or indirectly, by insurance proceeds, including but not limited to automotive repair shops, building contractors and insurance adjusters, or a licensee similarly licensed in other states ~~or~~ nations.

Premium. "Premium" means consideration paid or payable for coverage, or benefits, under an Insurance Policy. "Premium" includes any payments, whether due within the Insurance Policy term or otherwise, and deductible payments whether advanced by the Insurer or Insurance Professional and subject to reimbursement by the insured or otherwise, any self insured retention or payments, whether advanced by the Insurer or Insurance Professional and subject to reimbursement by the insured or otherwise, and any collateral or security to be provided to collateralize obligations to pay any of the above.

Premium Finance Company. "Premium Finance Company" means a Person engaged or purporting to engage in the business of advancing money, directly or indirectly, to an Insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement, including but not limited to loan contracts, notes, agreements or obligations, wherein the insured has assigned the unearned Premiums, accrued dividends, or loss payments as security for such advancement in payment of Premiums on Insurance Policies only, and does not include the financing of insurance Premiums purchased in connection with the financing of goods and services.

Premium Finance Transaction. "Premium Finance Transaction" means a transaction by, between or among an insured, a producer or other party claiming to act on behalf of an insured and/or a third-party Premium Finance Company, for the purposes of purportedly or actually advancing money directly or indirectly to an Insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement,

wherein the insured has assigned the unearned Premiums, accrued dividends or loan payments as security for such advancement in payment of Premiums on Insurance Policies only, and does not include the financing of insurance Premiums purchased in connection with the financing of goods and services.

Reckless. “Reckless” means without reasonable belief of the truth, or, for the purposes of Section 3(c), with a high degree of awareness of probable insolvency.

Withhold. “Withhold” means to fail to disclose facts or information which any law, or regulation, (other than this act) requires to be disclosed. Mere failure to disclose information does not constitute “withholding” if the one failing to disclose reasonably believes that there is no duty to disclose.

Section 2. Fraudulent Insurance Act

Any Person who, knowingly and with intent to defraud, ~~and~~ or for the purpose of falsely depriving another of property or for pecuniary gain, commits, or attempts to commits, participates in or aids, abets, or conspires to commit or solicits another Person to commit, or permits its employees or its agents to commit any of the following acts, has committed a Fraudulent Insurance Act:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact concerning any of the following:

- (1) The application for, rating of, or renewal of, any Insurance Policy;
- (2) Any claim, whether in whole or in part, for payment or benefit pursuant to any Insurance Policy;
- (3) Payments made in accordance with the terms of any Insurance Policy;
- (4) ~~The~~ Any application used in any Premium Finance Transaction;

(b) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

- (1) ~~The~~ Any solicitation for sale of any Insurance Policy or purported Insurance Policy;

- (2) An application for certificate of authority;
 - (3) The financial condition of any Insurer;
 - (4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;
- (c) Solicits or accepts new or renewal insurance risks by or for an insolvent Insurer;
- (d) Removes the assets or records of assets, transactions and affairs or such material part thereof, from the home office or other place of business of the Insurer, or from the place of safekeeping of the Insurer, or destroys or withholds ~~sequesters~~ the same from the Department of Insurance;
- (e) Diverts, misappropriates, converts or embezzles funds of an Insurer, an insured, claimant or applicant for insurance in connection with:
- (1) Any Insurance Transaction;
 - (2) Any claim for payment or benefit pursuant to any Insurance Policy.
 - ~~(3)~~ The conduct of business activities by an Insurer or Insurance Professional;
 - ~~(4)~~ The acquisition, formation, merger, affiliation or dissolution of any Insurer.

It shall be unlawful for any Person to commit, or to attempt to commit, or to aid assist, abet or solicit another to commit, or to conspire to commit any Fraudulent Insurance Act.

Section 3. Unlawful Insurance Act

Any Person who commits, or participates in, or aids, abets, or conspires to commit, or solicits another Person to commit, or permits its employees, contractors or its agents to commit any of the following acts with an intent to induce reliance, has committed an Unlawful Insurance Act:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which the Person knows to contain false representations, or representations the falsity of which the Person has Recklessly disregarded, as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

- (1) ~~The~~ Any application for securing, rating of, or renewal of, any Insurance Policy;

(2) Any claim, in whole or in part, for payment or benefit pursuant to any Insurance Policy;

(3) Payments made in accordance with the terms of any Insurance Policy;

(4) ~~The~~ Any application for the financing of any insurance Premium;

(b) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which the Person knows to contain false representations, or representations the falsity of which the Person has Recklessly disregarded, as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) ~~The~~ Any solicitation for sale of any Insurance Policy or purported Insurance Policy;

(2) Any application for certificate of authority;

(3) The financial condition of any Insurer;

(4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;

(c) Solicits or accepts new or renewal insurance risks by or for an Insurer which the Person knows was insolvent or the insolvency of which the Person Recklessly disregards.

It shall be unlawful for any Person to commit, or to attempt to commit, or to aid assist, abet or solicit another to commit, or to conspire to commit an Unlawful Insurance Act.

Section 4. Criminal Penalties

Any Person who violates Section 2 of this Act is guilty of:

(a) A Class A misdemeanor if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____;

(b) A Class B misdemeanor if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully

obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____, and the defendant has been previously convicted of any class or degree of insurance fraud in any jurisdiction;

(c) A Class C misdemeanor if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____;

(d) A felony in the third degree if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____, and the defendant has been previously convicted two or more times of any class or degree of insurance fraud in any jurisdiction;

(e) A felony in the second degree if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____

(f) A felony in the first degree if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____ and the defendant has been previously convicted two or more times of any degree of felony insurance fraud in any jurisdiction; or

(3) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____ and his violation of Section 2 of this Act placed any Person at risk of, or caused, death or serious bodily injury.

Drafting Note: It is the intent of the coalition that the criminal penalties for fraudulent insurance acts should track the existing criminal penalties for similar crimes or fraudulent acts ~~fraud~~.

Section 5. Restitution

Any Person convicted of a violation of Section 2 of this Act shall be ordered to make monetary restitution for any financial loss or damages sustained by any other Person as a result of ~~the~~ any violation. Financial loss or damage shall include, but is not necessarily limited to, loss of earnings, out-of-pocket and other expenses, paid deductible amounts under an Insurance Policy, Insurer claim payments, all ~~costs~~ reasonably attributable to investigations, legal actions, and recovery efforts, including reasonable attorneys fees, by owners, Insurers, Insurance Professionals, law enforcement and other public authorities, and all ~~costs~~ of prosecution.

When restitution is ordered, the court shall determine its extent and methods. Restitution may be imposed in addition to a fine and, if ordered, any other penalty, but not in lieu thereof. The court shall determine whether restitution, if ordered, shall be paid in a single payment or installments and shall fix a period of time, not in excess of _____, within which payment of restitution is to be made in full.

To the extent permissible, it is the intention such Restitution shall not be dischargeable in any bankruptcy or similar proceeding.

Section 6. Administrative Penalties

(a) (1) Any Practitioner determined by the Court to have violated Section 2 shall be deemed to have committed an act involving moral turpitude that is inimical to the public well being. The court or prosecutor shall notify the appropriate licensing authority in this state of the judgment for appropriate disciplinary action, including revocation of any such professional license(s), and may notify appropriate licensing authorities in any other jurisdictions where the Practitioner is licensed. Any victim may notify the appropriate licensing authorities in this State and any other jurisdiction where the Practitioner is licensed, of the conviction.

(2) Upon notification of a conviction of ~~the~~ any crimes enumerated in Section 2 of this Act or a substantially similar crime under the laws of another state or the United States, this State's appropriate licensing authority shall hold an administrative hearing, or take other appropriate administrative action authorized by state law, to consider the imposition of the administrative sanctions, up to and including license revocation, as provided by law against the Practitioner. Where the Practitioner has been convicted of a felony violation of Section 2 of this Act or a substantially similar crime under the laws of another state or of the United States, this state's appropriate licensing authority shall hold an administrative hearing, or take other appropriate administrative action authorized by state law,

and shall summarily and permanently revoke the license. It is hereby recommended by the legislature that the ~~name of the~~ highest court in the state, bar association or other disciplinary agency or responsible organization shall summarily and permanently disbar any attorney found guilty of such felony.

(3) All such referrals to the appropriate licensing or other agencies, and all dispositive actions thereof, shall be a matter of public record.

(b) (1) A Person convicted of a felony involving dishonesty or breach of trust shall not participate in the business of insurance and may not be eligible for any state licensure relative in any capacity to the business of insurance.

(2) A Person in the business of insurance shall not knowingly or intentionally permit a Person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance.

Section 7. Civil Remedies

(a) Any Person injured in his or her person, business or property by reason of a violation of Section 3 may recover therefor from the Person[s] violating Section 3, in any appropriate ~~_____ Court~~ court of this state the following:

(1) Return of any profit, benefit, compensation or payment received by the Person violating Section 3 directly resulting from said violation;

(2) Reasonable attorneys fees, related legal expenses, including internal legal expenses and court costs, ~~not to exceed \$5,000;~~

An action maintained under this subparagraph may neither be certified as a class action nor be made part of a class action.

(b) Any Person injured in his or her person, business or property by reason of a violation of Section 2 may recover therefor from the Person[s] violating Section 2, in any appropriate ~~_____ Court~~ court of this state the following:

(1) Return of any profit, benefit, compensation or payment received by the Person violating Section 2 directly resulting from said violation;

(2) Reasonable attorneys fees, related legal expenses, including internal legal expenses and court costs;

(3) All other economic damages directly resulting from the violation of Section 2;

(4) Reasonable investigative fees based on a reasonable estimate of the time and expense incurred in the investigation of the violation(s) of Section 2 proved at trial:

(5) A penalty of no less than \$_____ and no greater than \$_____.

An action maintained under this subparagraph may neither be certified as a class action nor be made part of a class action.

(c) Any Person injured in his or her person, business or property by a Person violating Section 2, upon a showing of clear and convincing evidence that such violation was part of a Pattern or Practice of such violations, shall be entitled to recover threefold the injured Person's economic damages together with all reasonable attorneys fees and costs. An action for treble damages must be brought within _____ year(s) of such violation. One third of the treble damages awarded shall be payable to the state to be used solely for the purpose of investigation and prosecution of violations of this Act or other fraudulent behavior relating to Insurance Transactions, and/or for public education relating to insurance fraud. An action maintained under this subparagraph may neither be certified as class action nor be made part of a class action, unless the violations of Section 2 giving rise to the action resulted in criminal conviction of the violator[s] under Section 4.

(d) The State Attorney General, District Attorney or other authorized prosecutorial agency shall have authority to maintain Civil proceedings on behalf of the State Insurance Department and any victims of violations of Section 2. In any such action, the court shall proceed as soon as practicable to the hearing and determination thereof. Pending final determination thereof, the court may at any time enter such restraining orders or prohibitions, or take such other actions, including the acceptance of satisfactory performance bonds, as it shall deem proper.

(1) The _____ Courts of the state shall have jurisdiction to prevent and restrain violations of Section 2 of this Chapter by issuing appropriate orders.

(2) In any action commenced under this subparagraph (d), the Court, upon finding that any Person has violated Section 2, shall levy a fine of up to \$25,000 for each violation.

Any court in which a prosecution for violation of Section 2 is pending shall have authority to stay or limit proceedings in any civil action regarding the same or related conduct. Any court in which is pending a civil action brought pursuant to subparagraph (d) of this Section 7 may stay or limit proceedings in actions brought pursuant to subparagraphs (a)-(c) regarding the same or related conduct or may transfer such actions or consolidate them before itself or allow the plaintiffs in such actions to participate in the action brought pursuant to subparagraph (d), as it shall prescribe.

Any cause of action under this section for violation of Section 2 or Section 3 must be brought within _____ three (3) years of the commission of the acts constituting such violation, or within _____ three (3) years of the time the plaintiff discovered (or with reasonable diligence could have discovered) such acts, whichever is later.

An insurer shall not pay damages awarded under this Section 7, or provide a defense or money for a defense, on behalf of an insured under a contract of insurance or indemnification. A third party who ~~has asserted~~ a claim against an insured shall have no cause of action under this Section against the Insurer of the insured arising out of the Insurer's processing or settlement of the third party's claim. An obligee under a surety bond shall not have a cause of action under this section against the surety arising out of the surety's processing or settlement of the obligee's claim against the bond.

Any Person injured in his business or property by reason of a violation of Section 2 or Section 3 of this Chapter may recover under only one of the subparagraphs in this Section.

Section 8. Exclusivity of Remedies

The remedies expressly provided in Section 7 shall be the only private remedies for violations of this Act and no additional remedies shall be implied. The remedies available under Section 7 shall not be used in conjunction with or in addition to any other remedies available at law or in equity to duplicate recovery for the same element of economic damage. Further, in any civil action pleading both exemplary damages and the treble damages available in Section 7(c), plaintiff shall elect one or the other remedy, but not both, at the conclusion of the evidentiary phase of the trial.

However, nothing in this Act shall limit or abrogate any right of action which ~~would have~~ may existed in the absence of this Act, but no action based on such a right shall rely on this Act to establish a standard of conduct or for any other purpose.

Section 9. Cooperation

~~(c)~~ When any law enforcement official, ~~or authority, any insurance department, state division of insurance fraud, or state or federal regulatory or licensing authority~~ requests information related to an investigation or prosecution of allegations of potential insurance fraud, from an Insurer or Insurance Professional for the purpose of detecting, prosecuting or preventing insurance fraud, the Insurer or Insurance Professional shall take all reasonable actions to provide the any such information in its possession requested, subject to any legal privilege protecting such information.

~~(a)~~ Any Insurer or Insurance Professional that has reasonable belief that an act violating Sections 2 or 3 will be, is being, or has been committed shall furnish and disclose upon request any information in its possession concerning such act to the appropriate law enforcement official or authority, insurance department, state division of insurance fraud, or state or federal regulatory or licensing authority, subject to any legal privilege protecting such information.

~~(d)~~ Any Insurer or Insurance Professional failing or refusing to cooperate with a request for information from an appropriate local, state or federal governmental authority may,

~~subject to the court's discretion, forfeit any eligibility for restitution from any proceeds resulting from such governmental investigation and prosecution. providing information to any law enforcement, regulatory, licensing or other governmental agency under subparagraphs (a) or (b) of this section, shall have the right to request information in the possession or control of the agency relating to the suspected violation or to a pattern of related activity, except information which was privileged or confidential under the laws of this state prior to its submission to the agency. In instances where disclosure would not jeopardize an ongoing investigation or prosecution, the agency shall provide the requested information to the Insurer or Insurance Professional. The agency may request that the Insurer or Insurance Professional keep the disclosed information confidential.~~

~~(b)~~ Any Person that has a reasonable belief that an act violating Sections 2 or 3 this Chapter will be, is being, or has been committed; ~~or any Person who collects, reviews or analyzes information concerning insurance fraud~~ may furnish and disclose any information in its possession concerning such act to an authorized representative of an Insurer that requests the information for the purpose of detecting, investigating, prosecuting or preventing insurance fraud subject to any legal privilege protecting such information.

~~(e) Failure to cooperate with a request for information from an appropriate local, state or federal governmental authority shall bar a Person's eligibility for restitution from any proceeds resulting from such governmental investigation and prosecution.~~

Section 10. Immunity

~~(a) In the absence of Actual Malice, no Person furnishing, disclosing or requesting information pursuant to Section 9 shall be subject to civil liability for libel, slander, or any other cause of action arising from the furnishing, disclosing or requesting of such information. No Person providing information pursuant to Section 9(a) shall be subject to civil liability for any and no civil cause of action shall arise for any of the following: from the Person's provision of requested information.~~

(1) The disclosure of information related to Persons or conduct suspected of violating Sections 2 or 3 of this Act to federal, state or local agencies, officials, their agents, employees and/or designees.

(2) The receipt or possession of information related to Persons or conduct suspected of violating Sections 2 or 3 of this Act when the information was received pursuant to and for the purpose of complying with the provisions of this Act.

(3) The disclosure of information to any organization, whether governmental or private, established to detect and prevent fraudulent insurance acts, their agents, employees or designees; and/or a recognized comprehensive database system approved by the Insurance Department.

(4) The receipt or possession of information received from any organization established to detect and prevent fraudulent insurance acts, their agents, employees or designees; and/or a recognized comprehensive database system approved by the Insurance Department.

(b) The immunity granted in subsection (a) shall also apply to employees, contractors and agents of Insurers or insurance licensees whose responsibilities include the investigation and/or disposition of claims involving suspected violations of Sections 2 or 3 of this Act when sharing information on such acts or persons suspected of engaging in such acts with other entities or organizations employees of the same or other Insurers or insurance licensees, or other appropriate individuals or organizations, whose responsibilities include the investigation and/or disposition of claims involving suspected violations of Sections 2 or 3 of this Act.

(c) State agencies and their employees and/or designees shall not be subject to civil liability for disclosing information identified in subsection (b). No civil cause of action shall arise against any of them by virtue of the publication of a report or bulletin related to the official activities of the State agency.

(d) Any Person against whom any civil action is brought who is found to be immune from liability under this section, shall be entitled to recover reasonable attorney's fees and costs from the Person or party who brought the action.

(e) Nothing in ~~This section does not~~ is intended to abrogate or modify in any way any a common law or statutory ~~privilege or~~ immunity heretofore enjoyed by any Person.

Section 11. Regulatory Requirements

(a) Anti-Fraud Plans - Within six months of the effective date of this legislation, every Insurer with total annual direct written premiums in excess of five-hundred thousand dollars (\$500,000) shall prepare, implement, maintain and submit to the department of insurance an insurance anti-fraud plan.

Each Insurer's anti-fraud plan shall outline specific procedures, appropriate to the type of insurance the Insurer writes in this state, to:

(1) prevent, detect and investigate all forms of insurance fraud for which the carrier is authorized to issue policies or bonds, including fraud involving the Insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies; claims fraud; and security of the Insurer's data processing systems.

(2) educate appropriate employees on fraud detection and the Insurer's anti-fraud plan.

(3) inform policyholders about insurance fraud and how to protect against and prevent fraud.

~~(4)~~ provide for the hiring of or contracting for fraud investigators.

~~(5)~~ report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

~~(6)~~ pursue restitution for financial loss caused by insurance fraud, where appropriate.

(7) designate the person responsible for oversight and implementation of the insurer's anti-fraud plan, and provide full contact information.

The Commissioner may review, and in their discretion accept or reject, each Insurer's anti-fraud plan to determine if it complies with the requirements of this subparagraph.

It shall be the responsibility of the Commissioner to assure Insurer compliance with anti-fraud plans submitted to the Commissioner. The Commissioner may require reasonable modification of the Insurer's anti-fraud plan, or may require other reasonable remedial action if the review or examination reveals substantial non-compliance with the terms of the Insurer's own anti-fraud plan.

The Commissioner may require each Insurer to file a summary of the Insurer's anti-fraud activities and results. The anti-fraud plans and the summary of the Insurer's anti-fraud activities and results are not public records and are exempt from any privacy or the _____ public records act, and shall be proprietary and not subject to public examination, and shall not be discoverable or admissible in any civil action, whether arising under this Act or any other proceeding involving civil litigation.

This section confers no private rights of action.

(b) Fraud Warnings

(1) (A) No later than six months after the effective date of this Act, all applications for insurance, and all claim forms regardless of the form of transmission provided and required by an Insurer or required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following:

“It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.”

(B) The lack of a statement required in this subparagraph does not constitute a defense in any criminal prosecution under Section 2 nor in any civil action under Sections 2 or 3.

(2) The warning required by this subsection shall not be required on forms relating to reinsurance.

(c) Enforcement - Notwithstanding any other provision of the Insurance Code, the following are the exclusive monetary penalties for violation of this Section. Insurers that fail to prepare, implement, maintain and submit to the department of insurance an insurance anti-fraud plan are subject to a penalty of \$500 per day, not to exceed \$25,000 together with license suspension or revocation.

Proposed by the Coalition Against Insurance Fraud, 1012 14th Street NW, Suite 200, Washington, D.C. 20005, 202-393-7330. The Coalition is an independent, nonprofit organization of consumers, government agencies and insurers dedicated to combating all forms of insurance fraud through public information and advocacy.

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National Council of Insurance Legislators (NCOIL)

Model Act Concerning Interpretation of State Insurance Laws

**Sponsored by Rep. Joseph Fischer (KY)*

**To be discussed and considered by the Property & Casualty Insurance Committee on Friday, July 12th, 2019*

Section 1. Title

This Act shall be known as the "Model Act Concerning Interpretation of [State] Insurance Laws."

Section 2. Interpretation of [State] Insurance Laws

A statement of the law in the American Law Institute's Restatement of the Law, Liability Insurance does not constitute the law or public policy of this state if the statement of the law is inconsistent or in conflict with:

- (1) The Constitution of the United States or of this state;
- (2) A statute of this state;
- (3) This state's case law precedent; or
- (4) Other common law that may have been adopted by this state.

Section 3. Effective Date

This Act shall take effect immediately.

ENROLLED

CS/HB 1057, Engrossed 2 2019 Legislature

CODING: Words stricken are deletions; words underlined are additions.

hb1057-04-er

Page 1 of 14

*****To be discussed during the Financial Services & Multi-Lines Issues Committee on July 12th, 2019*****

FLORIDA HOUSE OF REPRESENTATIVES

An act relating to motor vehicles; amending s. 316.235, F.S.; authorizing a motor vehicle to be equipped with certain lamps or devices under certain circumstances; amending s. 316.2397, F.S.; authorizing certain vehicles to display red and white lights; amending s. 316.2398, F.S.; authorizing certain vehicles to display red and white warning signals under certain circumstances; providing requirements and penalties; amending s. 316.224, F.S.; conforming a cross-reference; amending s. 319.30, F.S.; authorizing an insurance company to provide an independent entity with a certain release statement authorizing it to release a vehicle to the lienholder; authorizing a certain notice sent by certified mail that a motor vehicle is available for pickup to be sent by another commercially available delivery service that provides proof of delivery; requiring the notice to state that the owner has a specified period during which to pick up the vehicle; authorizing an independent entity to apply for a certificate of destruction or a certificate of title if the vehicle is not claimed within a specified time after the delivery or attempted delivery of the notice; specifying requirements for an independent entity if the Department of Highway Safety and Motor Vehicles' records do not contain the owner's address; requiring an independent entity to maintain specified records for a minimum period; requiring an independent entity to provide proof of all lien satisfactions or proof of a release of all liens on a motor vehicle upon applying for a certificate of destruction or salvage certificate of title; requiring an independent entity to provide an affidavit with specified statements if such entity is unable to obtain a lien satisfaction or a release of all liens on the motor vehicle; providing that notice to lienholders and attempts to obtain a release from lienholders may be by certain written request; amending s. 320.03, F.S.; allowing authorized insurers, licensed salvage motor vehicle dealers, and licensed motor vehicle auctions to be authorized electronic filing system agents for processing certain transactions or certificates for derelict or salvage motor vehicles; deleting obsolete provisions; authorizing the department to adopt rules; amending s. 322.01, F.S.; revising the definition of the term "authorized emergency vehicle"; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsections (3) through (6) of section 316.235, Florida Statutes, are renumbered as subsections (4) through (7), respectively, and a new subsection (3) is added to that section to read:

316.235 Additional lighting equipment.—

(3) Any motor vehicle may be equipped with one or more lamps or devices underneath the motor vehicle as long as such lamps or devices do not emit light in violation of s.316.2397(1) or (7) or s. 316.238.

Section 2. Subsections (1) and (3) and paragraph (c) of subsection (7) of section 316.2397, Florida Statutes, are amended to read: 316.2397 Certain lights prohibited; exceptions.—

(1) ~~A No~~ person may not shall drive or move or cause to be moved any vehicle or equipment upon any highway within this state with any lamp or device thereon showing or displaying a red, red and white, or blue light visible from directly in front thereof except for certain vehicles ~~hereinafter~~ provided in this section.

(3) Vehicles of the fire department and fire patrol, including vehicles of volunteer firefighters as permitted under s. 316.2398, may show or display red or red and white lights. Vehicles of medical staff physicians or technicians of medical facilities licensed by the state as authorized under s. 316.2398, ambulances as authorized under this chapter, and buses and taxicabs as authorized under s. 316.2399 may show or display red lights. Vehicles of the fire department, fire patrol, police vehicles, and such ambulances and emergency vehicles of municipal and county departments, public service corporations operated by private corporations, the Fish and Wildlife Conservation Commission, the Department of Environmental Protection, the Department of Transportation, the Department of Agriculture and Consumer Services, and the Department of Corrections as are designated or authorized by their respective department or the chief of police of an incorporated city or any sheriff of any county may operate emergency lights and sirens in an emergency. Wreckers, mosquito control fog and spray vehicles, and emergency vehicles of governmental departments or public service corporations may show or display amber lights when in actual operation or when a hazard exists provided they are not used going to and from the scene of operation or hazard without specific authorization of a law enforcement officer or law enforcement agency. Wreckers must use amber rotating or flashing lights while performing recoveries and loading on the roadside day or night, and may use such lights while towing a vehicle on wheel lifts, slings, or under reach if the operator of the wrecker deems such lights necessary. A flatbed, car carrier, or rollback may not use amber rotating or flashing lights when hauling a vehicle on the bed unless it creates a hazard to other motorists because of protruding objects. Further, escort vehicles may show or display amber lights when in the actual process of escorting overdimensioned equipment, material, or buildings as authorized by law. Vehicles owned or leased by private security agencies may show or display green and amber lights, with either color being no greater than 50 percent of the lights displayed, while the security personnel are engaged in security duties on private or public property.

(7) Flashing lights are prohibited on vehicles except:

(c) For the lamps authorized under subsections (1), (2), (3), (4), and (9), s. 316.2065, or s. 316.235(6) ~~s. 316.235(5)~~ which may flash.

Section 3. Section 316.2398, Florida Statutes, is amended to read:

316.2398 Display or use of red or red and white warning signals; motor vehicles of volunteer firefighters or medical staff.—

(1) A privately owned vehicle belonging to an active firefighter member of a regularly organized volunteer firefighting company or association, while en route to the fire station for the purpose of proceeding to the scene of a fire or other emergency or while en route to the scene of a fire or other emergency in the line of duty as an active firefighter member of a regularly organized firefighting company or association, may display or use red or red and white warning signals. ~~or~~ A privately owned vehicle belonging to a medical staff physician or technician of a medical facility licensed by the state, while responding to an emergency in the line of duty, may display or use red warning signals. Warning signals must be visible from the front and from the rear of such vehicle, subject to the following restrictions and conditions:

(a) No more than two red or red and white warning signals may be displayed.

(b) No inscription of any kind may appear across the face of the lens of the red or red and white warning signal.

(c) In order for an active volunteer firefighter to display such red or red and white warning signals on his or her vehicle, the volunteer firefighter must first secure a written permit from the chief executive officers of the firefighting organization to use the red or red and white warning signals, and this permit must be carried by the volunteer firefighter at all times while the red or red and white warning signals are displayed.

(2) ~~A~~ ~~It is unlawful for any~~ person who is not an active firefighter member of a regularly organized volunteer firefighting company or association or a physician or technician of the medical staff of a medical facility licensed by the state may not display on any motor vehicle owned by him or her, at any time, any red or red and white warning signals as described in subsection (1).

(3) ~~It is unlawful for~~ An active volunteer firefighter may not ~~to~~ operate any red or red and white warning signals as authorized in subsection (1), except while en route to the fire station for the purpose of proceeding to the scene of a fire or other emergency, or while at or en route to the scene of a fire or other emergency, in the line of duty.

(4) ~~It is unlawful for~~ A physician or technician of the medical staff of a medical facility may not ~~to~~ operate any red warning signals as authorized in subsection (1), except when responding to an emergency in the line of duty.

(5) A violation of this section is a nonmoving violation, punishable as provided in chapter 318. In addition, a ~~any~~ volunteer firefighter who violates this section shall be dismissed from membership in the firefighting organization by the chief executive officers thereof.

Section 4. Subsection (3) of section 316.224, Florida Statutes, is amended to read:

316.224 Color of clearance lamps, identification lamps, side marker lamps, backup lamps, reflectors, and deceleration lights.—

(3) All lighting devices and reflectors mounted on the rear of any vehicle shall display or reflect a red color, except the stop light or other signal device, which may be red, amber, or yellow, and except that the light illuminating the license plate shall be white and the light emitted by a backup lamp shall be white or amber. Deceleration lights as authorized by s. 316.235(6) ~~s. 316.235(5)~~ shall display an amber color.

Section 5. Effective July 1, 2019, subsection (9) of section 319.30, Florida Statutes, is amended to read:

319.30 Definitions; dismantling, destruction, change of identity of motor vehicle or mobile home; salvage.—

(9)(a) An insurance company may notify an independent entity that obtains possession of a damaged or dismantled motor vehicle to release the vehicle to the owner. The insurance company shall provide the independent entity a release statement on a form prescribed by the department authorizing the independent entity to release the vehicle to the owner or lienholder. The form must ~~shall~~, at a minimum, contain the following:

1. The policy and claim number.
2. The name and address of the insured.
3. The vehicle identification number.
4. The signature of an authorized representative of the insurance company.

(b) The independent entity in possession of a motor vehicle must send a notice to the owner that the vehicle is available for pickup pick-up when it receives a release statement from the insurance company. The notice shall be sent by certified mail or by another commercially available delivery service that provides proof of delivery to the owner at the owner's address contained reflected in the department's records. The notice must state inform the owner that the owner has 30 days after delivery receipt of the notice to the owner at the owner's address to pick up the vehicle from the independent entity. If the motor vehicle is not claimed within 30 days after the delivery or attempted delivery of the owner receives the notice, the independent entity may apply for a certificate of destruction or a certificate of title.

(c) If the department's records do not contain the owner's address, the independent entity must do all of the following:

1. Send a notice that meets the requirements of paragraph (b) to the owner's address that is provided by the insurance company in the release statement.

2. Identify the latest titling jurisdiction of the vehicle through use of the National Motor Vehicle Title Information System or an equivalent commercially available system and attempt to obtain the owner's address from that jurisdiction. If the jurisdiction returns an address that is different from the owner's address provided by the insurance company, the independent entity must send a notice that meets the requirements of paragraph (b) to both addresses.

(d) The independent entity shall maintain for a minimum of 3 years the records related to the 30-day notice sent to the owner, the results of searches of the National Motor Vehicle Title Information System or an equivalent commercially available system, and the notification to the National Motor Vehicle Title Information System made pursuant to paragraph (e).

~~(e)~~(e) The independent entity shall make the required notification to the National Motor Vehicle Title Information System before releasing any damaged or dismantled motor vehicle to the owner or before applying for a certificate of destruction or salvage certificate of title.

~~(f)~~(d) Upon applying for a certificate of destruction or salvage certificate of title, the independent entity shall provide a copy of the release statement from the insurance company to the independent entity, proof of providing the 30-day notice to the owner, proof of notification to the National Motor Vehicle Title Information System, proof of all lien satisfactions or proof of a release of all liens on the motor vehicle, and applicable fees. If the independent entity is unable to obtain a lien satisfaction or a release of all liens on the motor vehicle, the independent entity must provide an affidavit stating that notice was sent to all lienholders that the motor vehicle is available for pickup, 30 days have passed since the notice was delivered or attempted to be delivered pursuant to this section, attempts have been made to obtain a release from all lienholders, and all such attempts have been to no avail. The notice to lienholders and attempts to obtain a release from lienholders may be by written request delivered in person or by certified mail or another commercially available delivery service that provides proof of delivery to the lienholder at the lienholder's address as provided on the certificate of title and to the address designated with the Department of State pursuant to s. 655.0201(2) if such address is different.

~~(g)~~(e) The independent entity may not charge an owner of the vehicle storage fees or apply for a title under s. 713.585 or s. 713.78.

Section 6. Subsection (10) of section 320.03, Florida Statutes, is amended to read:
320.03 Registration; duties of tax collectors; International Registration Plan.—

(10)(a) Jurisdiction over the electronic filing system for use by authorized electronic filing system agents to:

1. Electronically title or register motor vehicles, vessels, mobile homes, or off-highway vehicles;

2. For derelict or salvage motor vehicles, process title transactions, derelict motor vehicle certificates, or certificates of destruction, pursuant to s. 319.30(2), (3), (7), or (8);

3. Issue or transfer registration license plates or decals;

4. Electronically transfer fees due for the title and registration process; and

5. Perform inquiries for title, registration, and lienholder verification and certification of service providers, is expressly preempted to the state, and the department shall have regulatory authority over the system. The electronic filing system shall be available for use statewide and applied uniformly throughout the state.

(b) The following entities that meet all established requirements may be authorized electronic filing system agents and may not be precluded from participating in the electronic filing system in any county:

1. An entity that, in the normal course of its business, sells products that must be titled or registered and, provides title and registration services on behalf of its consumers; or

2. An authorized insurer as defined in s. 624.09(1), a licensed salvage motor vehicle dealer as defined in s. 320.27(1)(c)5., or a licensed motor vehicle auction as defined in s. 320.27(1)(c)4. For these entities, authorization for use of the electronic filing system under this subparagraph is limited exclusively to processing, in the normal course of business pursuant to s. 319.30(2), (3), (7), or (8), title transactions, derelict motor vehicle certificates, or certificates of destruction for derelict or salvage motor vehicles physically located in the state and meets all established requirements may be an authorized electronic filing system agent and shall not be precluded from participating in the electronic filing system in any county.

(c) Upon request from a qualified entity, the tax collector shall appoint the entity as an authorized electronic filing system agent for that county. The department shall adopt rules in accordance with chapter 120 to replace the December 10, 2009, program standards and to administer the provisions of this section, including, but not limited to, establishing participation requirements, certification of service providers, electronic filing system requirements, and enforcement authority for noncompliance. The December 10, 2009, program standards, excluding any standards which conflict with this subsection, shall remain in effect until the rules are adopted.

(d) An authorized electronic filing system agent may charge a fee to the customer for use of the electronic filing system.

(e) The department may adopt rules to administer this subsection, including, but not limited to, rules establishing participation requirements, certification of service providers, electronic filing system requirements, disclosures, and enforcement authority for noncompliance.

Section 7. Subsection (4) of section 322.01, Florida Statutes, is amended to read:

322.01 Definitions.—As used in this chapter:

(4) "Authorized emergency vehicle" means a vehicle that is equipped with extraordinary audible and visual warning devices, that is authorized by s. 316.2397 to display red, red and white, or blue lights, and that is on call to respond to emergencies. The term includes, but is not limited to, ambulances, law enforcement vehicles, fire trucks, and other rescue vehicles. The term does not include wreckers, utility trucks, or other vehicles that are used only incidentally for emergency purposes.

Section 8. Except as otherwise expressly provided in this act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect October 1, 2019.

Peer-to-Peer Car Sharing Program Act

Final 4-10-19

Developed by Turo and the American Property Casualty Insurance Association of America (APCIA)

**To be discussed during the Property & Casualty Insurance Committee on July 12th, 2019*

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

Chapter 2. Definitions

Application of definitions

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

“Peer-to-Peer Car Sharing”

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

“Peer-to-Peer Car Sharing Program”

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

“Car Sharing Program Agreement”

Sec. 4. “Car Sharing Program Agreement” means the terms and conditions applicable to a shared vehicle owner and a shared vehicle driver that govern the use of a shared vehicle through a peer-to-peer car sharing

program. “Car Sharing Program Agreement” does not mean rental car agreement, or similar, as defined in _____.

“Shared Vehicle”

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

“Shared Vehicle Driver”

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

“Shared Vehicle Owner”

Sec. 7. “Shared Vehicle Owner” means the registered owner, or a person or entity designated by the registered owner, of a vehicle made available for sharing to shared vehicle drivers through a peer-to-peer car sharing program.

“Car Sharing Delivery Period”

Sec. 9. “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. 10. “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. 11. “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. 12. “Car Sharing Termination Time” means the earliest of the following events:

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

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

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

Chapter 3. Insurance

Insurance Coverage During Car Sharing Period

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

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

(i) 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

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

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

(d) A peer-to-peer car sharing program shall ensure that, during each car sharing period, the shared vehicle owner and the shared vehicle driver are insured under a motor vehicle liability insurance policy that provides insurance coverage in

amounts no less than the minimum amounts set forth in *[insert citation to applicable statute establishing state minimum coverage]*, and:

- (1) Recognizes that the shared vehicle insured under the policy is made available and used through a peer-to-peer car sharing program; or
 - (2) Does not exclude use of a shared vehicle by a shared vehicle driver.
- (e) The insurance described under subsection (d) may be satisfied by motor vehicle liability insurance maintained by:

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

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

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

- (1) a dispute exists as to who was in control of the shared motor vehicle at the time of the loss; and
- (2) the peer-to-peer car sharing program does not have available, did not retain, or fails to provide the information required by Section 5 of this Chapter 3.

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

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

(i) Coverage under an automobile insurance policy maintained by the peer-to-peer car sharing program shall not be dependent on another automobile insurer first

denying a claim nor shall another automobile insurance policy be required to first deny a claim.

(j) Nothing in this Chapter:

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

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

Notification of Implications of Lien

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

Exclusions in Motor Vehicle Liability Insurance Policies

Sec. 3. 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:

- a. liability coverage for bodily injury and property damage;
- b. personal injury protection coverage as defined in [CITE STATUTE];
- c. uninsured and underinsured motorist coverage;
- d. medical payments coverage;
- e. comprehensive physical damage coverage; and
- f. collision physical damage coverage

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

Recordkeeping; Use of Vehicle in Car Sharing

Sec. 5. A peer-to-peer car sharing program shall collect and verify records pertaining to the use of a vehicle, including, but not limited to, times used, fees paid by the shared vehicle driver, and revenues received by the shared vehicle owner and provide that information upon request to the shared vehicle owner, the shared vehicle owner's insurer, or the shared vehicle driver's insurer to facilitate a claim coverage investigation. The peer-to-peer car sharing program shall retain the records for a time period not less than the applicable personal injury statute of limitations.

Exemption; Vicarious Liability

Sec. 6. 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. 7. A motor vehicle insurer that defends or indemnifies a claim against a shared vehicle that is excluded under the terms of its policy shall have the right to seek contribution against the motor vehicle insurer of the peer-to-peer car sharing program if the claim is: (1) made against the shared vehicle owner or the shared vehicle driver for loss or injury that occurs during the car sharing period; and (2) excluded under the terms of its policy.

Insurable Interest

Sec. 8. (a) Notwithstanding any other law, statute, rule or regulation to the contrary, a peer-to-peer car sharing program shall have an insurable interest in a shared vehicle during the car sharing period.

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

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

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

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

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

Chapter 4. Consumer Protections Disclosures

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

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

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

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

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

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

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

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

Driver's License Verification and Data Retention

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

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

(2) Is a nonresident who:

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

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

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

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

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

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

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

Responsibility for Equipment

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

Automobile Safety Recalls

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

- (1) Verify that the shared vehicle does not have any safety recalls on the vehicle for which the repairs have not been made; and
 - (2) Notify the shared vehicle owner of the requirements under subsection (b) of this section.
- (b)
- (1) If the shared vehicle owner has received an actual notice of a safety recall on the vehicle, a shared vehicle owner may not make a vehicle available as a shared vehicle on a peer-to-peer car sharing program until the safety recall repair has been made.
 - (2) If a shared vehicle owner receives an actual notice of a safety recall on a shared vehicle while the shared vehicle is made available on the peer-to-peer car sharing program, the shared vehicle owner shall remove the shared vehicle as available on the peer-to-peer car sharing program, as soon as practicably possible after receiving the notice of the safety recall and until the safety recall repair has been made.
 - (3) If a shared vehicle owner receives an actual notice of a safety recall while the shared vehicle is being used in the possession of a shared vehicle driver, as soon as practicably possible after receiving the notice of the safety recall, the shared vehicle owner shall notify the peer-to-peer car sharing program about the safety recall so that the shared vehicle owner may address the safety recall repair.

Chapter 5. EFFECTIVE DATE.

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

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

**To be discussed during the Financial Services & Multi-Lines Issues Committee on July 12th, 2019*

AN ACT relating to the insurance industry.

Be it enacted by the General Assembly of the Commonwealth of Kentucky:

SECTION 1. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

As used in Sections 1 to 8 of this Act, unless context requires otherwise:

- (1) "Applicant" means a person that has filed an application under Section 2 of this Act;
- (2) "Beta test" means the phase of testing of an insurance innovation in the regulatory sandbox through the use, sale, license, or availability of the insurance innovation by or to clients or consumers under the supervision of the department;
- (3) "Client" means a person, other than a consumer, utilizing a participant's insurance innovation during a beta test to carry on some activity regulated by the department;
- (4) "Director" means the director of insurance innovation;
- (5) "Extended no-action letter" or "extended letter" means a public notice setting forth the conditions for an extended safe harbor beyond the beta test under which the department will not take any administrative or regulatory action against any person using the insurance innovation described in the extended no-action letter;
- (6) "Innovation's utility" means an evaluation by the commissioner of the insurance innovation's ability to adequately satisfy factors set forth in subsection (1)(b)1. of Section 2 of this Act;
- (7) "Insurance innovation" or "innovation" means any product, process, method, or procedure relating to the sale, solicitation, negotiation, fulfillment, administration, or use of any product or service regulated by the department:
 - (a) That has not been used, sold, licensed, or otherwise made available in this Commonwealth before the effective filing date of the application, whether or not the product or service is marketed or sold directly to consumers; and
 - (b) That has regulatory and statutory barriers that prevent its use, sale, license, 2 or availability within this Commonwealth;
- (8) "Limited no-action letter" or "limited letter" means a letter setting forth the conditions of a beta test and establishing a safe harbor under which the department will not take any

administrative or regulatory action against a participant or client of the participant concerning the compliance of the insurance innovation with Kentucky law so long as the participant or client abides by the terms and conditions established in the limited no-action letter;

(9) "Participant" means an applicant that has been issued a limited no-action letter under Section 4 of this Act; and

(10) "Regulatory sandbox" or "sandbox" means the process established under Sections 1 to 8 of this Act by which a person may apply to beta test and obtain a limited no-action letter for an innovation, potentially resulting in the issuance of an extended no-action letter.

SECTION 2. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS 16
CREATED TO READ AS FOLLOWS:

(1) Except as provided in subsection (2) of this section, on or before December 31, 2025, a person may apply to the department for admission to the sandbox by submitting an application in the form prescribed by the commissioner, accompanied by the following:

(a) A filing fee of seven hundred fifty dollars (\$750);

(b) A detailed description of the innovation, which shall include:

1. An explanation of how the innovation will:

a. Add value to customers and serve the public interest;

b. Be economically viable for the applicant;

c. Provide suitable consumer protection; and

d. Not pose an unreasonable risk of consumer harm.

2. A detailed description of the statutory and regulatory issues that may prevent the innovation from being currently utilized, issued, sold, solicited, distributed, or advertised in the market;

3. A description of how the innovation functions and the manner in which it will be offered or provided;

4. If the innovation involves the use of software, hardware, or other technology developed for the purpose of implementing or operating it, a technical white paper setting forth a description of the operation and general content of technology to be utilized, including:

- a. The problem addressed by that technology; and
- b. The interaction between that technology and its users;

5. If the innovation involves the issuance of a policy of insurance, a statement that either:

- a. If the applicant will be the insurer on the policy, that the applicant holds a valid certificate of authority and is authorized to issue the insurance coverage in question; or

- b. If some other person will be the insurer on the policy, that the other person holds a valid certificate of authority and is authorized to issue the insurance coverage in question; and

6. A statement by an officer of the applicant certifying that no product, process, method, or procedure substantially similar to the innovation has been used, sold, licensed, or otherwise made available in this Commonwealth before the effective filing date of the application;

(c) The name, contact information, and bar number of the applicant's insurance regulatory counsel, which shall be a person with experience providing insurance regulatory compliance advice;

(d) A detailed description of the specific conduct that the applicant proposes should be permitted by the limited no-action letter;

(e) Proposed terms and conditions to govern the applicant's beta test, which shall include:

1. Citation to the provisions of Kentucky law that should be excepted in the notice of acceptance issued under subsection (6) of Section 3 of 6 this Act; and

2. Any request for an extension of the time period for a beta test under subsection (1) of Section 5 of this Act and the grounds for the request;

(f) Proposed metrics by which the department may reasonably test the innovation's utility during the beta test;

(g) Disclosure of all:

1. Persons who are directors and executive officers of the applicant;

2. General partners of the applicant if the applicant is a limited partnership;

3. Members of the applicant if the applicant is a limited liability applicant;
4. Persons who are beneficial owners of ten percent (10%) or more of the voting securities of the applicant;
5. Other persons with direct or indirect power to direct the management and policies of the applicant by contract, other than a commercial contract for goods or non-management services; and
6. Conflicts of interest with respect to any person listed in this paragraph and the department;

(h) A statement that the applicant has funds of at least twenty-five thousand dollars (\$25,000) available to guarantee its financial stability through one (1) or a combination of any of the following:

1. A contractual liability insurance policy;
2. A surety bond issued by an authorized surety;
3. Securities of the type eligible for deposit by authorized insurers in this Commonwealth;
4. Evidence that the applicant has established an account payable to the commissioner in a federally insured financial institution in this Commonwealth and has deposited money of the United States in an amount equal to the amount required by this paragraph that is not available for withdrawal except by direct order of the commissioner;
5. A letter of credit issued by a qualified United States financial institution as defined in KRS 304.9-700; or
6. Another form of security authorized by the commissioner; and

(i) A statement confirming that the applicant is not seeking authorization for, nor shall it engage in, any conduct that would render the applicant unauthorized to make an application under subsection (2) of this section.

(2) (a) The following persons shall not be authorized to make an application to the department for admission to the sandbox:

1. Any person seeking to sell or license an insurance innovation directly to any federal, state, or local government entity, agency, or instrumentality as the insured person or end user of the innovation;

2. Any person seeking to sell, license, or use an insurance innovation that is not in compliance with subsection (1)(b)5. of this section;
3. Any person seeking to make an application that would result in the person having more than five (5) active beta tests ongoing within the Commonwealth at any one (1) time; and
4. Any person seeking a limited or extended no-action letter or exemption from any administrative regulation or statute concerning:
 - a. Assets, deposits, investments, capital, surplus, or other solvency requirements applicable to insurers;
 - b. Required participation in any assigned risk plan, residual 3 market, or guaranty fund;
 - c. Any licensing or certificate of authority requirements; or
 - d. The application of any taxes or fees.

(b) For the purposes of this subsection, "federal, state, or local government entity, agency, or instrumentality" includes any county, city, municipal corporation, urban-county government, charter county government, consolidated local government, unified local government, special district, special purpose governmental entity, public school district, or public institution of education.

**SECTION 3. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS 13
CREATED TO READ AS FOLLOWS:**

- (1) There shall be a director of insurance innovation within the department, responsible for administering Sections 1 to 8 of this Act. The director shall be appointed by the secretary of the Public Protection Cabinet with the approval of the Governor in accordance with KRS 12.050.
- (2) The director shall review all applications for admission to the sandbox.
- (3)
 - (a) Unless extended as provided in paragraph (b) of this subsection, the commissioner shall issue a notice of acceptance or rejection in accordance with this section within sixty (60) days from the date an application is received.
 - (b) The commissioner may extend by not more than thirty (30) days the period provided in paragraph (a) of this subsection if he or she notifies the applicant before expiration of the initial sixty (60) day period.
 - (c) An application that has not been accepted or rejected by a notice of acceptance or rejection issued by the commissioner prior to expiration of the initial sixty (60)

day period, or if applicable, the period provided in 2 paragraph (b) of this subsection, shall be deemed accepted.

(4) The commissioner may request from the applicant any additional material or 4 information necessary to evaluate the application, including but not limited to:

- (a) Proof of financial stability;
- (b) A proposed business plan;
- (c) Pro-forma financial statement; and
- (d) Executive profiles on the applicant and its leadership demonstrating 9 insurance or insurance-related industry experience and applicable 10 experience in the use of the technology.

(5) The commissioner shall review the application to:

- (a) Identify and assess:
 - 1. The potential risks to consumers, if any, posed by the innovation; and
 - 2. The manner in which the innovation would be offered or provided; and
- (b) Determine whether it satisfies the following requirements:
 - 1. The application satisfies the requirements of Section 2 of this Act;
 - 2. The application proposes a product, process, method, or procedure that meets the definition of innovation under Section 1 of this Act;
 - 3. Approval of the application does not pose an unreasonable risk of consumer harm;
 - 4. The application identifies statutory or regulatory requirements that actually prevent the innovation from being utilized, issued, sold, solicited, distributed, or advertised in this Commonwealth; and
 - 5. The application proposes an innovation that is not substantially similar to an innovation:
 - a. That has been previously beta tested; or
 - b. Proposed in an application that is currently pending with the department.

(6) Upon review of the application, the commissioner shall, in his or her discretion, issue one (1) of the following:

(a) If the commissioner determines that the application fails to satisfy any of the requirements under subsection (5)(b) of this section, he or she shall:

1. Issue a notice of rejection to the applicant; and
2. Describe in the notice of rejection the specific defects in the application;
or

(b) If the commissioner determines that the application satisfies the requirements of subsection (5)(b) of this section, he or she shall issue a notice of acceptance to the applicant. The notice of acceptance shall:

1. Set forth the terms and conditions that will govern the applicant's beta test, which shall include, at a minimum:

a. Requiring the applicant to:

i. Abide by all Kentucky law, except where explicitly excepted;

ii. Utilize the insurance innovation within this Commonwealth; and

iii. Report any change in the disclosures made pursuant to subsection (1)(g) of Section 2 of this Act;

b. Notice of the licenses required to be obtained prior to the commencement of the beta test;

c. Monthly reporting obligations structured to determine the progress of the beta test;

d. Consumer protection measures deemed necessary by the commissioner to be employed by the applicant;

e. The level of financial stability required to be in place for the beta test. The commissioner may increase, decrease, or waive the requirements for financial stability required under subsection (1)(h) of Section 2 of this Act, commensurate with the risk of consumer harm posed by the insurance innovation;

f. Duration of the beta test, including any extension authorized under Section 5 of this Act;

- g. Permitted conduct under the limited letter;
- h. Any limits established by the commissioner on the:
 - i. Financial exposure that may be assumed by an applicant during the beta test;
 - ii. Number of customers an applicant may accept; and
 - iii. Volume of transactions that an applicant or its clients may complete during the beta test; and
- i. Metrics the commissioner intends to use to determine the innovation's utility; and

2. Provide that the notice of acceptance shall expire unless:

- a. It is accepted by the applicant in writing; and
- b. The acceptance is filed with the department within sixty (60) days of the issuance of the notice.

(7) An applicant may request a hearing pursuant to KRS 304.2-310 on:

- (a) A notice of rejection; and
- (b) A notice of acceptance, if the request is made prior to its expiration.

SECTION 4. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) Within ten (10) days following the timely receipt of an acceptance pursuant to subsection (6)(b)2. of Section 3 of this Act, the commissioner shall issue a limited no-action letter that:

- (a) Sets forth terms and conditions for the participant that are the same as those set forth in the notice of acceptance issued under subsection (6) of Section 3 of this Act; and
- (b) Provides that so long as the participant and any clients of the participant abide by the terms and conditions set forth in the letter, no administrative or regulatory action concerning the compliance of the insurance innovation with Kentucky law will be taken by the commissioner against the participant or any clients during the term of the beta test.

(2) If the application is deemed accepted under subsection (3)(c) of Section 3 of this Act, the proposed limited no-action letter included with the application shall be deemed to have the effect of a limited letter issued by the commissioner.

(3) The safe harbor of the limited letter shall persist until the earlier of:

(a) The early termination of the beta test under Section 5 of this Act;

(b) The issuance of an extended no-action letter; or (c) The issuance of a notice declining to issue an extended no-action letter.

(4) A limited no-action letter issued by the commissioner under this section shall be exempt from the application of KRS 13A.130.

(5) The commissioner shall publish any limited letter issued pursuant to this section on the department's Web site.

**SECTION 5. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS 22
CREATED TO READ AS FOLLOWS:**

(1) The time period for a beta test shall be one (1) year. The time period may be extended by the commissioner in the notice of acceptance for a period that is not longer than one (1) year if a request is made in accordance with subsection (1)(e) of Section 2 of this Act.

(2) During the beta test, the participant and any clients of the participant shall:

(a) Comply with all terms and conditions set forth in the limited no-action letter;
and

(b) Provide the department with all documents, data, and information requested by the commissioner.

(3) (a) For any violation of the terms or conditions set forth in the limited letter, the commissioner may:

1. Issue an order terminating the beta test and the safe harbor of the limited letter before the time period set forth in the limited letter has expired; and

2. Impose a fine of not more than two thousand dollars (\$2,000) per violation.

(b) The commissioner may also issue an order under paragraph (a)1. of this subsection if, following receipt of information or complaints, the commissioner determines the beta test is causing consumer harm.

(4) (a) The commissioner may issue an order requiring a client to cease and desist any activity violating the terms or conditions set forth in the limited letter.

(b) The issuance of a cease and desist order to one (1) client shall not otherwise impact the ability of the participant or any other clients to continue activities relating to the innovation in a manner compliant with the requirements of the limited letter.

(5) A participant or client may request a hearing on any order issued under this section pursuant to KRS 304.2-310.

SECTION 6. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) (a) Within sixty (60) days of completion of the beta test, unless the time period is extended up to thirty (30) days upon notice from the commissioner, the commissioner shall issue an extended no-action letter or a notice declining to issue an extended no-action letter.

(b) The participant may continue to employ the insurance innovation pursuant to the terms and conditions of the limited letter during the period between the completion of the beta test and the issuance of either an extended no action letter or a notice declining to issue an extended no-action letter.

(2) The commissioner shall review the results of the beta test to determine whether the innovation satisfies the following requirements:

(a) The data presented demonstrates that the innovation's utility was meritorious of an extension;

(b) Regulatory and statutory barriers prevent continued use of the innovation within this Commonwealth;

(c) The innovation provided a benefit to Kentucky consumers; and

(d) The issuance of an extended no-action letter:

1. Presents no risk of unreasonable harm to consumers or the marketplace;
and

2. Serves the public interest.

(3) Upon review of the results of the beta test, the commissioner shall, in his or her discretion, issue one (1) of the following:

(a) If the commissioner determines that the innovation fails to satisfy any of the requirements under subsection (2) of this section, he or she shall:

1. Issue a notice declining to issue an extended no-action letter;
2. Describe in the notice the reasons for the declination;
3. Notify the participant for the innovation of the notice; and
4. Publish the notice on the department's Web site; or

(b) If the commissioner determines that the innovation satisfies the requirements under subsection (2) of this section, he or she shall issue an extended no action letter. An extended no-action letter issued by the commissioner shall include:

1. A description of the insurance innovation and the specific conduct permitted by the extended letter in sufficient detail to enable any person to use the innovation or a product, process, method, or procedure not substantially different from the innovation within the safe harbor of the extended letter;
2. Notice of any certificate of authority, license, or permit the commissioner determines is necessary to use, sell, or license the innovation, or make the innovation available, in this Commonwealth;
3. An expiration date not greater than three (3) years following the date of issuance;
4. Notice that the extended no-action letter may:
 - a. Only be modified by:
 - i. Promulgation of an administrative regulation, if the safe harbor addresses a requirement established by administrative regulation; or
 - ii. An act of the General Assembly; and
 - b. Be rescinded prior to its expiration if the commissioner receives complaints and determines continued activity poses a risk of harm to consumers;
5. Clarification of required procedures related to the issuance and cancellation of any policies of insurance, if applicable, due to the expiration period; and

6. Notice that, upon expiration, all persons relying on the extended no action letter shall cease and desist operations related to the innovation unless changes have been made to Kentucky law to permit the innovation by:

- a. The promulgation of an administrative regulation, if the safe harbor address a requirement established by administrative regulation; or
- b. An act of the General Assembly.

(4) A hearing on a notice of declination may be requested in accordance with KRS 304.2-310.

(5) An extended no-action letter issued by the commissioner pursuant to this section shall be:

- (a) Exempt from the application of KRS 13A.130; and
- (b) Published on the department's Web site.

SECTION 7. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) All documents, materials, or other information in the possession or control of the department that are created, produced, obtained, or disclosed in relation to Sections 1 to 8 of this Act and that relate to the financial condition of any person shall be confidential and shall not be subject to public disclosure pursuant to the Kentucky Open Records Act, KRS 61.870 to 61.884.

(2) Notwithstanding any law to the contrary, the commissioner may disclose in an extended no-action letter any information relating to the insurance innovation necessary to clearly establish the safe harbor of the extended letter.

SECTION 8. A NEW SECTION OF SUBTITLE 3 OF KRS CHAPTER 304 IS CREATED TO READ AS FOLLOWS:

(1) One hundred twenty days (120) days prior to the start of the 2021, 2022, 2023, 2024, and 2025 regular sessions of the General Assembly, the commissioner shall submit a written report to the Interim Joint Committee on Banking and Insurance that meets the requirements of subsection (2) of this section. Thereafter, the commissioner shall submit the report annually, upon request.

(2) The report shall include the following:

- (a) The number of:

1. Applications filed and accepted;
2. Beta tests conducted; and
3. Extended letters issued;

(b) A description of the innovations tested;

(c) The length of each beta test;

(d) The results of each beta test;

(e) A description of each safe harbor created under Section 6 of this Act;

(f) The number and types of orders or other actions taken by the commissioner or any other interested party under Sections 1 to 8 of this Act;

(g) Identification of any statutory barriers for consideration of amendment by the General Assembly following successful beta tests and the issuance of extended letters; and

(h) Any other information or recommendations deemed relevant by the commissioner.

(3) The commissioner shall also provide the Interim Joint Committee on Banking and Insurance a detailed briefing, upon request, to discuss and explain any report submitted under this section.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
NASHVILLE, TENNESSEE
MARCH 16, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Saturday, March 16, 2019 at 2:30 p.m.

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

Other members of the Committees present were:

Rep. Matt Lehman (IN)
Rep. George Keiser (ND)

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

Other legislators present were:

Rep. Roy Takumi (HI)
Rep. Edmond Jordan (LA)
Rep. Daire Rendon (MI)

Sen. Paul Wieland (MO)
Rep. Tracy Boe (ND)
Sen. Jerry Klein (ND)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Rep. Matt Lehman (IN), NCOIL Vice President, to waive the quorum requirement, the Committee unanimously approved the minutes of its December 7, 2018 meeting in Oklahoma City, OK upon a Motion made by Rep. Keiser and seconded by Rep. Lehman.

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

Rep. Ferguson stated that there are two amendments to the NCOIL bylaws for consideration. First, the the Financial Services Committee is proposed to be changed to the Financial Services & Multi-Lines Issues Committee in order to have a committee with specific jurisdiction over matters that cross multiple lines of insurance. Section III.B.6. of the bylaws is proposed to be amended to reflect that change.

Upon a Motion made by Rep. Keiser and seconded by Rep. Tom Oliverson, M.D. (TX), the committee approved the change by way of a voice vote without objection. The other change is to ensure that Section VI. of the bylaws, "Rules of Procedure", contains the new name of the Committee when listing all of NCOIL's policy committees.

Upon a Motion made by Rep. Keiser and seconded by Rep. Oliverson, the committee approved the change by way of a voice vote without objection.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
NCOIL SPRING MEETING - NASHVILLE, TN
MARCH 17, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Sheraton Grand on Sunday, March 17, 2019 at 10:32 a.m.

NCOIL President, Sen. Dan "Blade" Morrish, LA, Chair of the Committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Rep. Matt Lehman, IN, Vice President
Asm. Ken Cooley, CA, Treasury
Asm. Kevin Cahill, NY, Secretary
Sen. Jason Rapert, AR, Immediate Past
President
Rep. Deborah Ferguson, AR
Rep. Bart Rowland, KY

Rep. Edmond Jordan, LA
Sen. Paul Wieland, MO
Rep. George Keiser, ND
Asm. Andrew Garbarino, NY
Sen. Bob Hackett, OH
Rep. Tom Oliverson, M.D., TX

OTHER LEGISLATORS PRESENT:

Rep. Daire Rendon, MI
Rep. Carl Anderson, SC

ALSO PRESENT:

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

QUORUM

A motion was made by Asm. Garbarino and seconded by Asm. Cooley to waive the quorum that carried on a voice vote.

MINUTES

A motion was made by Rep. Oliverson and seconded by Asm. Garbarino to approve the minutes of the December 8, 2018 Committee Meeting minutes. It carried without opposition.

FUTURE LOCATIONS

Commissioner Considine discussed 4 options in 3 states for the 2021 Summer Meeting. Boston, Minneapolis, Cleveland and Columbus were all considered. He recommends Boston because the NAIC Summer Meeting will be in Columbus that year and will have been in Minneapolis the year before in Summer 2020. A motion by Sen. Rapert and seconded by Rep. Jordan to host the 2021 Summer Meeting in Boston and it carried on a voice vote.

ADMINISTRATION

Commissioner Considine noted that there were 274 registrants for the Spring Meeting, 44 legislators and participants from 24 states. 14 first time legislators, 4 legislators participated via ILF scholarship. 5 Commissioners participated, and 13 insurance departments were present.

Paul Penna gave the 2018 year-end unaudited financial report through December 31, 2018 showing revenue of \$1,022,393.60 and expenses of \$911,686.96 for an excess of \$110,706.64.

Rep. Oliverson made a motion to accept the administration report that was seconded by Asm. Garbaino. It carried on a voice vote.

CONSENT CALENDAR

Sen. Morrish asked if any member had an item to take off the consent calendar. No member did so and Asm. Cooley made a motion to accept and Asm. Cahill seconded the consent calendar. The motion carried on a voice vote

ARTICLES OF INCORPORATION & BYLAWS REVISION COMMITTEE REPORT

Sen. Morrish recognized Rep. Ferguson who gave the Article of Incorporation and Bylaws Committee report stating that one change was made – The Financial Services Committee will now be known as the Financial Services and Multiline Issues so issues that cross-insurance lines has a logical place to be considered. Rep. Lehman made a motion that was seconded by Sen. Hackett to accept the change. The motion carried on a voice vote.

OTHER SESSIONS

Sen. Morrish noted that the Griffith Foundation Legislator Luncheon “Mega-Trends in Insurance: The Long View” with Christopher McDaniel, President of The Institute’s RiskBlock Alliance was informative and timely.

He also noted and thanked the featured speakers including TN Rep. Ron Travis, the TN House Insurance Committee Chair who spoke at the Welcome Breakfast; David Maurstad, Chief Executive of the NFIP and Deputy Associate Administrator for Insurance & Mitigation, FEMA who spoke at the initial meeting of the Special Committee on Natural Disaster Recovery and Nicholas Whyte, Ph.D., who was the featured speaker at the Keynote Luncheon on the implications of Brexit.

OTHER BUSINESS

Sen Morrish made a motion to approve the resolution honoring the life of former Rep. Stan Bainter, NCOIL President and was seconded by Asm. Kevin Cahill. Motion carried on voice vote.

Sen. Morrish thanked Nashville for being a wonderful host city and noted there were 3 first time legislators from TN in attendance. He noted the first meeting of the Special Committee on Disaster Relief and encouraged legislators to participate.

ADJOURNMENT

There being no further business, Asm. Cahill made a motion to adjourn that was seconded by Asm. Garbarino. The committee adjourned at 10:47 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
NASHVILLE, TENNESSEE
MARCH 15, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, March 15, 2019 at 3:15 p.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Rep. George Keiser (ND)
Rep. Matt Lehman (IN)	Sen. Jerry Klein (ND)
Rep. Joseph Fischer (KY)	Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Sen. Mark Johnson (AR)	Rep. Daire Rendon (MI)
Rep. David Santiago (FL)	Sen. Vickie Sawyer (NC)
Rep. Roy Takumi (HI)	Asm. Ken Blankenbush (NY)
Rep. Deanna Frazier (KY)	Rep. Lewis Moore (OK)
Rep. Bart Rowland (KY)	

Also in attendance were:

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

MINUTES

Upon a Motion made by Asm. Ken Cooley (CA), NCOIL Treasurer, and seconded by Sen. Jerry Klein (ND), the committee waived the quorum requirement. Upon a Motion made by Asm. Cooley and seconded by Sen. Klein, the committee approved the minutes from its December 6, 2018 meeting. Both motions carried without objection by way of a voice vote.

DISCUSSION ON THE IMPACT OF BLOCKCHAIN IN THE INSURANCE AND FINANCIAL SERVICES INDUSTRIES

Christopher McDaniel, President of the Institutes RBA Alliance (Alliance), stated that there are three things you need to know to understand what blockchain is and what its implications are for the insurance industry. The first thing is to understand what ubiquitous data is, which is the ability to have information and data shared between different parties. That means if insurance carrier A and insurance carrier B have agreed to share some type of data, any time either carrier updates the data, it is automatically updated for the other carrier as well. That remains the same whether you are talking about 2 or 50 carriers. Blockchain therefore makes you feel like you have all the

information you need on your server that is connected to the blockchain. In reality, everything is being synchronized behind the scenes, but you don't have to worry about that. From an insurance perspective, this data sharing can take place between carrier to carrier, carrier to distributor, carrier to consumer, distributor to consumer, and all points in between.

The second thing to understand is that blockchain is immutable which means you cannot delete anything off of the blockchain. So if some type of record is put on the blockchain and it needs to be changed, a second record needs to be put on the blockchain so an audit trail is always there of what the first record was. Therefore, the blockchain is a very secure mechanism for exchanging information because there is a permanent record of everything that happens. For that reason, blockchain is often called a "trust engine" because, for example, it allows for two carriers who may be competitors to share information in a trusted manner. The third thing to understand is that blockchain has "smart contracts." Ironically, smart contracts are neither smart nor contracts. Rather, they are the ability to automate a process, i.e. if "A and B happen, then C happens." From an insurance industry standpoint, those three things translate to: increased efficiency; reduced risk; improved customer service; new market opportunities; new delivery models; improved market position; and improved regulatory tools such as fraud detection. Mr. McDaniel stated that in the insurance industry there are so many things that qualify as "low hanging fruit" in terms of improving their functionality by putting them on the blockchain that the insurance industry really is ready for a sea change in terms of how it does business.

Mr. McDaniel stated that the Alliance has a value proposition consisting of three components. First, it is a non-profit organization and its governance model was built in such a way as to encourage deep participation within the insurance organizations. That is extremely important because the Alliance wanted to avoid the situation where it was building solutions and just throwing them over the wall to the insurance industry. The Alliance has good participation from government organizations and has a group called the "forward thinking states" consisting of 15 states. The Alliance wants state regulators involved in what they are doing so solutions are created the right way.

Second, the Alliance has a standardized framework which is important because what it saw when it first started was a lot of "reinventing the wheel" occurring which defeats the purpose of blockchain. Therefore, the Alliance created "Canopy" which is a standardized framework for blockchain and it allows you to have one set of blockchains and be able to have multiple applications built on top of the same set of blockchains. The first applications built thus far have been in the personal auto space relating to proof of insurance and first notice of loss. Approximately 7 other applications are currently in development. Third, the Alliance created a global software factory to pull the best and brightest from around the world to build the applications that run on top of Canopy. Mr. McDaniel stated that some areas in which the Alliance is currently in are P&C, life, annuities, and commercial. This year, the Alliance will also move into the retirement space, group health, reinsurance, workers' compensation, and surety bonds. The Alliance has a very strong presence in the U.S., with 39 P&C firms participating and 10 firms participating on the life and annuity side. The Alliance is also expanding outside the U.S. as well.

With regard to use-cases, Mr. McDaniel stated that the Alliance has created two applications that are being implemented by its members: proof of insurance and first

notice of loss. Those are very important use-cases because if you are using proof of insurance that means you are putting policy data on the blockchain and with first notice of loss you are putting claims data on the blockchain. The Alliance has conducted an ROI study on proof of insurance and first notice of loss and with a 22% market penetration, the industry stands to save about \$69 million dollars and by year three it is anticipated that there will be about 80% market penetration consisting of more than \$300 million dollars saved annually.

Mr. McDaniel stated that other applications currently being worked on relate to: reinsurance; verification of certificates of insurance which is very important to many of the players in the commercial space; a commercial version of proof of insurance; a commercial version of first notice of loss; a know your customer piece for the life and annuity space, the first aspect dealing with having a verified source for the death master file in order to address issues with unclaimed property. Mr. McDaniel closed by stating that there so many exciting things going on in the industry right now, and it is only going to accelerate, not slow down.

Erin Collins, Asst. VP – State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that there are many positive and exciting possibilities for the use of blockchain in the P&C industry. NAMIC is hopeful that as the technology moves forward that there will be a lot of discussion and interest in the topic. However, one caveat is that over the last couple of years, NAMIC has seen well-intentioned bills introduced that are generalized blockchain bills and they are almost a calling-card to business saying “we are open to innovation and technology in this state” which is understandable. But that causes some concern for the insurance industry if when using the blockchain technology the legislation was phrased in such a way that could be interpreted as setting apart a separate section of regulation apart from insurance regulation whereby an insurance product from a non-admitted carrier could argue that they are not subject to the state-based insurance regulator. Therefore, it is important to ensure that the insurance industry is involved when this type of legislation is considered in order to make sure that the state-based system of insurance regulation is not disrupted.

Sen. Hackett asked how insurer’s fears relating to the access and storage of their data can be addressed with regard to blockchain legislation and initiatives. Mr. McDaniel stated that it is first and foremost important to make sure that insurers and regulators are involved in all of these conversations which is why the forward-thinking states group mentioned earlier has been formed. The last thing the Alliance wants to do is build something that has no regulator input which would lead the regulators trying to regulate on the backend. Having everyone involved from the start enables issues such as data privacy to be addressed from each perspective. One of the things that the Alliance is working on is called a declaration of privacy which will state from an Alliance standpoint exactly how it is handling and covering privacy related issues. The Alliance will then take that declaration to various parties in the industry and ask for their input and to join that declaration in order to avoid the situation of having 50 different state requirements for data privacy.

Rep. George Keiser (ND) asked Mr. McDaniel if you must have an encrypted key to get into a specific block. Mr. McDaniel replied yes, but the Canopy framework is built upon a platform called Corda which is distributed ledger technology and it actually does not copy data between parties. If you think of it as Carrier A as a building with a window and

Carrier B is a building with a window and they need to share information, all they do is open their windows so they can see their data on other systems and when no longer needed, the windows close. Data is not copied and never actually leaves the systems of the insurance carrier.

DISCUSSION ON INSURANCE MODERNIZATION INITIATIVES

Sen. Hackett stated that this discussion on insurance modernization is aimed towards developing either an omnibus insurance modernization model or separate “rifle shot” models aimed at helping the insurance industry move past some outdated ways of doing business. For example, some states still don’t have legislation that allows consumers the option of receiving electronic insurance coverage notices from insurers; they require paper. Today, the committee will be hearing about that electronic insurance coverage notice issue, along with rebate reform initiatives, and the electronic issuance of salvage titles. Those are just three issues that we have preliminarily identified as ripe for inclusion in the insurance modernization topic and the goal is to gather more issues for discussion before our Summer Meeting in July. Legislators and interested parties are encouraged to reach out to the NCOIL National Office with any issues they think would be appropriately addressed under this topic of insurance modernization. Sen. Hackett noted that a few years ago in Ohio, a large omnibus insurance modernization bill was passed that dealt with issues ranging from alternative investment and holding company systems law, to automated insurance transactions. The legislation proved to be very beneficial for industry and consumers alike and the goal is for the Committee to produce something similarly beneficial.

a.) Rebate Reform Initiatives

Jamie Anderson-Parson, JD – Asst. Prof. in the Dep’t of Finance, Banking & Insurance at Appalachian State University, stated that current rebating laws have presented challenges for insurtech’s in particular. An insurtech is basically a business model that is used for technology and innovation to help with efficiency and deal with cost savings. Ms. Parson noted that she does not have a “dog in the fight” when it comes to addressing issues relating to rebate reforms. Ms. Parson further noted that reforming rebating laws has been a topic for discussion for quite some time as evidenced by a 1981 quote: “It’s time to dust off the anti-rebate laws...and see if they really serve the purpose they were intended to serve when they were put in the books in a totally different age.”

Ms. Parson stated that over 100 years ago, life insurance agents paid rebates to clients to encourage sales which led those agents to demand higher commissions to make up for the rebates. In addition, it also led to unfair discrimination practices as those rebates were not applied equally to everyone. Those are the two main policy reasons for creating anti-rebating statutes. The general rule is fairly consistent throughout the states in that agents and brokers are not allowed to offer a discount or other inducement to an insured or prospective insured unless it is specified in the policy, contract, or insurer’s filings; many states follow the National Association of Insurance Commissioners (NAIC) Model #880. The idea is to preclude individuals from purchasing a policy because of the inducement.

States interpret anti-rebate laws differently but there are some states that have incorporated a variety of exceptions into such laws to allow agencies and agents to engage in some basic marketing practices. The exceptions occur by statutory reference, common law, and regulatory directive. One exception is for promotional items. The value of promotional items ranges anywhere from \$5 to \$200 but the general consensus is that as long as you are offering that promotional item not in connection with the sale of the insurance product it is acceptable. Another exception relates to referral fees which are generally permissible as long as they are not contingent upon the sale. This is likened most to the purchase of a lead. Raffles are permitted in some jurisdictions as long as they are not contingent upon the sale and the raffled product is within a certain dollar range. Charity donations are permissible as long as the client or prospective client has no influence over the choice of charity.

Ms. Parson stated that the area with perhaps the most recent challenges is that of value-added services. The original rule was that a value-added service is not prohibited if it is directly related to the insurance product sold, intended to reduce claims, and provided in a fair and nondiscriminatory manner. Things like risk-control tools, claims assistance, legislative updates, and risk assessments have been permitted, but things like COBRA administration, preparing employee handbooks and performing drug testing are things not permitted. Ms. Parson then discussed introducing technology disruptors that combine the idea of being an insurance broker with offering a product into the traditional interpretation of anti-rebate laws. For example, what distinguishes Zenefits is that a couple of years ago when they first started, in addition to offering recordkeeping services, its website had a button that enabled someone to choose Zenefits as their broker. Accordingly, some friction arose with anti-rebating laws because they were providing a service that was outside the scope of said laws. Zenefits operates a little differently today in that they have a "find a broker" button as opposed to serving as the broker, but that situation presented some arguments and challenges worth looking at.

The first challenge was whether offering free services on a single integrated platform induces a consumer to purchase insurance through Zenefits vs. another broker. The counterargument was that purchasing insurance through them is a choice and there are no additional perks if you use Zenefits as a broker. The second challenge was that the "free" services have a cost and value associated to them that likely exceeds the value allotted by the state thus preventing a level playing field. Some states began to ask: what is the value?; is it truly free?; is it leveling the playing field and who are we trying to level the playing field for considering the intent of the anti-rebating statutes? Ms. Parson stated that another issue that is not gaining a lot of traction but is worth mentioning is: who would have jurisdiction in the event of a conflict with one of the platforms? Would it be up to the department of insurance or is it something that would need to go to the court system?

Ms. Parson stated that a regulatory challenge exists in that if you don't do anything you risk stifling innovation but if you do away with the anti-rebating statutes you may encourage some unethical behavior and not have a metric to measure that behavior. Additionally, there are concerns about leveling the playing field but Ms. Parson stated that was not the original intent of the anti-rebate statutes – it was to protect consumers. The call for change is really to carve out exceptions that allow services to go beyond the four corners of the policy as long as it relates to the function of the policy, and to make sure consumer friendly integration models can co-exist with the consumer protection policies that were put in place with the anti-rebate statutes.

Ms. Parson then discussed some regulatory solutions to these issues that have been enacted across the country. Utah passed a law two years ago that stated as long as the goods or services are offered on the same terms to the general public and not contingent upon the sale of an insurance product, the value-added service through the technology platform was permissible. Washington introduced a similar bill that did not pass. The vast majority of states that have addressed these issues have done so through insurance department directives and advisory letters, some of which contain direct references and some of which contain indirect references to certain value-added services.

Ms. Parson then discussed the Maine rebate statute (§2163-A) which she believes is a great starting point for considering model rebate reform legislation. That statute is divided into three issues, the first being distinguishing value-added services from permissible gifts and prizes. The statute also states that “[A]n insurer, an employee of an insurer or a producer may offer to provide a value-added service or activity, offered or provided without fee or at a reduced fee, that is related to the coverage provided by an insurance contract if the provision of the value-added service or activity does not violate any other applicable statute or rule and is....directly related to the servicing of the insurance contract or offered or undertaken to provide risk control for the benefit of a client.” Ms. Parson stated that language helps tie into the original purpose of anti-rebating laws. Ms. Parson stated that it is important to come to a consensus on an appropriate range for “value amount” to allow promotional items, and perhaps set two different thresholds for promotional items and value-added service. What entices one person may not entice another. Ms. Parson also recommended a model statute working group, such as NCOIL, to work on innovating anti-rebate laws.

Frank O’Brien, VP of Gov’t Relations for the American Property Casualty Insurance Association (APCIA), stated that when anti-rebate laws were first enacted, they were cutting edge and necessary to prevent a particular evil and to provide consumer protection related to solvency. Fast forward 100 years and the laws have certain parts that still retain some value. In APCIA’s view, that value would call for the retention of some of the language of anti-rebating laws in existence. However, what has happened over the years is that as the insurance industry and products have evolved, so have consumer expectations. The language has stayed relatively static in a number of states and what has happened over time is that exceptions have arisen that various insurance departments have enacted through bulletins, or desk drawer rules or amendments. The Maine statute mentioned by Ms. Parson began as an amendment by a particular company that was looking for the opportunity to provide a lottery that was related to a charity and that was prohibited under the prior version of the statute.

Mr. O’Brien stated that currently, APCIA is seeing a point in time where some of the frictional costs associated with anti-rebating statutes have eroded their value. One of the ways that APCIA believes that the statutes need to be changed is by making it clear that risk mitigation devices and risk controlling devices and services are to be carved out from the prohibitions. Maine has already taken action and Alabama is looking at this issue. Other states have said to APCIA that “we already do this and you just need to come to us and explain what your product is and we will tell you whether you are allowed to do this under the statute.” However, from a fintech point of view, that is not particularly helpful. Mr. O’Brien stated that the time has come to provide some clear rules of the road and NCOIL is uniquely positioned to begin the process of putting

together a Model law for states to consider. This effort is not eliminating or replacing statutes but rather amending statutes that have value in such a way as to make sure that value continues to exist in this high-tech environment.

Rep. Matt Lehman (IN), NCOIL Vice President, stated that as the Committee moves forward on this issue it is important to consider how to create a baseline regarding promotional items and value-added services. As an agent, he can have a state that would allow certain value-added services while another state does not even though the clients in those states are very similar. The client is not going to understand that it is an issue with rebating laws, they are just going to wonder why they don't get that value-added service. Therefore, coming up with a good baseline from the industry, agents and regulators would be beneficial. This is a great time for NCOIL to move forward with this issue.

b.) Electronic Issuance of Salvage Titles

Jim Taylor, VP of Auto Data Direct (ADD), stated that ADD was founded in 1999 with the sole purpose of helping DMV's modernize the way they communicate information to industry as well as the way they process transactions. ADD was the first company to put motor vehicle records in Florida on the internet such that claims offices around the country and insurers could in real-time access that data and not have to wait for the snail mail to arrive in order to make decisions faster. Currently, ADD provides direct access to 39 state DMV data bases so that industry can get information in real-time. ADD was also the first company to: provide access to the National Motor Vehicle Title Information System which is a title history database run by the U.S. Department of Justice; and receive information from the insurance and salvage industry that must be reported to that database. Therefore, ADD is a leader when it comes to pushing the DMV modernization effort.

Mr. Taylor stated that when it comes to the issuance of a salvage title, when a claim is made on a car in an accident and it's deemed to be a total loss and the insurer pays the consumer for that total loss, the insurer is then required to take ownership of that vehicle. As you can imagine, the owners don't always know where that title may be and it may take them awhile to locate it and fill out the appropriate paperwork such as DMV forms and powers of attorney, and send that to the insurer. The insurer then must pull all of that information together and submit it to the DMV for processing. That entire process is currently being done by snail mail.

As an example, in Florida there are over 400,000 total loss claims per year and if you assume 5 documents per claim, that amounts to 2 million pieces of paper per year that goes from consumer to insurer to the DMV by snail mail. There is a better way to handle those transactions to speed up the process so that the industry can save money, consumers can receive their money faster, and the DMVs can eliminate some of the workload that they have. Models have been in place in over 20 states that allow automobile dealers to process titles and registrations electronically. The question then becomes why can't insurers have that same access to those platforms to process total loss insurance claims electronically instead of having to do it all by paper?

Mr. Taylor stated that ADD has been pushing legislation in Florida that would allow the state to take the platforms mentioned and allow insurance carriers at salvage auctions to access those platforms to process total loss applications in an electronic format. SB 974

passed its first committee hearing earlier this week and HB 1057 will have its first hearing next week. The bottom line in this is that there are currently electronic processes that can be used by the insurance industry and everyone involved to save time and money. NCOIL is an excellent organization that can put forth model legislation to move forward on this issue to transition from the snail mail world to the electronic world.

Alex Hageli, Director – Policy & International at APCI, stated that motor vehicle titles are still very much a paper-based process. Paper takes time and insurance companies handle hundreds of thousands salvage transactions per year and thousands daily. That means insurers must collect paperwork from policyholders that many times they don't have or can't find which necessitates having to file for a duplicate title. All of that takes time in the snail mail world. Meanwhile, storage fees are racking up and risk of theft is rising and that delay is ultimately being paid for by policyholders in the form of higher premiums. Mr. Hageli stated that states are beginning to eliminate some of the requirements that were adopted before the introduction of the internet but a federal regulation still exists – The Odometer Disclosure Regulation – that requires a wet signature on odometer disclosures. Mr. Hageli stated that APCIA advocates for a completely digital process and he has no doubt that the regulation will eventually be amended and/or repealed but the process can be sped up.

In the meantime, the insurance industry should be allowed access to state electronic platforms accessible by dealers and lenders. There is no reason why dealers and lenders can access those platforms while insurers cannot. Many states have established electronic lien and title programs that allow lenders to avoid holding paper titles. Those electronic titles should be able to be shifted electronically to an insurance company that is paying a total loss to save time and money.

c.) Optional Electronic Delivery of Policyholder Information

Mr. Hageli stated that in recognition of the growing want of consumers to be able to everything on their cell phones, the industry took the federal e-signature law and customized it for the insurance industry. The customized law is opt-in meaning that the customer must consent to receiving documents electronically and it applies to all documents that a policyholder would receive from their insurer. The law has been adopted in approximately 38 states and is currently pending in Nebraska and North Dakota. Mr. Hageli stated that the law could be a great starting point for NCOIL to use in its development of insurance modernization model legislation. Mr. Hageli noted that of those 38 states mentioned, some have enacted the law through bulletin rather than legislation.

Mr. Hageli then touched upon the issue of “e-posting.” It is opt-out meaning that if a company so chooses to take advantage of e-posting, they are allowed to enroll their policyholders autonomically without their consent. However, it only applies to the policy document itself which does not contain any personal information. The policyholder can also request a paper copy which most policyholders do. This law is currently adopted in approximately 25 states and APCIA would like that number to increase and it could be another issue included in NCOIL's insurance modernization model legislation.

Ms. Collins began by stating that NAMIC is supportive of the comments made by the other panelists regarding the drive towards e-commerce and believes that is an

important component of any modernization legislative package. In addition to ecommerce, NAMIC believes that outdated regulation needs to be examined in an effort to modernize the system. One example is instituting sunsets on data calls. There is an ever-growing body of consistent data calls that may or may not provide value to the regulatory authority but a sunset provision will enable legislatures to take a concerted look on an ongoing basis as to whether they are still relevant and still being utilized by the regulator. Another example is a review of the exam system as we have moved towards a risk-based regulatory system, which NAMIC supports. As an example, if companies are required to annually report on solvency through risk-based vehicles like ERM (Enterprise Risk Report/ORSA/Risk Profiles); Independent Audits/Internal Audits (Model Audit Rule); Corporate Governance (CGAD) etc., then the Financial Exam process (every 3-5 years) is therefore redundant, outmoded, and should be eliminated.

Ms. Collins further stated that a review of the confidentiality of underwriting guidelines and other trade secret provisions will help enable innovation and help modernize certain systems. Another issue to examine relates to product flexibility. As we talk about some of the exciting and disruptive technologies that come into this space and new forms of insurance such as usage based and micro insurance, we don't have a regulatory framework that accurately reflects those products especially as it pertains to consumer notice. That conversation could be aided by the conversation of allowing full electronic notice delivery. Ms. Collins stated that NAMIC is a strong believer that in order to modernize the regulatory system and insurance industry, fraud mitigation needs to be examined. That is a major cost-driver and major concern to insurers around the country and it is a body of increasing sophistication in terms of the offenders. Enabling fraud mitigation units and standards to accurately and effectively address those issues will help bring the industry and regulatory system to a more modern state.

Collaborative regulation is another way for NCOIL to discuss insurance modernization as a way to help the state-based system of insurance regulation work together. One issue under that topic that could be addressed is that of reciprocal licensing for companies and agents. Lastly, the conversation needs to be continued regarding the insurance industry's investment in the U.S. economy. The insurance industry is the largest purchaser of municipal bonds in the country, and through premium taxes is one of the largest revenue producers for states. NAMIC believes that there are some steps in the NCOIL insurance modernization package that could be taken to appreciate that investment such as premiums tax offsets for fees and assessments; keeping premium taxes invested in the regulation through appropriations to the department of insurance instead of opening it a general fund. Ms. Collins stated that, in general, NAMIC is very supportive of the insurance modernization efforts taken up by NCOIL and looks forward to working with this committee.

Rep. Keiser stated that relative to data calls, the NAIC should not be restricted in its ability to make data calls, but then asked if it would be reasonable for legislators to consider from the point in which the last piece of data is sent that the state has 90 days to submit a statement as to the purpose of the call and findings. Ms. Collins replied yes and stated that it should be required to demonstrable that the data is being utilized for some purpose. Additionally, part of the concern is that there are still ongoing data calls that come annually that have been established for decades and insurance companies are continuing to have to dedicate resources to those calls. Ms. Collins stated that she is not sure of the usefulness or continued attention the calls are to regulators. Ms. Collins further stated that she would be happy to share NAMIC's work on this issue with

the committee. Rep. Keiser stated that insurance companies pay for all of the work done relative to data calls and it adds to premiums.

Rep. David Santiago (FL) asked whether Ms. Collins was suggesting changes to specific data calls by the insurance commissioner pursuant to regulations or if statutory language should be developed regarding every data call. Ms. Collins stated that she believes a conversation could be had in terms of putting parameters around data calls but NAMIC's suggestion regarding sunset provisions would be that ongoing data calls should be reviewed on a certain basis to establish their continued need. Rep. Santiago stated that he is interested in hearing more about data calls and the need to possibly eliminate unnecessary work on the part of insurers.

Rep. Santiago also noted that a bill was passed out of committee in Florida last week that put a cap of \$100 for any loss-mitigating services such as leak detectors. Rep. Santiago further noted that a bill relating to the electronic salvage title issue was also passed out of Committee in Florida last week. With regard to product flexibility, Rep. Santiago asked Ms. Collins if there are any examples of states enacting reforms similar to those referenced by Ms. Collins. Ms. Collins stated that one such measure involves reducing the number of days of notice in terms of cancellation. In some states it may be as long as 30 or 60 days which probably relates to snail mail. However, as consumers continue to demand information more quickly, bills have been introduced in some states to reduce the number of days cancellation requirement. Rep. Santiago noted that he tried to pass life insurance modernization legislation in Florida related to notifying certain people with regard to lapsed policies and the industry fought him on that issue.

The Honorable Tom Considine, NCOIL CEO, stated that with regard to the data call issue, they are not always done with the intent to be burdensome on insurers. Also, sometimes the industry will ask an insurance commissioner to enact or repeal something because it is burdensome and the insurance commissioner will then ask his or her staff to get some information to see if what the industry is saying is true. Cmsr. Considine stated that during his time as Cmsr. of the NJ Dep't of Banking and Insurance he in fact did that but with the thinking that the resulting information would be used once. However, Cmsr. Considine stated that he just recently heard that the information he had requested was still being asked of insurers every single year without purpose. Therefore, a sunset provision should be pursued for data calls to combat that practice.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
NASHVILLE, TENNESSEE
MARCH 15, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, March 15, 2019 at 1:15 p.m.

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

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Rep. George Keiser (ND)
Sen. Jason Rapert (AR)	Sen. Jerry Klein (ND)
Asm. Ken Cooley (CA)	Asm. Kevin Cahill (NY)
Rep. Matt Lehman (IN)	Asm. Andrew Garbarino (NY)
Rep. Joseph Fischer (KY)	Sen. Bob Hackett (OH)
Sen. Dan "Blade" Morrish (LA)	Rep. Lewis Moore (LA)
Sen. Paul Wieland (MO)	

Other legislators present were:

Rep. Roy Takumi (HI)	Sen. Vickie Sawyer (NC)
Rep. Deanna Frazier (KY)	Rep. Tracy Boe (ND)
Rep. Edmond Jordan (LA)	Asm. Ken Blankenbush (NY)
Rep. Daire Rendon (MI)	

Also in attendance were:

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

MINUTES

After a motion was made by Rep. Deborah Ferguson (AR) and seconded by Sen. Jerry Klein (ND) to waive the quorum requirement, the Committee unanimously approved the minutes of its December 8, 2018 meeting in Oklahoma City, OK upon a Motion made by Sen. Dan "Blade" Morrish (LA), NCOIL President, and seconded by Asm. Ken Cooley (CA), NCOIL Treasurer.

DISCUSSION ON PHARMACEUTICAL VALUE BASED CONTRACTING

Rachel Licata, VP of Policy Research at the Pharmaceutical Research and Manufacturers of America (PhRMA), stated that value based arrangements, or value based contracts (VBCs), are defined as voluntary arrangements between manufacturers and private entities whether that be payers or risk based providers. This is where the payment or price for a specific medicine is linked to value or some sort of metrics. For example, "we will give you this price for this product if certain outcomes are met." The

outcome may be a certain number of patients on the drug meeting certain criteria. Other arrangements known as differential pricing say “for this condition, the price of this medicine is this, and for another condition, the price is this.”

There are many benefits to VBCs. For example, a payer may not want to immediately cover a new medicine that was just approved or may impose a variety of different restrictions like utilization management. A VBC can allow a drug manufacturer to take on a little more risk and in turn the payer can provide additional access and potentially at a lower cost so the drug can be more affordable. Additionally, engaging in VBCs can allow for additional support services to increase the likelihood that a patient would remain adherent on that medicine. From better adherence there are better outcomes in avoiding complications which can have far-reaching implications for other healthcare services.

Ms. Licata stated that PhRMA has conducted some research that highlights the benefits and opportunities of VBCs. Specifically, in state regulated exchange plans PhRMA has seen that plans that have value-based arrangements in place have subjected patients to lower copays, so patients are better able to afford the cost sharing provided to them at the pharmacy. PhRMA has also seen some research showing the potential impact savings more broadly if value-based arrangements were expanded. PhRMA has also seen incredible interest and uptake in the number of VBCs as more payers become involved. Payers are saying that VBCs reduce not only their pharmacy costs but also their medical costs. Through better adherence and better access to prescription drugs, payers are saying that they are seeing the value of VBCs more broadly.

Ms. Licata stated that state Medicaid programs want predictability and flexibility with regard to their prescription drug benefits. Medicaid is unique since it is required to cover almost all medicines when there is a rebate agreement in effect and manufacturers provide significant statutory rebates to states and the federal government. However, there are also voluntary arrangements known as supplemental rebate agreements where manufactures and states can engage for an additional level of rebating for better access in Medicaid. Thus far, three states have received federal approval to use supplemental rebates to engage in VBCs with manufactures, and another state is awaiting approval. Additionally, Louisiana and Washington have tried to use new, alternative methods such as a subscription known as a “Netflix model” to try to expand access and provide unlimited access to the new curative Hepatitis C therapies.

Ms. Licata stated that Oklahoma was the first state to receive federal approval for their state plan amendment (SPA) to engage in VBCs with manufacturers. To date, OK has 4 public contracts in place and has been finding some success in manufacturers taking on some additional risk through the contracts while the state is able to expand access and remove barriers to patients receiving those medicines. Louisiana issued an RFI in August on the creation of a subscription-based payment model for Hepatitis C medication; solicitation for offers began in January 2019. LA has made it a priority over the past few years to try and find a way to treat and eradicate Hepatitis C in that state. With the onset of the new curative Hepatitis C therapies that have cure rates above 90%, the state is trying to engage in a model that would allow them some predictability with regard to their Hepatitis C drug costs while expanding access to the medicines. Essentially the state has laid out that they would like a manufacturer to engage with them to provide unlimited access to their medicines for both the Medicaid population as well as the correctional population. The state has essentially set a ceiling of the price

they are willing to pay and are hoping that a manufacturer can use supplemental rebate agreements to provide unlimited access in the Medicaid program.

There is significant value with VBCs, but additional reform is needed to both enhance the uptake and outreach to other markets. The FDA recently ruled to clear one of the hurdles with regard to manufacturer communications with providers so that manufacturers have the ability to communicate with providers about unapproved products and unapproved uses to try to give a fair warning with regard to developing and operationalizing VBCs. However, there is a need for clear anti-kickback statute protection and updates. The federal Office of the Inspector General (OIG) has released a request for information on “ways in which it might modify or add new safe harbors to the anti-kickback statute ... in order to foster arrangements that would promote care coordination and advance the delivery of value-based care...” PhRMA is hopeful that regulations will be promulgated to modernize the anti-kickback statute and provide protections. Additionally, there are several price reporting issues that PhRMA is hopeful to see reformed through regulations. A rule is pending at the federal level that will hopefully allow manufacturers some additional flexibility in giving a very low net price to a state or to a private payer that would not trigger that price being available to all Medicaid programs throughout the country.

Asw. Hunter asked how conversations relative to federal Medicaid cuts might affect predictability of rebates. Ms. Licata stated that in the age of Medicaid cuts, VBCs can be a way that states can target and pick off some of the medications that they feel may be driving some of their costs and find ways to increase their predictability. Ms. Licata stated that some of the Medicaid cuts may provide additional incentives to states to do so but it may not have a direct impact.

Sen. Bob Hackett (OH) asked if by implementing VBCs the U.S. is mirroring Japan's healthcare system. Ms. Licata stated that she is not entirely familiar with Japan's healthcare system, but she does not believe so. Here, instead of one entity setting the value or price for a medicine payers and manufacturers come to an agreement with regard to the price and specifics of those contracts. Ms. Licata also stated that PhRMA believes the Administration's goal is to move from fee for service pay for volume towards value for pharmaceuticals and more broadly.

Sen. Morrish stated that with regard to contracts, those at the state level are transparent because they are done through an RFP process, but what about the individual health market. Ms. Licata stated that even PhRMA does not have access to those contracts, but some are publicly reported although they may not contain stipulations and net costs. There is some transparency at the state level with regard to the various entities engaging in those contracts but not a lot as they are private contracts.

CONTINUED DISCUSSION ON DRAFT NCOIL MODEL LAW ON DRUG PRICING TRANSPARENCY

Asw. Hunter introduced the panel and noted that Melodie Shrader, Senior Director of State Affairs at the Pharmaceutical Care Management Association (PCMA) was scheduled to appear before the committee today but she fell ill and could not make it. PCMA will be submitting comments on the model.

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee, stated that he and Senator Morrish are very confident that the bi-partisan framework is a great starting point for this discussion and can be built upon and modified throughout 2019. The goal is the successful adoption of an NCOIL Drug Pricing Transparency Model Law in a form that can be adopted by states across the country. Rep. Oliverson thanked those who have submitted comment letters and noted that NCOIL has a good track record with regard to developing framework-type model legislation as evidenced most recently by the NCOIL PBM Model Act. Rep. Oliverson stated that he believes there are two driving points behind any model legislation regarding drug pricing transparency. First, the model is not meant to and should not be able to be weaponized in any way to interfere with the ability of for-profit entities competing in a marketplace in fairness with one another for the best possible rates. Rep. Oliverson stated that he understands that drug manufactures, health plans, and PBMs are for-profit entities and the model law should not create an opportunity for one party to show their hand in cards before the bets are placed. This is not meant to be a punitive measure but rather a measure for transparency. Second, Rep. Oliverson stated that he believes it is abundantly clear when discussing why prescription drugs are so high there is not one person you can point the finger at. That is why the model law aims to involve the entire drug supply chain.

Alex Jung, Partner/Managing Director at EY-Parthenon, first provided some background remarks that contextualize her views on drug pricing transparency. Ms. Jung stated that she is a forensic accountant and worked for Arthur Anderson for many years doing audits of hospital systems, pharmacies, and employee plan sponsor organizations. Accordingly, Ms. Jung was able to see the financial statements of most of the organizations in the drug value chain. Ms. Jung then worked in the employee benefits space for both Mercer and Aon Hewitt as both an insurance broker and agent working on behalf of large, middle-market, small, and public agencies as their agent representative in placing benefits with large insurance companies and PBMs. Ms. Jung has negotiated hundreds of contracts and has seen firsthand what influences the terms and conditions and financial arrangements for many large corporations in the U.S. Ms. Jung then worked for Walgreens as its Senior VP of Corporate Strategy. In that role, she was exposed to the economic model of the pharmacy itself. Ms. Jung now works for a different accounting firm and represents all of the aforementioned stakeholders with regard to their corporate strategy which includes their business growth goals and their operating model re-design.

Accordingly, Ms. Jung has seen how the money moves in this system very intimately and there are many levers that are like a linear equation in algebra. There are multiple variables that are solved for by these organizations in order to back into their required return on investment and margin targets to meet, if they are a publicly traded company, Wall Street expectations for earning per share. In doing so, they must balance their costs as well as their profit. Those decisions are considerations that go into the terms and conditions of how they negotiate the money flow. The money flow begins with payroll deductions and most of that sits in a trust. However, what happens after that money hits the trust gets very convoluted. There are a lot of details that may not be openly evident.

Ms. Jung stated that what is being asked for in the Model is commendable and is, in accounting parlance, a receipt for services. Ms. Jung urged the Committee to also look at where the money began and how it got to the final price because there are a lot of adjustments that are made in the calculation by the time the net price gets to the patient

at the time of sale and the exposure of the out of pocket expense creates an affordability issue for the average American. Ms. Jung stated that throughout the past 35 years she has seen the drug supply chain economic model become completely complicated while every organization is pulling up to 6 different levers of incentives. Most of the calculations in determining the price of a drug come in the form of incentives. The incentives are not aligned and they are talked about in the public domain as if they are a credit but they really are a negotiation. That negotiations requires compromise between two parties to a contract and the negotiations are never going to be transparency because they are considered proprietary contract terms and conditions. However, there are ways to create accountability beyond transparency for fair negotiations. That is not going to be solved in a single model law, but Ms. Jung urged the Committee to look at the role of other parties in the value chain that inadvertently create incentives that are not necessarily aligned with the express purpose of lowering the price of drugs.

Ms. Jung stated that as she functioned as both a broker and consultant, she received a commission and incentive from the PBM to place business with them. The more volume given to the PBM the higher the commission. Ms. Jung also received a commission from her employer plan sponsor for the public health agencies she represented many of whom were state Medicaid agencies. There is a dual compensation model for not necessarily an independent role. Brokers can play agents on both sides and in order to be licensed the broker must be appointed to an agency in order to represent paper, the insurance contract, which they are signing. In the case of the PBM, that paper was the contract that Ms. Jung had with the PBM. Individual brokers do not have visibility into the aggregate commissions that are paid between large organizations. That is one example of credits in the system that work to create an economic model that is far more complicated than what is seen as the wholesale price. The wholesale price then gets manipulated again. There are differences between the amount that is billed and the amount that is allowable under the plan design. That plan design also has a major impact on affordability. What the model is trying to get to is the paid amount, i.e. the receipt, but Ms. Jung urged the Committee to also look at what was billed and what was allowed.

Saiza Elayda, Director of State Policy at PhRMA, stated that PhRMA supports NCOIL developing a drug pricing transparency model law and appreciates that the entire drug supply chain is involved. One important thing to keep in mind is why this is being done – is this transparency for transparency's sake or do we want this to be transparency that helps the patient know what they are going to pay when they are standing at the pharmacy counter. Currently, we are seeing the growth of money spent on medicines hit the lowest levels in years. IQVIA, formerly the IMS Institute, released a report looking at 2017 and the net spending on drugs only increased by 0.6%. Express Scripts' drug trending report in 2017 showed that their spending also decreased by 1.5%; CVS decreased by 1.9%; and Prime Therapeutics had a negative growth rate at -0.2%. All of those figures are down from about 2-3% from the previous year. CMS also reported that retail prescription drug spending also came down to 0.4% from 2.3% the year before. Accordingly, we are seeing historic lows in spending on prescription drugs. However, the question of "why am I paying so much at the pharmacy counter?" continues to be important and prevalent.

Ms. Elayda stated that there have been several policies that have passed in states that have tried to answer that question. A lot of those policies have been asking for a lot of data that PhRMA members believe is proprietary and confidential and should not be put

out there and could affect the marketplace and how things are priced. The data provisions are also a huge administrative burden for not just the company but also for the state to track the data and put it on a website. California's drug pricing transparency law has led to several problems in terms of compliance difficulties. PhRMA believes that requiring any disclosures from manufacturers, PBMs, or insurers need to focus on helping the patient. Part of the competitive marketplace is allowing consumers to have the information to meaningfully compare the drug benefits when they are shopping for their insurance plans. It is important that consumers are aware of their drug being covered and how much they are going to pay. It is also especially hard when consumer's see a coinsurance of 20% but they do not know what that entails – is it 20% of the WAC or list price; or 20% of something else?

PhRMA has conducted research which shows that negotiated discounts and other price concessions that manufactures have negotiated with the PBMs or insurers are not being passed down to the patient at the pharmacy counter. It is commonly heard that discounts and rebates are helping keep premiums down which is fine except for the scenario where you have sick patients who need medicines to stay healthy and active community members are subsidizing the healthy folks. Ms. Elayda stated that in 2017, the total rebates and discounts that drug manufacturers paid to PBMs was \$153 billion dollars. PhRMA believes that should be shared with the patient. By sharing those negotiated payments with the patient at the pharmacy counter versus putting it to lower premiums, research showed that commercially insured patients, especially those with high deductibles and coinsurance, can save from \$145 to \$800 dollars annually and it would only increase premiums by about 1%.

Ms. Elayda stated that while the Model does take into account the rebates on price concessions, the patient needs to be the highest priority in terms of affordability issues. PhRMA understands the want for transparency but believes that anything done in this space should be meaningful to the patient and not just resulting in throwing out numbers that patients will not understand.

Joshua Keepes, Regional Director of State Affairs at America's Health Insurance Plans (AHIP) stated that AHIP is pleased that the Committee has taken an interest in pursuing a much-needed discussion on the cost of prescription drugs and in particular how it impacts families, patients, state budgets and the country as a whole. Of the many issues facing consumers right now in the healthcare sector, the soaring costs of prescription drugs is the most critical. Data shows that overall spending on prescription drugs now represents the largest segment of your health insurance premium dollar and accounts for more than 23% of commercial premiums. The documented and substantial price increases driven by constantly increasing list prices from pharmaceutical manufactures pose a threat to both state budgets and consumer pocketbooks. The important thing to consider throughout this discussion is that pharmaceutical manufactures alone set list prices for prescription drugs and any attempt to lower drug costs that does not include a robust discussion on how prescription drug prices are reached will not increase transparency or benefit consumers. A meaningful discussion requires participation from all actors including PhRMA, PBMs, AHIP, and consumers so that hopefully tools for transparency can be developed for consumers.

Mr. Keepes stated that despite AHIP's ongoing concerns about rising costs and the impact on consumers, AHIP believes that each party to the drug supply chain has a role to play in shaping a better and more efficient healthcare system including those with

whom not everyone will always agree with. AHIP will be the first to say that pharmaceutical advances have brought about life saving medications that have revolutionized treatment for many diseases and dramatically improve quality of life, but that does not mean that we cannot or should not have a frank discussion about how to tackle the costs of those drugs without overly burdening pharmaceutical manufacturers or unnecessarily hindering their ability to develop and adopt new technologies and treatments. However, while an integral part of the broader health system, it is important to keep in mind that prescription drugs are only one element of patient care and that needs to be weighed and balanced with other elements of patient care and care settings. While AHIP applauds the innovation of the pharmaceutical industry, the existence of a drug and the development and putting it to market is only one element of access. Simply because a drug exists and is on the market does not mean that every patient can access it which brings us back to the cost issue and why it is so important.

Mr. Keepes stated that stakeholders and lawmakers are tasked with assessing costs, benefits, and impacts that drug costs have on consumers and other stakeholders. In assessing those costs in the medications that come to the market it is important to take into account the current state of the prescription drug market. Prescription drug spending has reached a level where it is now hundreds of billions of dollars annually. High cost specialty drugs account for a substantial part of that. Despite the many generic and cost-effective options, branded medications continue to make up 75% of drugs spent despite accounting for only 10% of prescriptions written, indicating that the development of generics to the market does not have the ability to control prices on its own. Drug spending is also a critical concern for public programs. In particular, the Medicare Payment Advisory Commission (MedPAC) which oversees and reports on issues related to Medicare, indicated that drug spending in 2016 was \$137.4 billion dollars for Medicare Part D alone, and \$29.1 billion dollars for Medicare Part B. The most obvious impact that we are seeing here, whether at the federal or state level, is the cost of healthcare coverage where prescription drug prices are having a disproportionate impact.

Mr. Keepes stated that currently, policymakers and other stakeholders do not have readily accessible information about what goes into those costs and how we are supposed to balance the benefits along with the costs. That is why AHIP believes there is a lot of value in the NCOIL project to develop a drug pricing transparency model law because it is crucial to enhancing consumer understanding power in the market. Currently, prescription drugs are developed and acquired in price with very little transparency or accountability to consumers. Conversely, health plans are subject to multiple layers of state and federal regulation that provides a picture of how premiums are earned and spent. AHIP supports greater transparency for prescription drug manufacturers because it is a vital tool to encouraging more appropriate pricing behavior. The traditional arguments regarding the burden of research and development costs as well as associated regulatory barriers are often put forth as a way of explaining dramatic increases. However, the public has very little information to validate any of those claims without transparency. Armed with new knowledge, AHIP believes that consumers will have better insight into the factors that are driving their prescription drug costs to sometimes unaffordable levels. Unfortunately, the public cannot say with any real degree of accuracy how much research and development is driving the cost of prescription drugs or what goes into any price increase. We can't say any of this because quite simply we don't have the information.

Mr. Keepes stated that it is important to also look at what AHIP is not saying. AHIP is not asking for intervention into the market to set prices for pharmaceutical drugs as AHIP acknowledges that the pharmaceutical industry has the right to price their drugs as they see fit. AHIP hopes that transparency will help to reduce those costs a bit in the future. Instead, AHIP is supporting approaches such as this that rely on transparency and new data to help state and private purchasers better understand how drug prices are set and potentially give them the ability to negotiate more effectively. That is why AHIP has requested in its comment letters effective trigger amounts and percentage change thresholds to make the reporting requirement more robust and ensure more drugs are brought into that transparency requirement. Mr. Keepes closed by noting that AHIP submitted a comment letter on the Model on December 4, 2018, and another comment letter in conjunction with Blue Cross Blue Shield Association (BCBSA) on March 8, 2019. AHIP looks forward to being a part of these discussions going forward.

Jeremy Crandall, Managing Director – State Affairs at BCBSA, stated that BCBSA strongly endorses the spirit of the model which is to bring greater transparency to how prescription drug prices are determined. Understanding how and why drug prices are what they are is a necessary step in giving state legislators the tools necessary to address this issue. BCBSA believes that there should be greater transparency regarding how manufacturers price their drugs and it is crucial that it includes some level of specific information related to the correlation between a drug's list price and the research, development, marketing, and other components that go into setting the cost for that specific drug. BCBSA recognizes that health plans have an important role to play in this conversation as well. Health plans are comfortable with disclosing much of the data that the model asks for related to prescription drug spending and spending trends.

Mr. Crandall stated that BCBSA's main concern with the model is how the transparency is achieved. The sponsors clearly sought to strike a balance between all of the parties that are at the table and that approach is applauded and is the right way to proceed. The concern is whether that balance is equitable. As written, the model essentially hits the "go" button for health plans to gather and distribute and reveal extensive information related to transparency immediately, regardless of whether a drug's price goes up by 40%, drops by 10% or essentially remains the same. Conversely, the model as written for manufacturers, if a drug's price never hits the 50% threshold that is listed in the model then that means that the entity that sets that list price has complete control over essentially hitting that same "go" button of determining what the ultimate cost of a drug is going to be. Health plans have a role in that as well but the price setter would never have to reveal any of the details that policymakers have said they very much need, and health plans believe they need, in order to address this issue.

In short, transparency for health plans related to drug costs with this model starts at 0% and for manufacturers it essentially starts at that 50% threshold. That is the one piece of the model that BCBSA has concerns with. Taken together, BCBSA believes that it creates an inequitable balance that inhibits the ability of the model to fully address the problem that the committee is trying to solve. Mr. Crandall stated that BCBSA believes transparency is a good thing and health plans are already called upon to provide an immense amount of information for consumers, legislators, and regulators whether it is medical loss ratios, statements of benefits, or annual rate reviews. That information is asked for the right reason – to better inform policymakers and consumers. That is why

BCBSA supports the concept of the model but asks that it be equitable when trying to get information.

The Honorable Matt Rosendale, Montana Commissioner of Securities and Insurance, stated that his office has been working on the cost of healthcare very feverishly for the past two years and upon looking to see what the cost drivers were, prescription drug prices were identified as a main cost driver. Accordingly, Cmsr. Rosendale charged his staff with finding out what was going on within the prescription drug industry to drive those costs. Since the introduction of the prescription drug benefits that were being offered by insurance companies what has occurred is the development of a delivery chain in which a lot of different players are involved, from the manufacturers of the product to the consumer who is utilizing it. There are a lot of people along the trail within that delivery system that make a lot of money off of it. Cmsr. Rosendale stated that he believes and embraces very closely the free market system but when you have different incentives being introduced by different entities, the current system has driven costs up.

Cmsr. Rosendale stated that during the past 18 months, his staff has been able to gather a lot of data about what was taking place within the delivery system. Much of that information was only able to have been obtained through the legal process because the entities were not willing to provide it voluntarily. What was found was that there are many people within the drug supply chain that are making money but the PBMs are one of the largest culprits and they are taking money from several different areas, not from just insurance companies. Transparency is no good unless you have tools to help drive the costs down. If you can see what the costs are but can't do anything about it the consumer will not benefit. Accordingly, legislation is pending in Montana that gives insurance companies the tools to reduce costs and direct additional fees that certain PBMs are taking from other parties back into the reduction of premium costs for consumers.

Derek Oestreicher, Attorney for the Office of the Montana State Auditor, Commissioner of Securities and Insurance, stated that he was tasked by Cmsr. Rosendale with finding out why drug prices are so high and what can be done at the state level to reduce the cost of prescription medications for consumers. With that very broad task, Mr. Oestreicher first had to determine what a PBM was and whether or not the Montana Insurance Department had regulatory authority over them, and how the overall drug supply chain and system works. Mr. Oestreicher stated that there are so many moving parts to the system, such as group purchasing organizations (GPOs), pharmacy services administration organizations (PSAOs), brokers, physicians, healthcare facilities, hospital pharmacies, and the 340B drug program. What states have done, and what Montana has started to do, is focus on the PBMs as the middlemen in the system.

Through Montana's regulatory authority, it was discovered that the insurance department had authority to ask for information from PBMs. On October 3, 2017, 14 separate letters were sent out to PBMs that were working in the state at the time or had worked in the state within the past 5 years. The letters asked for transaction data dating back 5 years and all associated contracts. PBMs consistently responded by saying that the information requested was protected from disclosure by trade secret, were confidential, and were proprietary algorithms. CVS Caremark responded by suing and the result was a settlement in which they produced a box of contracts to the Montana insurance department. The Montana insurance department also sued Prime Therapeutics, Express Scripts, and Aetna Health Plans in administrative actions to recover data.

Additionally, with Prime Therapeutics and Express Scripts, those entities did not have proper licensure in Montana. With Prime Therapeutics, they had not had a proper license in Montana for 6 years so that made every single transaction that they had taken part in a separate violation of Montana law.

Mr. Oestreicher stated that was the first part of the effort and the second part was to figure out what to do with it and how to create informed policy to lower consumer's costs for prescription medications. Like other states, the focus was on PBMs but the problem with that is when states have acted directly against PBMs, oftentimes they have been shut down by PCMA on ERISA preemption grounds. When a state acts in any way that relates to or makes an impermissible reference to an employee benefit plan that law is preempted by ERISA. After trying to circumvent ERISA preemption, it was decided to go back to the drawing board. What was settled on was what is already regulated and that is health insurers. The Montana insurance department knew that it had regulatory authority over health insurers and knew that individual market plans did not fall within the definition of "employee benefit plan" as defined in ERISA. Accordingly, the insurance department knew it could regulate within that sphere, no matter how small, by developing a set of best practices for health insurers in the administration and provision of their pharmacy benefit and hoped it would gain steam.

Mr. Oestreicher stated that the best practices come from some work of his colleague Marilyn Bartlett, the former director of the Montana employee health benefit plan, and she had implemented them in the pharmacy benefit for the employees in Montana and in the first year saved \$7.4 million dollars off of a \$33 million dollar spend so that is a 30-35% savings and that is continuing. The best practices include prohibiting spread pricing which is the mechanism in which, by way of example: a health insurer agrees to pay \$10 for acne medication every time it is dispensed; a PBM has a separate contract with the pharmacy that says it will be reimbursed \$5 every time acne medication is dispensed, and the PBM pockets the difference. Spread pricing was viewed as superfluous money in the system and a contractual agreement by an insurer or anyone providing a pharmacy benefit to agree to overpay for the prescription drug. That was thought not to be in the best interest of consumers and consumers premium dollars are being used to do that.

Another best practice is to disincentivize the use of rebates. It was decided that rebates could not be eliminated outright but if they could be disincentivized to the point that the PBM couldn't use them, the manufacturer wouldn't have any incentive to give them directly to a health insurer and a health insurer wouldn't want the rebate. Then the list price and starting point for negotiation would have to come down. Eliminating spread pricing and disincentivizing rebates are the two core provisions in the pending Montana legislation. A version of the Montana legislation has also been introduced in Maine and the National Academy of State Health Policy (NASHP) recently endorsed it as a model law. Mr. Oestreicher stated that he and his colleagues are very proud of the work they have done and it is unique in that they are not pointing the finger at one player in the industry and not saying that the rise in prescription drug costs is because of PBMs or insurers. Rather, the finger is being pointed at the system itself as it is broken. The system itself contains perverse incentives. Rebates in particular make formulary placement for drugs a perverse incentive and it is a pay to play system. If you don't offer a rebate you will not get on a formulary and thus you have to offer larger and larger rebates to compete with manufacturers who have similar or competing products. Accordingly, if you disincentivize rebates the list price will be reduced.

Mr. Oestreicher stated that in Montana, Kalispell Regional Hospital went with a passthrough transparency PBM and in the first year saved \$1.1 million on their pharmacy spend and in the second year saved \$1.9 million. This is a proven system. From the perspective of Mr. Oestreicher and his colleagues, other state laws, and model laws, in the area of PBMs and drug pricing are all well intentioned, but transparency alone is not going to reduce costs and is not going to price shame people into lowering their costs. Figures like \$153 billion dollars per year in rebates already exist and that is already not enough to bring drug prices down so price shaming is not an option. We are also dealing with humanity. You place an infinite value on your life so to put a price on prescription drugs that might prolong life or improve quality of life is difficult. You can't put a value on that so value based models do not work in this context when you don't know what the starting value is or when the starting value is infinite.

Mr. Oestreicher stated that the Montana legislation benefits everyone by creating more competition and a truer marketplace. Competition is also being created between PBMs as they will no longer have spread pricing and be allowed to retain rebates – they will have administrative fees for the quality services that they do provide as there is nothing wrong with a PBM administering or managing the pharmacy benefit for a health insurer. What is offensive are the nefarious things like spread pricing and rebate mechanisms and schemes. At the end of the day, the Montana approach saves money for consumers. Projections show that if just implemented in the individual market alone in Montana, \$8 million dollars in savings in the first year will be realized.

Asw. Hunter asked Ms. Jung for her thoughts on the remarks from the other panelists. Ms. Jung stated that as a rule, accounting firms must remain independent and represent the interests of all clients regardless of what role they play in the value chain. There are a lot of things that don't get discussed in the dialogue when we talk about drug prices. There are business inefficiencies that exist that also need to be addressed. For example, we have close to 10,000 licensed products on the market and the average formulary has about 2,000 products. Of those products, there is close to an 80% generic dispensing rate in the U.S. For those products that are branded, they are prescribed because there is no generic equivalent because they are protected by patent so by nature they cannot be replaced or substituted.

The other issue often run into is that the formularies are not rationalized based on clinical efficacy but rather rationalized based on incentives like rebates. Formulary placement should be prioritized based on clinical comparative effectiveness and that is not in the dialogue of any conversations Ms. Jung has been a party to. The primary task of the P&T committee is to look first at cost and second at clinical efficacy. Formularies must be addressed, and they also must be rationalized. We are paying for products that have superior replacements that are currently on the formulary because of the economic incentive and not because of their clinical efficacy. Rationalizing those portfolios will create money by nature because we are creating a more efficient inventory of available products to pay for.

Additionally, there are plan design incentives or disincentives in the way we have created exposure from an out of pocket perspective with high deductible plans. Those high deductible plans have actually functioned in some regard to create awareness of this issue as this issue is not new and these practices are ancient. What we are debating is the exposure of the practices and the terms and conditions in how the contracts are negotiated are not going to change just because we change the algebraic

variables. Ms. Jung again commended the committee in asking for transparency and a receipt, but as an accountant she asks for more – she wants to know where the money went.

Sen. Hackett stated that large corporations have not been complaining because this system saves them money and stated that what Montana is doing is trying to make the system fair for everyone and that is what everyone wants because the cost of healthcare is rising so much. Sen. Hackett asked of PhRMA that when it brings numbers back, they should be broken down per category because generics are costing more than they ever have. Sen. Hackett commended Rep. Oliverson and Sen. Morrish on the model because transparency is needed.

Ms. Elayda stated that PhRMA only represents about 37 brand name manufacturing companies and does not represent generic companies so she cannot speak on behalf of generics and how their pricing works or how they view things.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, commended Rep. Oliverson and Sen. Morrish on the model and stated that the issues discussed today are not new and the more revealed represents a brick on the wall of PBM grievances that soon will crumble. Sen. Rapert asked Mr. Oestreicher if spread pricing was removed from Montana's Medicaid program. Mr. Oestreicher replied no because in an effort to avoid ERISA preemption the Montana bill only applies to the individual market. The beauty of the proposed Montana solution is that anybody can do it and it does not take legislation for somebody to voluntarily conduct business in the manner called for. But because of some of the perverse incentives in the system, health plans and employer sponsored plans may not want to do it. For example, in the individual market for health insurance there is something called the minimum loss ratio for which there is an 80/20 split. That is well intentioned, but it is a perverse incentive because health plans are actually incentivized to spend more in order to make more. If your 80% medical expense goes up, then your 20% administrative costs and profit also goes up. If you disincentivize rebates to the point where rebates must be passed through directly from a manufacturer to a health insurer, that offsets the medical expense and reduces it. Health insurers don't want rebates passed through directly to them because it will offset that medical expense thereby reducing their profit.

Sen. Rapert stated that his experiences and conversations with those in the industry have made him realize that formularies revolve around pay-to-play practices which are illegal in the financial services and other industries. Sen. Rapert asked Mr. Oestreicher if he is concerned if that particular practice has not been exposed to the level to where everyone understands what it actually is. Mr. Oestreicher stated that the system is intentionally complex to the point where you must spend a year and a half to even get a basic understanding of how it operates. Montana is trying to spread the word so everyone does not have to spend a year and a half themselves. Rebates are a perverse pay to play system and Mr. Oestreicher stated that he believes they should be eliminated. Mr. Oestreicher noted that PhRMA supports the Montana legislation and in his conversations with PhRMA lobbyists in Montana, if rebates are eliminated the list price is going to come down because they must come down.

Rep. George Keiser (ND) stated that North Dakota brought the PBM function in-house for Medicaid several years ago and rebates were taken out. The difference in cost is very significant and as a result the state is bringing Medicaid expansion in house and

public employees. Workers' compensation has been in house for several years. When you bring these functions in house you can truly implement value-based initiatives because you have control. Hearings were held last summer with some of the foremost experts on PBMs on both sides of the issue and not one of them could say anything but "congratulations."

Cmsr. Rosendale stated that there are PBMs that are operating on an administrative fee and do not collect rebates or use spread pricing and they are performing a tremendous service. Rep. Keiser noted that in North Dakota's hearings there were only a couple of those types of PBMs – not several.

Sen. Morrish asked Mr. Oestreicher if he believes the model, which is a combination of Louisiana and Connecticut law, goes far enough. Mr. Oestreicher replied no and stated that a step in the right direction would be to implement some provisions from the Montana bill.

Rep. Oliverson thanked everyone for their comments and assured everyone that he is listening and will do his best to incorporate changes to the model. Rep. Oliverson noted that Section 4(a)(1) of the model requires pharmaceutical manufacturers to report WAC costs quarterly but Sections 5 and 6 require PBMs and insurers to report annually. There are triggers for additional reporting requirements for pharmaceutical manufacturers if certain thresholds are achieved but by no means is that the only report they are filing so there is some parity in terms of reporting.

With regard to Section 4(b)(1) of the model which requires supplemental reporting of the pharmaceutical manufacturer after an increase in WAC of 50% or greater for a drug with a WAC of \$100 or more for a thirty-day supply, Rep. Oliverson stated that those numbers were not randomly chosen but rather carefully negotiated in Louisiana. The issue at hand is not the ability of a pharmaceutical manufacturer to report more detailed information – the issue at hand is the ability of the state to keep up with the actual administrative cost of collating and publishing all of the data. In other words, there is definitely a cost associated at the state level with the more data you ask for, the more FTEs that department will have to dedicate to that. When introducing this bill in Texas, that was the insurance department's main concern since they would have to build a new website and there would be a lot of administrative costs. Accordingly, moving forward, it is important to realize that the lower the 50% threshold goes, the bigger the fiscal note will be when the model is introduced in states.

Lastly, Rep. Oliverson stated that the model is designed to answer the question of what forces are causing pharmaceutical prices to increase and where are the biggest increases happening within the supply chain. What emerged today is a different conversation which may be more valuable depending on how the committee wishes to proceed and that is along the lines of what are the best business practices within the health plan/PBM/pharmaceutical manufacture negotiation process, and should we be using transparency as a means to compel those practices into existence. Therefore, there seem to be two issues at play here and Rep. Oliverson stated that he may benefit from some direction from the committee as to how it wants to proceed.

**DISCUSSION/CONSIDERATION OF RESOLUTION IN SUPPORT OF AMENDING
ERISA TO ENABLE STATE PUBLIC POLICYMAKERS TO ENACT MORE
MEANINGFUL STATE HEALTHCARE REFORMS**

Asm. Kevin Cahill (NY), NCOIL Secretary, first made a Motion to adopt the resolution he has sponsored In Support of Amending ERISA to Enable State Public Policymakers to Enact More Meaningful State Healthcare Reforms. Rep. Keiser seconded the Motion. Asm. Cahill stated that at the 2018 NCOIL Annual Meeting in December, there was a terrific presentation on the role of ERISA and how it interplays with state legislators' obligation to create a meaningful system of regulation for health insurance. One of the speakers during that session, Prof. Elizabeth McCuskey of the University of Toledo Law School, opined that it may be time to ask the federal government for an ERISA waiver.

Waivers currently exist for Medicare and Medicaid and states have control over its state regulated insurance markets. However, now more than 60% of all workers with private, employer-based health insurance are in self-funded employee benefit plans and therefore governed by ERISA and out of the scope of state regulation. That creates huge problems as states attempt to bring reforms to the marketplace as states run the risk of being preempted. No one wants to do away with the real and important protections that ERISA has brought. However, when looking at the acronym of ERISA, "RIS" stands for retirement and income security and healthcare is not mentioned. ERISA was enacted with the intent of establishing uniform federal standards to protect private employee pension plans from fraud and mismanagement. It has served that purpose, but it has also allowed the growth of what is essentially an unregulated health insurance market at the state level.

Enacting a waiver system envisioned in the resolution would provide more consistency and create less confusing in the marketplace. Asm. Cahill noted that oftentimes constituents call his office and do not understand the ERISA marketplace – they just want help. Again, ERISA has been beneficial in certain respects so rather than try to dis-associate ERISA with health insurance altogether, the resolution calls upon Congress to create a waiver process similar to what exists for Medicare and Medicaid. The Committee then voted without objection by way of a voice vote to adopt the resolution.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES
COMMITTEE
NASHVILLE, TENNESSEE
MARCH 15, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, March 15, 2019 at 11:15 a.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Asm. Andrew Garbarino (NY)
Rep. Matt Lehman (IN)	Sen. Bob Hackett (OH)
Sen. Dan "Blade" Morrish (LA)	Rep. Lewis Moore (OK)
Rep. George Keiser (ND)	Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Vickie Sawyer (NC)
Sen. Mark Johnson (AR)	Rep. Tracy Boe (ND)
Rep. David Santiago (FL)	Asm. Kevin Cahill (NY)
Rep. Deanna Frazier (KY)	Asw. Pam Hunter (NY)
Sen. Paul Wieland (MO)	

Also in attendance were:

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

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

Sen. Klein stated that IBT laws have been growing in popularity across the country and Asm. Andrew Garbarino (NY) and Rep. Lewis Moore (OK) have introduced a discussion draft of an NCOIL IBT Model Law (Model). The Model is largely based on the Oklahoma IBT law that was enacted last year, and this Committee will be working on the Model throughout the year.

The Honorable Beth Dwyer, Superintendent of Insurance at the Rhode Island Department of Business Regulation, stated that RI was the first state to enact an IBT law. RI passed a commutation plan statute in 2002 which was based off of the U.K. solvent schemes of arrangement. The commutation plan is the type of situation where the company actually goes out of business after paying off anyone which is slightly different than an IBT law. A couple of years ago, the commutation plan statute and regulation was amended to allow for IBTs. The RI law is limited to commercial P&C business which is a distinction between the RI and OK IBT laws. RI has no personal

lines provisions in its IBT law. Another difference between the two laws is that the independent expert that is in the OK IBT law is actually a person employed by the RI insurance department as its expert. Also, in the RI IBT law, policies must be at least 5 years old to qualify for an IBT.

Supt. Dwyer stated that there are really two groups of statutes to discuss: IBT statutes, which Vermont also has but it is further limited to surplus lines business and requires approval by the insurance dep't but not by a court; and corporate division statutes (division statutes), which appear in IL, CT, PA, and AZ. Supt. Dwyer noted that the National Association of Insurance Commissioners (NAIC) is also studying IBT and corporate division statutes and has recently formed a working group (WG) that is cochaired by herself and Buddy Combs, OK Deputy Cmsr. of IBTs. The WG is currently working on an overview of all IBT and division statutes which could also benefit NCOIL in its efforts in developing an IBT Model.

Supt. Dwyer stated that the WG has just been formed and will be having discussions and presentations at the NAIC Spring Meeting next month. The WG hopes to produce a white paper that will provide an overview of all IBT and division statutes in existence. Supt. Dwyer also noted that some bills have been introduced in other states relating to IBT and division statutes. The white paper will also examine the need for IBT and division statutes which is why the WG is asking people to come before it and explain why industry and consumers need these statutes and what the appropriate uses of them are. Consumer protections within the statutes will also be discussed and examined. Supt. Dwyer further stated that the WG has a subgroup which is charged with, among other things, studying the financial standards of IBT and division statutes. When you create an IBT, which is actually transferring business to a new company, you must know how much capital is going to that business because insolvency is obviously a huge concern.

Supt. Dwyer further stated that the WG will also be examining issues related to guaranty funds. Since the RI IBT law is limited to commercial P&C business, guaranty fund issues are less important because while theoretically you could have small businesses that are guaranty fund participants, that is not the norm and in fact, all of the IBTs in RI thus far have been reinsurance transactions, and therefore guaranty fund issues do not exist. Supt. Dwyer noted that the current RI IBT statute would essentially transfer liability for the guaranty fund in the new IBT company to the RI guaranty association. That is a very important thing for states to realize – that the new company may not be licensed in other states and therefore, if there is an insolvency, it may be your state that is on the hook for the guaranty association.

Mr. Combs stated that throughout 2017 and 2018, he was heavily involved in the drafting, introduction, passage, and implementation of OK's IBT law. Mr. Combs also stated that he is speaking before the Committee today on behalf of the OK insurance dep't, not the aforementioned NAIC IBT WG. Mr. Combs noted that passage and implementation of a law are two different things, which is why a follow-up piece of legislation to the IBT law that was enacted last year has been introduced in OK this year (SB 885). Mr. Combs then focused on two provisions of SB 885, the first dealing with confidentiality. The current OK IBT law, and the current draft of the NCOIL IBT Model, have no provisions relating to the confidentiality of documents that are submitted to the insurance department during the process of examining an IBT transaction. Insurance regulators should expect to see a host of very sensitive documents such as actuarial

information, financial information, and background information on the companies, many of which should be kept confidential. Mr. Combs noted that while SB 885 is pending in OK, the insurance department has told interested parties that it will treat the review of an IBT transaction like the examination of the financial condition or market conduct of the company so those relevant statutes would apply.

Mr. Combs stated that SB 885 states that all of the documents that are submitted are confidential so long as they are under review by the Commissioner. After such review is completed, the documents will remain confidential as long as they are otherwise confidential by law or the company has requested they remain confidential. Conversations are also taking place with regard to making that provision more closely align with OK's examination statute which is very well understood by the industry and regulators. Mr. Combs stated that there should be some provision in any IBT law that outlines the confidentiality of documents that a regulator is going to receive throughout the process.

The next provision of SB 885 focused on by Mr. Combs related to guaranty fund application. There is a provision in SB 885 which states that nothing in the Act shall affect the guaranty association coverage that existed on the policies prior to them being transferred. OK does not have the legal ability to tell another state's guaranty fund association statute that it will apply in the event of an insolvency. There is a host of issues that accompany this serious issue as those in OK realize the possibility that if you transfer business to a company that is not licensed in the states in which those policies are written, the OK guaranty association could be on the hook for those orphan policies. Mr. Combs stated that OK is sensitive to that reality and stressed to the Committee that said reality will come up during its discussions throughout the year.

Mr. Combs stated that obviously the hope is that a future insolvency is not experienced during an IBT, and in fact, in the more than 250 part VII transfers that have occurred in the U.K., none have resulted in an insolvency. When you have a Form A process and a new party purchases a company, that is just an administrative process with the insurance commissioner and his/her staff. However, an IBT is a much more robust and comprehensive review consisting of an independent expert and judicial review. To the extent that you would have a transaction that would eventually end up in an insolvency, while not impossible, the hope is that there are enough protections in place to ensure that it remains a very remote possibility. Mr. Combs closed by stating that he is happy to offer himself as a resource to the Committee as it further considers an IBT Model law.

Robert Redpath, Senior Vice President & US Legal Director at Enstar, stated that Enstar is one of the largest acquirers of run-off business in the world and is therefore very interested in the IBT and division statutes in the U.S. With regard to the fundamental question of why do we need IBT and division statutes, Mr. Redpath stated that it is really about the efficient use of capital. The ability to divest non-core business and redeploy capital is important. One thing to note, at least on the P&C side, is that almost every single insurance company probably with the exception of a start-up, has run-off business. Accordingly, IBT and division statutes help redeploy capital, save costs, protect the financial solvency of the seller entity, and reduce management and other costs when there is an internal reorganization. Mr. Redpath further stated that IBT and divisions statutes allow for focused management of non-core lines. Very often a life carrier may go into a line of business, pull out of it, and that block of business is still

there and is not being managed properly. Accordingly, a specialized live or run-off carrier can handle the business more efficiently and better service policyholders.

Mr. Redpath reiterated that, unlike the RI IBT statute, the OK IBT statute applies to all lines of insurance and is not limited to runoff business. The OK IBT statute is very similar to existing legislation in the U.K. known as the Part VII transfer that has been very successful. The U.K. Part VII transfer allows for the transfer of a block of business by way of a statutory novation; transfers outwards reinsurance with the policies (as well as other assets and liabilities where required); requires U.K. regulator approval; and requires court approval and an independent expert report.

In response to the concern that IBT and division statutes are a way to simply get rid of bad business, Mr. Redpath stated that there is a very robust procedure of checks and balances. The OK IBT law, and the draft NCOIL IBT Model, require: approval of the domestic regulator of the transferring company; regulatory review and approval by the domestic regulator of the assuming company; independent expert review; and court review and approval. Mr. Redpath stated that he believes the reason why there have been no issues thus far in Europe under similar legislation is due to that robust procedure.

Mr. Redpath noted that due process is an issue that must be examined when discussing IBT and division statutes since such statutes may deal with the novation of policies without the consent of the policyholder. In order to deal with that, extensive notice provisions are in place in the OK IBT statute involving policyholders, agents and brokers of record, state regulators, state guaranty funds, and reinsurers. All of them have the ability to comment and present evidence to the court at a hearing. The assuming insurer is also expected to have the same licenses for the business that is coming to it, which touches upon the state licensing and guaranty fund issues mentioned earlier. Mr. Redpath stated that a Model IBT Law is needed because there is a need for consistency among states and it is not beneficial to the industry or regulators to have conflicts. Also, IBT and division statutes both have value and one might be better for a particular state depending on that state's needs. Mr. Redpath also noted that part VII transfers in the U.K. are derived from EU directives requiring other EU members to implement similar legislation relating to IBTs which therefore makes the process smoother.

Doug Wheeler, Senior Vice President of Gov't Affairs at New York Life, first stated that as a former regulator at the NJ Dep't of Banking and Insurance he can appreciate the comments made by Supt. Dwyer and Mr. Combs. There is a group of companies that are concerned with IBT and division laws. Mr. Wheeler stated that he believes that RI and OK are the strongest IBT laws in existence and there are other state division laws that lack a lot of the protections present in the RI and OK laws. Mr. Wheeler further stated that the IBT process is extraordinary and a dramatic shift in longstanding state law because a promise the transferring insurer made to the policyholder is essentially being broken when it transfers the policy to another insurer, without the policyholder's consent. That is not to say that the IBT process should not be allowed, but a careful and deliberate approach needs to be taken.

Mr. Wheeler stated that policyholder consent is a critical issue and should be included in any national IBT model law or regulation. Also, a concerning issue is the creation of a possible good company – bad company situation which could increase the chances for a

company insolvency. Company insolvencies do occur, and states have protections in place to account for them, but incentives should not be created for companies that could lead to increased insolvencies which could erode trust in the industry and products sold. Mr. Wheeler also noted that the most recent life and long term care (LTC) insurer insolvencies were experienced by monoline companies, where diversification and scale are reduced.

Mr. Wheeler encouraged the Committee members to speak to those who have experience in the U.K. with the Part VII transfer process. In his conversations with a U.K. law firm with such experience, one of the things highlighted was that the independent expert must consider whether the new company is at least as strong, from a solvency perspective, as the old company, which is a very high burden to meet. That is one of the main reasons why the U.K. Part VII transfer process has been so successful. Another reason why is that the process requires the transferring insurer who has business in other countries to obtain licenses in those countries and the regulators in those countries have to sign-off on the transfer. That requirement is not in the OK IBT law or the NCOIL draft IBT model law.

Mr. Wheeler stated that the most concerning issue with the IBT process is the guaranty association coverage issue mentioned by Supt. Dwyer and Mr. Combs. To use the Penn Treaty insolvency as an example, if Penn Treaty had become a monoline company through the Illinois corporate division process and it only had a license in Illinois, it would have taken 10 years for that insolvency to run through the system and would have bankrupt the Illinois guaranty association fund. Mr. Wheeler encouraged the Committee members to reach out to Peter Gallanis, President of the National Organization of Life and Health Insurance Guaranty Associations (NOLHGA) as he is an expert on these issues and NOLHGA has concerns. Mr. Wheeler also stated that NY Life believes that the independent expert involved in these transfers needs to be truly independent and a very strong standard of review should be in place such as the requirement that the new company be as strong as the old company solvency-wise. The most important issue when discussing these transfers is ensuring that policyholders are protected.

Karen Melchert, Regional VP of State Relations at the American Council of Life Insurers (ACLI), stated that ACLI is still in the process of developing its principles and guidelines that it wants to see considered in IBT and division laws. Ms. Melchert stated that it is important to consider the division laws moving forward in addition to the IBT laws. ACLI is focused on ensuring that policyholder protection is the primary objective when developing these types of laws. The financial conditions of the assuming insurer, regulatory approval, court approval, notice and public hearing, utilization of an independent expert, and the impact on state guaranty associations are other very important issues that ACLI is examining. ACLI has not yet taken a formal position on these types of laws but it recognizes the need for such a business/division transfer mechanism. The fact that such mechanisms are increasing among the states makes it all the more important to work together to make sure policyholders are protected and the success rate mirrors that of the U.K. Part VII transfer process. ACLI looks forward to being involved in the Committee's work on the IBT Model law proposal.

Asm. Garbarino asked Mr. Wheeler what changes, if any, he would like to see made to the Model's provisions regarding the use of an independent expert. Mr. Wheeler stated that the independent expert utilized in the OK IBT law resides in the OK insurance department and it is his belief that the independent expert used to review these transfers

should be truly independent and outside the insurance department. Mr. Combs stated that the OK IBT law actually states that the two insurers have to jointly nominate two independent experts and then the Commissioner selects one. Therefore, the expert chosen is not someone who resides within the insurance department.

The OK IBT law also sets forth certain standards that the expert must meet in order to qualify, including but not limited to: not having a financial interest in either the assuming insurer or transferring insurer; not being employed by or having acted as an officer, director, consultant or other independent contractor for either the assuming insurer or transferring insurer within the past twelve (12) months. Therefore, Mr. Combs stated that OK agrees that the independent expert needs to be very independent. Supt. Dwyer noted that the independent expert in RI is employed by the insurance department but is still independent as the statute has a lot of the same qualifying criteria as mentioned by Mr. Combs. The expert acts more as an advisor to the department and the court. Mr. Combs further stated that one of the provisions in SB 885 states that nothing in the act will create a duty for the independent expert to the transacting companies. The duty of the independent expert is to the court and to the insurance regulator and SB 885 aims to make clear that even though the independent expert is paid by the transacting companies, they work only for the court and regulator.

Rep. Moore stressed that the most important issue that was discussed in OK was the protection of policyholders and he looks forward to working with the Committee to ensure that remains so when developing an NCOIL IBT Model law.

Asm. Garbarino asked if selling blocks of business is common in the insurance industry and if there are any differences between IBTs and what occurred between MetLife and Brighthouse. Supt. Dwyer stated selling blocks of business is very common, particularly in the life insurance industry. With regard to MetLife and Brighthouse, there was no court novation. Court novation is essential in an IBT which is essentially a court saying “your first company is no longer your company. The contract is changed and you are now with the new company.”

Nancy Davenport of Brighthouse Financial stated that the aforementioned MetLifeBrighthouse situation was a Form-A process in Delaware. Notice was given to policyholders and a hearing was conducted but the process did not require policyholder consent. The hearing also included independent experts who had to weigh in and ultimately a judge gave his opinion to the insurance commissioner who then allowed it. Brighthouse was actually formally part of MetLife which held MetLife’s U.S. retail individual life and annuity business. Three companies were then formed and for the Delaware company which is the 49-state company that writes the majority of the business, “ML USA”, it was essentially just a name-change – it was the same company that was writing the policies that had been writing them before. Ms. Davenport stated that she is involved with the ACLI’s IBT discussions and would be happy to discuss any of these issues with members of the Committee.

Sen. Bob Hackett (OH) asked for the panel’s thoughts on how IBT and division laws can be utilized for LTC business and whether or not that is a concern. Mr. Combs stated that when discussing IBT and division laws, LTC business is the elephant in the room. The RI statute only applies to commercial P&C business, but the OK statute is open to any line of business. Mr. Combs stated that OK is aware of the concerns in the industry and among regulators. OK Insurance Commissioner Glen Mulready has advised that even

though the statute allows for any line of business, that does not mean that every line of business is going to get the same level of scrutiny. LTC business scares OK regulators as much as it scares everyone else. Any future IBT involving LTC is not going to just be an OK transaction; several regulators will be at the table working together to collaborate.

Dennis Burke of the Reinsurance Association of America (RAA) stated that under current law in many states there exists an obligation to get the consent of policyholders when transferring a book of business. The IBT statute in OK and the draft NCOIL IBT Model would permit one state to conduct an IBT that would obviate the legislative intent of the other states. That is an important consideration to discuss as NCOIL considers whether it wants to develop and adopt an IBT Model law.

Mr. Redpath stated that having been through the experience of trying to conduct a 50-state novation process, it is virtually impossible because there are so many different types of laws among the states to consider and comply with. In the run-off scenario, policyholders do not care or do not understand that they still have a policy since it is so old and will therefore throw the notice in the trash or contact the sender and ask why they are being contacted as they thought they did not have a policy. Therefore, uniformity is needed and that is why an IBT Model Law is important.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL MARKET CONDUCT SURVEILLANCE MODEL LAW

Sen. Klein stated that there are no specific amendments to the NCOIL Market Conduct Surveillance Model Law (Model) at this time. The conversation today is meant to start a broader discussion of market conduct exams in general and whether there should be amendments made to the Model such as, for example, more specificity regarding regulatory and statutory standards. At the Summer Meeting in July, the Committee will aim to have some specific amendments to consider.

Paul Martin, Regional VP – Southwestern Region at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC appreciates the value of market conduct exams and understands that they provide both regulators and consumers the protection and confidence they need in the companies to move forward. However, there are some situations that NAMIC has been made aware of over the last 3 to 4 years regarding the scope and the nature of some ongoing market conduct exams. Mr. Martin stated that NAMIC is working on a red-line draft of the Model to suggest how to improve the exam process. Some ideas so far include: putting up some guardrails regarding the scope, timing, frequency, and cost of exams; clear delineations of when a full-blown market conduct exam is needed as opposed to a more targeted approach; preservations of due-process rights for companies, particularly on more extensive exams; and some sort of delineation of what constitutes a true harm vs. a de minimus violation of a regulation or statute. Mr. Martin stated that the red-line draft will be offered to the committee prior to the Summer Meeting in July.

INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC) UPDATE

Karen Schutter, Executive Director of the IIPRC (Compact), stated that the Compact is a state-based collaboration of legislators and regulators cooperating to modernize the insurance product approval process for life, annuities, and disability income. Many insurance legislators participate in the Compact as the Compact has a legislative

committee. NCOIL President, Sen. Dan “Blade” Morrish (LA) just recently joined the committee, as well as NCOIL Vice President, Rep. Matt Lehman (IN). Asw. Maggie Carlton (NV) is also on the committee, as was Sen. Hackett. Other members include Senator Bob Duff (CT); Rep. Matt Dollar (GA); Sen. Laura Fine (IL); and Rep. Jim Dunnigan (UT).

Ms. Schutter stated that the Compact is awaiting one more appointment from NCOIL for the northeastern zone. The Compact has 46 states and it represents a state-based solution for the industry in terms of speed-to-market, uniformity, and ability to compete with the banking and securities products that are regulated at the federal level. Ms. Schutter also noted that the Compact will have an in-person meeting on April 5th in conjunction with the NAIC Spring Meeting. The meeting will be focused on strategic-planning as this is the 13th year of the Compact and this year was the first in which it made a significant profit. Ms. Schutter welcomed NCOIL’s engagement in the Compact’s strategic planning as NCOIL is a very important part of the Compact.

Rep. Matt Lehman (IN), NCOIL Vice President, noted that he understands the conversation regarding market conduct exams was brief due to time constraints and he looks forward to further discussing the topic throughout the year.

MINUTES

Upon a Motion made by Rep. George Keiser (ND) and seconded by Rep. Moore the committee waived the quorum requirement. Upon a Motion made by Rep. Keiser and seconded by Rep. Moore, the committee approved the minutes from its December 7, 2018 meeting. Both motions carried without objection by way of a voice vote.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
NASHVILLE, TENNESSEE
MARCH 16, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Saturday, March 16, 2019 at 9:00 a.m.

Representative Joseph Fischer of Kentucky, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Sen. Jerry Klein (ND)
Sen. Jason Rapert (AR)	Asw. Pam Hunter (NY)
Asm. Ken Cooley (CA)	Sen. Bob Hackett (OH)
Rep. Matt Lehman (IN)	Rep. Lewis Moore (OK)
Sen. Dan "Blade" Morrish (LA)	Rep. Tom Oliverson, M.D. (TX)
Rep. George Keiser (ND)	

Other legislators present were:

Sen. Mark Johnson (AR)	Rep. Daire Rendon (MI)
Rep. Roy Takumi (HI)	Sen. Paul Wieland (MO)
Rep. Deanna Frazier (KY)	Rep. Tracy Boe (ND)
Rep. Mark Abraham (LA)	Sen. Vickie Sawyer (NC)

Also in attendance were:

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

MINUTES

After a motion was made by Sen. Jerry Klein (ND) and seconded by Rep. George Keiser (ND) to waive the quorum requirement, the Committee unanimously approved the minutes of its December 6, 2018 meeting in Oklahoma City, OK upon a Motion made by Sen. Jason Rapert (AR), NCOIL Immediate Past President, and seconded by Sen. Klein.

UPDATE ON SEC BEST INTEREST STANDARD PROPOSAL/STATE FIDUCIARY LAWS

Bill Mandia, Esq., Partner at Stradley Ronon, stated that in 2018 there were two big issues at the federal level, the first being what was going to happen with the Department of Labor's (DOL) Fiduciary Rule since the Trump Administration's view of the Rule differed from the Obama Administration's view, and the Rule was subject to litigation challenges. The Rule was vacated and nullified in total in May of 2018. The focus then shifted to the second big issue which was the Security and Exchange Commissions' (SEC) Regulation Best Interest (Reg BI) which was proposed in April of 2018. Reg BI

did not adopt a fiduciary standard but rather set forth a best interest standard that would require broker-dealers and registered representatives to act in the “best interest” of a “retail customer” at the time a “recommendation” of a securities transaction or investment strategy involving securities is made to a customer, without placing the financial or other interest of the broker-dealer or associated person ahead of the interest of the customer. However, Reg BI did not clearly define the term “best interest” which is one of the main subjects of debate surrounding the proposal. The SEC also proposed a new requirement for both broker-dealers and investment advisers to provide a brief relationship summary to retail investors, and it published for comment a proposed interpretation of the standard of conduct for investment advisers.

Mr. Mandia stated that the SEC has received thousands upon thousands of comments on the proposal from an array of interested parties. The general consensus of the comments was that folks support what the SEC is trying to do by creating a standard for broker-dealers that is different from the current suitability standard. However, there is a lot of concern about the proposal regarding its vagueness and certain industry groups have stated that the proposal goes too far in terms of where current broker-dealers currently are and where it would take them. Many commenters hoped the final rules would show significant improvements over the proposals. Mr. Mandia noted that there were actually hearings on the proposal this past week in Congress and there was a lot of concern expressed, particularly by consumer advocates, as to whether the proposal is sufficiently clear and defined. Concern was also expressed regarding how a fiduciary standard would be better than a best interest standard. The expectation is that the SEC will issue its final rule at some point in the Summer or Fall of this year.

Mr. Mandia stated that there has been a lot of activity during the past 12 to 18 months at the state level regarding fiduciary regulation and legislation. The most substantial regulation has come from New York. In 2018 the NY Department of Financial Services (NY DFS) issued its final Suitability and Best Interests in Life Insurance and Annuity Transactions regulation. The regulation was a significant broadening of the scope of prior regulations in a number of ways, the first being the number of products that were brought within the regulation’s scope. In addition to annuities, more conventional life insurance products such as term life insurance were included. Unlike the SEC’s proposal, the NY regulation tried to more clearly define what it covers and what the expectations are. The regulation lists criteria that a producer must consider whenever he or she is selling a life insurance or annuity product in an effort to try and be more transparent in terms of what factors should be considered in determining whether or not the recommendation is actually in the best interest of the consumer.

The regulation has a number of other elements to it in terms of disclosure requirements and compliance obligations such as training and record maintenance. The regulation is to take effect on August 1, 2019 for annuity contracts and February 1, 2020 for life insurance policies. New York also has a pending disclosure bill in the state legislature, the Investment Transparency Act, which would require brokers and other non-fiduciary financial advisers to disclose to their clients that they are not fiduciaries and that they may recommend investments that provide for higher fees even if those investments do not have the best combination of fees, risks and expected returns for a client. A prior attempt to pass this legislation in 2018 was unsuccessful so it remains to be seen how the pending bill will proceed.

Mr. Mandia further stated that the Maryland Financial Consumer Protection Act of 2019 is currently pending in the Maryland state legislature. Similar to NY's regulation, the MD bill broadens the scope of who is covered since it would apply to broker-dealers, broker-dealer agents and insurance producers. The bill states that they all would be fiduciaries and would be required "to act in the best interests of the customer without regard to the financial or other interest of the person or firm providing the advice." The bill delegates a lot of responsibility to the Commissioner of Financial Regulation to "adopt regulations to carry out the fiduciary duty required," including regulations that (1) define, require, prohibit, or exclude an act, practice, or course of business of a person subject to the statute; and (2) prevent a person from engaging in acts, practices, and courses of business in violation of the statute. The bill would also heighten the duty that investment advisers owe under Maryland law.

Mr. Mandia noted that a similar bill was introduced in Maryland in 2018 but was unsuccessful. However, that legislation directed the Maryland Financial Consumer Protection Commission to study whether Maryland should adopt a fiduciary standard and posed the question of whether existing standards in MD for investment-advisors needed to be heightened as well. The Commission made the recommendation that you see now in the current bill. The MD legislature is still in session until early April. There were hearings on the bill last week and it remains to be seen whether it will pass.

Mr. Mandia also noted that New Jersey Bureau of Securities announced in October 2018 that it would solicit comments on whether it should issue a regulation requiring brokerdealers and investment advisers to be fiduciaries without providing any proposal. Hearings occurred in November 2018 and the comment period closed in December 2018. There is an expectation that a proposed regulation will be introduced at some point in 2019 but it is hard to say what it will look like although Governor Murphy's statements in and around the release of this said that he wanted to see NJ at the forefront of providing maximum investor protection. Accordingly, it is possible that what is introduced in NJ is very similar to what was proposed in MD and NY. Mr. Mandia also stated that New Jersey also has a pending bill that would create disclosure obligations for non-fiduciary investment advisers similar to the legislation pending in New York.

Mr. Mandia further stated that Nevada passed legislation effective July 1, 2017 providing that a "financial planner" has "a duty of a fiduciary toward a client." The legislation also imposes a fiduciary duty on broker-dealers, sales representatives and investment advisers who for compensation advise other persons concerning the investment of money. However, the legislation does not apply to sales of insurance unless the sale is accompanied by investment advice. Mr. Mandia noted that the implementation of the legislation was dependent on the adoption of regulations and that has taken quite some time. On January 18, 2019 Nevada released draft regulations and the comment period ended on March 1, 2019. It is expected that the final regulation will be issued at some point in 2019.

Mr. Mandia noted that Arizona has also had a recent development as there was legislation introduced last month regarding annuity sales. That legislation is primarily focused on disclosure obligations and places certain requirements on the types of indices that can be used in the illustrations that are given when selling an annuity product. The legislation also contains record retention requirements relating to what is presented to someone when they purchase an annuity in terms of the illustrations and marketing materials and things of that nature.

Mr. Mandia also noted that the National Association of Insurance Commissioners (NAIC) released draft amendments to its Suitability in Annuity Transactions Model Regulation on November 19, 2018. The amendments do not set forth a fiduciary standard but rather requires insurers to act in the consumer's best interest without placing its financial interest ahead of consumers. There are also certain provisions relating to required disclosures and the expectation is that the amendments will be completed at some point in 2019.

Mr. Mandia stated that it is important to watch what will happen litigation-wise with regard to the abovementioned state efforts. A lawsuit by the National Association of Insurance and Financial Advisors for New York State challenging the best interest regulation has been filed which asserts that the regulation conflicts with existing NY statutory law, among other things. Mr. Mandia noted that regulations, while quicker to enact compared to statutory law, are more susceptible to challenges. Additionally, there is a lot of debate as to whether there may be potential federal preemption or other challenges to state legislation. One issue being talked about is whether the SEC's Reg BI could preempt state law which is a very thorny question.

Mr. Mandia also noted some industry reaction to all of the abovementioned legislation and regulation regarding its potential impact on the marketplace for customers. Morgan Stanley's response to the proposed Nevada regulation was that "absent substantial changes to the proposal, Morgan Stanley will be unable to provide brokerage services to the residents of the state of Nevada." The concern is that if there is an approach taken among the SEC, NAIC, and state laws that would promote uniformity, compliance and costs will be more manageable. But if there is a patchwork of legislation and regulation it will raise compliance and costs significantly, which is something that has been reiterated in comments submitted by both industry and consumer advocates to the SEC, NAIC and the states. Mr. Mandia closed by stating that he believes other states are waiting to see what will happen at the SEC and NAIC before considering any fiduciary or best interest proposals.

The Honorable Ray Farmer, South Carolina Insurance Commissioner and NAIC President-Elect, stated that there are certainly a lot of different opinions and very little agreement on these issues. The NAIC's Annuity Suitability Working Group (WG) has been working on the issue for over a year in the form of amending the NAIC's Suitability in Annuity Transactions Model Regulation that has been in effect for 15 years. That work has been handed off to the NAIC's Life Insurance Committee and the Committee recently received last month more comments on the proposed amendments. Cmsr. Farmer stated that the NAIC has sent comments to the SEC and the NAIC is waiting on the SEC's proposal to be published. The NAIC will do its best to harmonize its proposed amendments with the SEC's rule. This is a tough, thorny issue with no clear definition of "best interest." The NAIC has attempted to put the consumer first and will continue to do so.

Rep. Fischer asked Cmsr. Farmer what type of enforcement mechanism the NAIC envisions being set forth in the model – would it be a regulatory fine or an individual cause of action? Cmsr. Farmer stated that every state has administrative rules which enable them to take action against producers and agents and those would not change. Cmsr. Farmer stated that he is not sure whether any other cause of action would exist. Rep. Fischer stated that if NY adopted a standard that would apply to the sale of term life insurance and somebody asserted that the sale of term life insurance was not in their

best interest, how is that enforced? Mr. Mandia stated that the regulation itself has enforcement mechanisms and penalties in it. With respect to private litigation, the NY regulation does not create a private cause of action but from his perspective, consumer advocates will try to argue that it creates a common law duty that needs to be followed. Rep. Fischer asked if the NY regulation excludes a private cause of action. Mr. Mandia replied, no.

Sen. Rapert stated that the Committee has spent a significant amount of time discussing these issues and spoke put against the DOL Fiduciary Rule in the form of a Resolution in opposition to the Rule. Sen. Rapert asked who is really pushing a lot of the new state legislation and regulation in this arena because he is curious if all of the state efforts mentioned today are simply the vacated DOL Rule with new titles. Mr. Mandia stated that from his perspective 2018 was going to be a significant year given the Trump Administration's position on the DOL Rule and the real risk that the Rule would be struck down by the 5th Circuit Court of Appeals. Therefore, states that tend to be more Democratic in nature started to step in since they saw the writing on the wall. Sen. Rapert then asked who specifically is pushing the legislation. Mr. Mandia stated that it varies from state to state but above all it is legislators who are pushing it. Sen. Rapert stated that it is clear that it is not just state legislators who are pushing the legislation and we saw that certain states were getting into the retirement business with these types of laws, led by the AARP. Mr. Mandia noted that there are consumer advocacy groups that are lobbying for this type of legislation.

Sen. Rapert asked Mr. Mandia to clarify that consumer advocates pushing the legislation and not people who are in the business of helping folks save and invest for their retirement. Mr. Mandia stated that in terms of the states where you are seeing aggressive legislation and regulation, there is recognition from the industry that there needs to be some clarity around the standards and that they would prefer uniformity from the SEC and NAIC rather than a patchwork of state laws. There are also other organizations such as certified financial planners who are putting out their own set of ethical standards and guidelines to try and be very clear about what their obligations are.

Sen. Rapert stated that NCOIL's efforts on many issues including the recent PBM Model Law show that NCOIL cares about consumers. As a series 7 licensed financial advisor who has worked for regional brokerage firms and independent broker-dealers, Sen. Rapert stated that the only industry regulated more was the nuclear industry. You get to a point where a lot of advisors are leaving the business and we are having a problem with new advisors coming into the business. The industry is an aging group of people professionally as the average age of financial advisors is well past 50. One of the reasons is that it has gotten to the point where advisors cannot advise much anymore because they are so burdened with regulation and they simply flee the business to.

Sen. Rapert stated that the pushback against the DOL Rule was a pause to say: we're all about doing the best thing for clients but there is a point you reach where you are not going to that business. That is why people testified that if regulations keep going further and further and further, the cost of all of that advice will increase which is why small investors were those who would have been hurt the worst under the Rule. Sen. Rapert stated that he wants to make sure there is a good standard while avoiding setting forth a barrier to entry for people who want to get involved in the business and prevent businesses from helping the same people who were purported to benefit from the Rule.

Sen. Bob Hackett (OH) stated that he is also a licensed financial advisor and noted that in Ohio, even though the DOL Rule was vacated, most of the broker-dealers kept it for qualified IRA's. It is somewhat of a fight between the Merrill Lynch's and all of the big broker-dealers vs. the insurance industry as variable annuities are being targeted. That is not fair as broker-dealers want everything to moved to brokerage accounts and it is not cheaper for the consumer because every transaction in a brokerage account has a transaction fee. Sen. Hackett stated that with every IRA he has to jump through a lot of hoops before he can even write the business. Broker-dealers were jealous of the money the insurance industry was making but over the long-haul, it was still cheaper than broker-dealer's methods. The insurance industry just wants to protect its book of business. Cmsr. Farmer agreed and stated that the NAIC sees the conflict between broker-dealers and the agent community and the goal is to put the customer first.

DISCUSSION/CONSIDERATION OF RESOLUTION IN SUPPORT OF GOOD SAMARITANS' EFFORTS TO PREVENT LOSS OF LIFE DUE TO OPIOID OVERDOSE

Asw. Pam Hunter (NY) stated that the opioid crisis has claimed the lives of hundreds of thousands of Americans. According to the U.S. Dep't of Health and Human Services, on average, 130 Americans die every day from an opioid-related overdose. No matter where you live in this country, your family or a family that you know has experienced the traumatic effects of an opioid overdose. Fortunately, the use of opioid overdose-reversing drugs such as Naloxone – frequently referred to by its brand name Narcan – have been promoted by many as a vital part of the public health response to combat the opioid crisis, including the U.S. Surgeon General.

Further, states have recognized the importance of increasing accessibility of Narcan by issuing "Standing Orders" which permit Narcan to be sold over-the-counter at a pharmacy without an individual prescription to people who meet certain criteria so that they can be in a position to save others, whether it be family members, friends, coworkers, or even strangers. However, instances began to arise where applicants for life insurance were denied coverage for carrying Narcan, even in states with "Standing Orders." Asw. Hunter stated that this issue was brought to her attention which led her to ask Cmsr. Considine to make the appropriate inquiries. At approximately the same time, a Member of Congress reached out to the American Council of Life Insurers (ACLI) and NAIC, asking each organization for information, and if they were aware of this issue. Afterwards, the issue spread quickly across the country.

Asw. Hunter stated that she will let the representatives from the ACLI and NAIC here today speak for themselves, but she is happy to note that each organization has taken steps to research the issue and wholeheartedly agrees that no applicant for life insurance coverage who carries Narcan solely to save others should be denied insurance solely for that reason. Accordingly, this Resolution simply states that while NCOIL understands that applying for and issuing life insurance is a detailed risk-assessment process, of which an applicant's use of prescription drugs is a part, life insurers should review accordingly their current policy application review procedures and guidelines and if necessary make appropriate changes so that no applicants are denied coverage solely for having a prescription for Narcan, and so that life insurers can identify applicants who obtained a supply of Narcan because of their role as medical professionals or first responders or Good Samaritans in a state with a "Standing Order." Asw. Hunter stated that she believes this is an issue that is important for NCOIL to state what its policy is, and hopes this Committee will support this Resolution.

Karen Melchert, Regional VP of State Relations at ACLI, stated that ACLI supports the Resolution. When the story referenced by Asw. Hunter broke in Massachusetts, ACLI was very quick to respond with a press release setting forth ACLI's position on the issue and it is in-line with the Resolution. Ms. Melchert noted that she distributed to the Committee copies of a bulletin issued by Massachusetts Insurance Commissioner Gary Anderson which provides guidance to insurance companies issuing individual accident and sickness policies, life insurance policies and annuity contracts about certain medications which may be prescribed without any relevance to a potential applicant's health and other medications that are prescribed to prevent certain illnesses or diseases from impacting an individual. Ms. Melchert stated that ACLI supports that bulletin being used by committee members in their respective states as a step towards implementing this Resolution. Ms. Melchert noted that the copy of the bulletin distributed to the Committee contains one suggested change from ACLI which seeks to preserve life insurers' ability to underwrite based on other factors involving prescription drugs.

Lucy Adkins, Director of Pharmacy Practice Initiatives at the Tennessee Pharmacists Association (TPA), and a licensed Tennessee pharmacist, referenced some situations where someone would have Narcan for legitimate reasons. First, Naloxone co-prescribing is increasing in Tennessee which is usually done for patients who have a higher opioid usage than others, but some physicians are co-prescribing it every time they write an opioid prescription, even in instances such as wisdom teeth removal or dealing with the aftermath of childbirth. Additionally, elderly adults who have opioid prescriptions have an increased risk of respiratory depression and as they take opioids their risk of overdose increases. Ms. Adkins encouraged those taking care of elderly adults to have Naloxone on-hand just in case something happens. There have also been a lot of hospital closures, particularly in rural communities, and therefore the access to care is not there as much as it has been in the past. Accordingly, efforts have been made in Tennessee to teach its citizens how to use and administer Naloxone for those who cannot gain access to care.

Ms. Adkins stated that TPA supports the Resolution and believes that everyone, particularly those who know someone or might encounter someone who may experience an opioid overdose, should have Naloxone on hand. Ms. Adkins noted that Naloxone is certainly increasing in popularity, particular among healthcare providers and those who take care of others.

Cmsr. Farmer stated that the NAIC supports the Resolution. Every state and family in this country has been affected by the opioid crisis. South Carolina Governor Henry McMaster recently held an opioid summit during which law enforcement officials throughout the state were recognized as having used Naloxone to save lives. The last thing that should happen is someone being penalized in a life insurance application for having a Naloxone prescription. The NAIC encourages life insurers that look at prescriptions of their insureds or potential insureds to look behind the prescription to get all necessary information.

Rep. Daire Rendon (MI) stated that she supports the Resolution and thanked Asw. Hunter for sponsoring it. Rep. Rendon stated that opioid abuse harms communities and families and the fact that these drugs would be more accessible to family members who understand the risks would make it a lot easier to deal with some of the harmful effects of opioid overdoes. Rep. Rendon stated that in her community in rural northern

Michigan, there have been a lot of situations where law enforcement and EMTs have become lifesavers due to the fact that they show up and simply administer Naloxone.

Sen. Rapert thanked Asw. Hunter for bringing the Resolution and stated that he was surprised to hear that this had been occurring among life insurers and life insurance applicants. Sen. Rapert stated that in Arkansas he passed the Joshua Ashley-Pauley Act in honor of a young man who died 2 blocks from a hospital due to an opioid overdose. The friends he was with did not call 911 or police or take him to the hospital in a timely manner because they were fearful of getting in trouble since they all took opioids. Accordingly, the Act states that you will not be prosecuted if you make a call to authorities to save a life and you have also been using drugs. You might be prosecuted for dealing drugs or other crimes, but not just for using drugs. Sen. Rapert asked the panel if they are seeing other states enact similar laws.

Ms. Adkins stated that in TN there are similar laws in terms of people who reach out to authorities to save a life due to an overdose who are using drugs themselves get a certain number of chances before being prosecuted. Ms. Melchert stated that ACLI does not track legislation on that issue but does track legislation related to the issue that the Resolution addresses. Sen. Rapert asked staff to research that issue.

Rep. Tom Oliverson, M.D. (TX) stated that he supports the Resolution and asked Ms. Adkins if it is her understanding that doctors are routinely prescribing Narcan with all opioid prescriptions, even for tooth removal. Ms. Adkins stated that it is not something that happens on a routine basis and it is more so related to chronic pain patients. TN has guidelines which state that Narcan should be prescribed with chronic pain patients and noted that there has been a lot of changes to TN law recently which has put a lot of TN healthcare providers and physicians on edge because they are not sure what to do in some instances. TN has some of the strictest opioid prescribing laws in the nation that generally limit prescriptions to a 3-day supply in many instances. Ms. Adkins also noted that Narcan is a prescription drug so technically you are supposed to have a prescription filled. However, there are a lot of organizations that distribute Narcan at community events for free so it would never appear on someone's insurance. If you go to a pharmacy to get Narcan, just as you would get an immunization, even though there is a standing order an actual prescription is written.

Rep. Oliverson asked Ms. Adkins if she knew what the wholesale acquisition cost (WAC) was for Narcan in TN. Ms. Adkins stated no but it typically costs about \$150 at a pharmacy. Rep. Oliverson stated that when facing a crisis we typically have a tendency to do "that and then some" and we do not want to be in a situation where something like Narcan is automatically co-prescribed every time an opioid is prescribed because it is probably not necessary and it will massively increase healthcare premiums.

Asw. Hunter thanked everyone for their comments and stated that the conversation might need to expand outside the issues addressed by the Resolution to include where Narcan may need to be distributed. Defibrillators never used to be in schools but now they are and although you would hope that something like Narcan should not have to be in schools, it is a conversation perhaps worth having. Asw. Hunter also noted that in a local community she represents a fire department had a Narcan training session open to everyone. After completing the training, Narcan was distributed and they intentionally operated in the manner because they were worried about getting a prescription and

having trouble with their life insurance. Accordingly, this issue is being discussed across the country in large and small communities.

Upon a Motion made by Rep. Keiser and seconded by Asm. Ken Cooley (CA), NCOIL Treasurer, the Committee voted without opposition to adopt the Resolution by way of a voice vote.

RE-ADOPTION OF MODEL LAWS

Upon a Motion made by Rep. Keiser and seconded by Sen. Klein, the Committee voted without opposition by way of a voice vote to re-adopt the NCOIL Life Settlements Model Act and the NCOIL Model Unclaimed Life Insurance Benefits Act.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
NASHVILLE, TENNESSEE
MARCH 15, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, March 15, 2019 at 4:15 p.m.

Representative Matt Lehman of Indiana, NCOIL Vice President and Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Rep. George Keiser (ND)
Rep. Joseph Fischer (KY)	Sen. Jerry Klein (ND)
Sen. Dan “Blade” Morrish (LA)	Sen. Bob Hackett (OH)

Other legislators present were:

Sen. Mark Johnson (AR)	Sen. Vickie Sawyer (NC)
Rep. David Santiago (FL)	Rep. Tracy Boe (ND)
Rep. Daire Rendon (MI)	

Also in attendance were:

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

MINUTES

Upon a Motion made by Rep. George Keiser (ND), and seconded by Sen. Jerry Klein (ND), the committee waived the quorum requirement. Upon a motion made by Rep. Keiser and seconded by Sen. Klein, the Committee approved the minutes from its December 7, 2018 meeting in Oklahoma City, OK. The motions carried without objection by way of a voice vote.

UPDATE ON NAIC ANNUITY SUITABILITY WORKING GROUP

Rep. Lehman first asked for an update on the NAIC Annuity Suitability Working Group (WG), including what the most contentious issues are and when the WG expects to be finished with the amendments to the NAIC’s Suitability in Annuity Transactions Model Regulation (Suitability Model). The Honorable James Donelon, Commissioner of the Louisiana Department of Insurance, stated that the Suitability Model has been around for 15 years since its original adoption in 2003. Nearly every state has adopted some version of the Suitability Model as it was amended in 2006 and 2010. 39 states have adopted the most recent version. The WG was appointed in 2017 to review and revise the Model to promote greater uniformity across member jurisdictions. Renewed interest in the Suitability Model was prompted in part by work being done by the Department of

Labor (DOL). The DOL's final Fiduciary Rule was published in 2016 and was then vacated in its entirety in March of 2018 by the U.S. Court of Appeals for the 5th Circuit. The DOL declined to challenge the 5th Circuit's ruling and is considering regulatory options in light of the ruling. The DOL is expected to revisit the Fiduciary Rule by September 2019.

Cmsr. Donelon stated that, separately, the U.S. Securities and Exchange Commission (SEC) released a proposed rule package in April of 2018 which included "regulation best interest" (reg BI). The National Association of Insurance Commissioners (NAIC) submitted comments to the SEC in order to coordinate efforts so that their respective regulatory developments could be compatible, clear, and as efficient as possible. The SEC has also announced that it hopes to finalize its advice standard package by September 2019. Cmsr. Donelon stated that the NAIC believes first and foremost in the state's authority to regulate insurance products and that state based regulation better protects consumers. While acknowledging the SEC's and DOL's role, the NAIC believes that consumers are better protected when, to the extent possible, there is harmonization of the regulations enforced by the states, the SEC, and the DOL. Insurance carriers and agents need clear, understandable, and uniform requirements. Just as importantly, regulators need clarity. Broad principles have public relations appeal but inconsistent interpretations of vague requirements will be inefficient and ineffective. Consumers are more likely to be protected when carriers and agents have a clear understanding of conduct rules.

Cmsr. Donelon stated that the WG completed a draft of proposed revisions to the Suitability Model and presented them to the NAIC Life Insurance & Annuities (A) Committee (Committee) for its consideration. The Committee decided that it wanted to receive comments from a wide range of stakeholders and establish a public comment period ending February 5, 2019. While the work is not yet complete the Committee agreed that it would be helpful to receive input from a broader group of the NAIC membership with the goal of creating an NAIC draft containing placeholders for the SEC issues. The NAIC hopes to share that draft with the SEC to assist them with their process as it will allow the SEC to benefit from the NAIC's work so that Reg BI and the NAIC's Model regulation can provide consistency for consumers, industry, and regulators.

Cmsr. Donelon stated that the WG's goal is to elevate the standard of care for annuity sales so consumers understand the products they purchase, are made aware of any material conflicts of interest, and are assured those making the product recommendation are making that recommendation in the consumer's interest and not placing the producer's financial interest ahead of the consumer's interest. The new regulation would also require that agents and carriers act "with reasonable diligence, care, skill, and prudence."

Rep. Lehman asked Cmsr. Donelon if the NAIC anticipates bringing life insurance products into the scope of the regulation. Cmsr. Donelon stated that issue has been brought to the NAIC's attention and the question with annuities becomes, should the regulation apply to in-force annuity contracts. That question has generated a lot of controversy and the New York Department of Financial Services (NY DFS) has offered language addressing that issue for inclusion in the final version of the regulation. With regard to life insurance products, the Committee will have to consider whether to include them in the regulation and the NY DFS is the main proponent of that.

DISCUSSION ON DEVELOPMENT OF NEW CAPITAL STANDARDS FOR INSURANCE HOLDING COMPANIES

Rep. Lehman stated that on January 9, 2019, Federal Reserve Board (“FRB”) Vice Chairman for Supervision Randal Quarles gave an important speech previewing the next step in the FRB’s multiyear effort to develop capital standards for depository institution holding companies. This effort flows from the Dodd-Frank Act, which gave the FRB regulatory responsibility for insurance holding companies that own full-service, federally insured depository institutions significantly engaged in insurance activities (“insurance holding companies”). Rep. Lehman noted that at the last NCOIL meeting in Oklahoma City, NCOIL passed a Resolution “Asserting McCarran-Ferguson Reverse Preemption over the Supervision of Insurance Companies by the Federal Reserve Board and its Examiners” due to concerns that the Board’s examiners’ exercise of their limited examination powers conflict with the jurisdiction of state insurance regulators over solvency and market conduct regulation or, at best, will be duplicative. Rep. Lehman accordingly asked for an update on the development of the capital standards.

The Honorable Scott White, Virginia Commissioner of Insurance, stated that the International Associations of Insurance Supervisors (IAIS) is continuing its discussions on the International Capital Standards (ICS). U.S. regulators are involved and engaged in those discussions. Domestically, the focus has been the development of the group capital calculation (GCC) for use in solvency monitoring activities. On a separate track, the Federal Reserve is developing their own capital regime requirements for insurance groups under their jurisdiction which includes insurance companies with affiliated financial institutions or banks. Cmsr. White stated that he believes there are 12 companies that fall within that jurisdiction.

The NAIC has been coordinating with the Federal Reserve to ensure that their insurance capital requirements and the GCC are aligned to the greatest extent possible. Unlike the Federal Reserve’s capital regime, it is important to understand that the GCC is not a capital requirement or standard. It is really an analytical tool intended to provide additional information for lead states to use in assessing group risk and capital adequacy. It provides insights to regulators as to the capital adequacy of the group and then regulators will assess what actions, if any, should be taken if the calculation raises concerns about the firm. Such actions may include additional monitoring of the firm or requiring the posting of additional capital. Cmsr. White stated that it is important to understand that the GCC will compliment the current U.S. holding company analysis. The current system involves regulating at the legal entity level which is very different from the approach advocated by European regulators to regulate at the holding company level.

Cmsr. White stated that work on this is currently being led by the NAIC GCC Working Group (WG), Chaired by The Honorable David Altmaier, Florida Insurance Commissioner. Up until October of 2018, the WG was really focused on constructing the calculation and the field-testing template. That has been completed and the focus has shifted to actual testing and the public release of the field-testing template. A revised template and set of instructions was then released addressing comments received. Some of the things the WG is looking at is the scope of the group in terms of including captives and certain industries. One health insurance carrier has concerns that they have raised with the NAIC. Triple “x” reserving is also being looked at as are special purpose vehicles. There is a lot to resolve but a lot of progress has been made. Cmsr.

White stated that the NAIC is developing the GCC for domestic group capital purposes and the ultimate goal is for the calculation to be considered the outcome-equivalent to the ICS currently under development at the IAIS.

Rep. Keiser asked how long the NAIC has been working on the calculation. Cmsr. White stated that he believes work started approximately 10 years ago and the work has garnered increased urgency upon the signing of the Covered Agreement in 2017. Rep. Keiser asked when the calculation will be finished. Cmsr. White stated that he believes the NAIC has made significant progress. Field-testing will begin in late Spring and the work has certainly increased in speed and content since the signing of the Covered Agreement and the past year in particular. Cmsr. White is encouraged by the progress made.

Rep. Lehman stated that, with regard to trying to align with the Federal Reserve on this issue, where does that put state legislators when trying to address differences between the Federal Reserve's work and the NAIC's. Cmsr. White stated that it is the regulator's role to work closely with the Federal Reserve, just as regulators are currently doing with the SEC with regard to the best interest regulation. A continued dialogue is paramount between regulators and the Federal Reserve on this issue.

DISCUSSION ON DATA CALL PRINCIPLES

Rep. Lehman stated that data calls are undoubtedly a very important tool for regulators to use to serve important regulatory objectives such as ensuring that rates are not inadequate, excessive or unfairly discriminatory, and ensuring company solvency. However, when used improperly or too often, data calls can impose significant compliance costs on insurers and sometimes the insurer's agents, thus generating costs that may ultimately become reflected in the price of insurance. Rep. Lehman noted that NCOIL adopted a Resolution in November of 2017 Encouraging the Adoption of Voluntary Data Call Principles, and then asked for the NAIC's current position on data calls and what the NAIC envisions happening with such calls going forward.

The Honorable Matt Rosendale, Montana Commissioner of Securities and Insurance, stated that the disaster call template was adopted by the NAIC several years ago and states tried to use that template as a guide for their individual data calls. The NAIC Catastrophe Insurance Working Group (C) (WG) is working on a state disaster handbook and would welcome any feedback on the data call template or the process surrounding those data calls.

Cmsr. Rosendale stated that data calls can be very expensive and can consume a lot of time and resources. It is very important to make sure that the actual, correct data is being requested and sent to conduct the sought out analysis. That takes both flexibility and cooperation between both the requestor and receiver. The specific needs of certain areas must also be taken into consideration. For example, coastal states have different needs than interior states. Objective information is needed that would actually trigger a data call so that there is not some arbitrary need that someone can impose. Flexibility is also needed to only request pertinent data. If very broad guidelines are put in place then you may be forced to request more data than actually needed to accomplish a task. Cmsr. Rosendale stated that regulators try to collaborate with each other on data calls when they can but that is not always possible depending on individual state needs and state statutes.

Rep. Keiser noted the situation described by The Honorable Tom Considine, NCOIL CEO, during the preceding committee meeting in terms of when sometimes the industry will ask an insurance commissioner to enact or repeal something because it is burdensome and the insurance commissioner will then ask his or her staff to get some information to see if what the industry is saying is true. Cmsr. Considine stated that during his time as Cmsr. of the NJ Dep't of Banking and Insurance he in fact did that but with the thinking that the resulting information would be used once. However, Cmsr. Considine stated that he just recently heard that the information he had requested was still being asked of insurers every single year without purpose. Rep. Keiser then asked the NAIC to comment on how to stop that practice and whether a requirement should be implemented to the requestor of the data call that within 90 days from the point in which the last piece of data is sent to submit a statement as to the purpose of the call and findings.

Cmsr. Rosendale stated that as a former legislator and current Cmsr., he would like to be able to adjust and address data calls in statute with the ability to adjust more specifically through promulgation of regulations relating to triggers and demands for data.

Rep. Lehman stated that a common complaint heard by legislators regarding data calls is that the calls request data that is not relevant. Accordingly, Rep. Lehman asked if the NAIC is working on some type of standard that would narrow the data requested to true, insurance-specific data. Cmsr. Rosendale stated that ties into his point of having the flexibility to address these issues through regulations so a framework can be set forth via statute and then conversations can be had between the regulator and the insurer regarding the specifics of the data calls. Rep. Lehman acknowledged that setting a standard on data calls is a work in progress and looks forward to being a part of that conversation going forward. Cmsr. Rosendale agreed and stated that what will likely happen is that different state agencies will want to broaden, and narrow, data calls depending on that state's specific needs. Cmsr. Donelon stated that he would be happy to discuss any ideas regarding the limitation and transparency of data calls going forward.

UPDATE ON STATE ADOPTION OF NAIC INSURANCE DATA SECURITY MODEL LAW

Rep. Lehman asked for an update with regard to state adoption of the NAIC Insurance Data Security Model Law (Model). The Honorable Ray Farmer, South Carolina Insurance Commissioner and NAIC-President Elect, stated that the NAIC started to look at a long list of measures in 2014 because of several severe breaches in the health insurance industry. The NAIC's work culminated with development of the Model and it was adopted by the NAIC in October of 2017. South Carolina was the first state to adopt the Model. Cmsr. Farmer stated that he believes the Model is common sense legislation and companies should already be doing the things required by the Model regardless of whether it is adopted. Ohio also passed a similar law. Michigan passed a similar law but it exempted the health insurance industry. Connecticut, New Hampshire, Mississippi, and Nevada have also introduced the Model for their current legislative sessions.

Cmsr. Farmer noted that the U.S. Dep't of Treasury commended the NAIC in 2017 for adopting the Model and also urged prompt action by states to adopt the Model within 5 years or else the administration will ask Congress to preempt the states. Cmsr. Farmer stated that he believes more momentum behind the model will begin to take shape this year and next year. In South Carolina, the time has come to implement the Model as the statute became effective on January 1, 2019. The first piece of the statute, the notification piece, gives companies doing business in South Carolina 72 hours after a breach to report it to the insurance department. The second piece goes into effect on July 1, 2019 which deals with requiring companies to have an incident response plan with regard to breaches.

Cmsr. Farmer stated that he has participated in two roundtable discussions with Treasury and large insurers on this topic and large insurers generally know what to do when a breach occurs as they have forensic specialists on staff. The concern is with smaller, regional companies, and it was found that some had no clue what to do. Cmsr. Farmer stated that he was recently honored to host 13 companies of all sizes, along with Treasury and FBI representatives for a roundtable discussion during which a lot was learned. Some of the companies present stated that they didn't even think about cyber breaches until the legislature had adopted the Model which emphasizes that the Model should be adopted in all of the states and the companies should be held accountable upon adoption.

Rep. Lehman stated that only a very small amount of the breaches that have occurred during the past several years have been insurance related and asked what the NAIC envisions coming from the federal level with regard to data security and breach notification legislation and whether such legislation would complement or preempt state law. Cmsr. Farmer stated that he believes the federal government is monitoring the states and is waiting to see if any federal action is necessary. Training exercises and education will be essential to make sure states know how to react to and prevent breaches so that each state's citizens are protected.

Rep. Keiser stated that North Dakota is currently dealing with several different cybersecurity statutes and bills, and the definition of cybersecurity is different in each. The issue for North Dakota is that data protection and breach notification is a generic issue and not unique to the insurance department. North Dakota is struggling to pass the NAIC Model because it only deals with the insurance industry. Rep. Keiser stated that he believes work needs to be done on a true cyber bill that has a section that refers to the insurance industry.

Sen. Bob Hackett (OH) stated that Ohio has led the way on this issue. Before adopting the NAIC Model, Ohio passed a law that created an affirmative defense in a court of law if a company adhered to one of eight cybersecurity standards, NIST being one of them. Sen. Hackett stated that they had buy-in from the industry with that approach. Rep. Keiser acknowledged that but stated that North Dakota has not had that success and is interested in what the NAIC think on this issue. Cmsr. Farmer stated that the situation described by Rep. Keiser is certainly a dilemma but at the end of the day, whether it is the NAIC Model or another law, it is everyone's responsibility to do everything they can to protect citizens from breaches. Different states are going to have to look at different solutions.

DISCUSSION ON LIFE INSURANCE UNDERWRITING DEVELOPMENTS

Rep. Lehman asked for an update on the NAIC's position regarding carriers beginning to use more and more non-traditional tools for underwriting. The Honorable Beth Dwyer, Rhode Island Superintendent of Insurance, stated that big data is certainly here and it is amazing the amount of data that is out there and the ability of insurers and other industries to use it. The NAIC has had a working group (WG) on big data for 4 years and Supt. Dwyer has been Vice Chair of it for 3 years. The WG started with the property & casualty lines and that is still going on. There are phenomenal things going on with life insurance right now that can benefit insurers but we have to make sure that there are also consumer protections in place.

Supt. Dwyer stated that those who are the same age as her remember what was required when getting a life insurance policy such as multiple unpleasant doctor visits. Life insurers are now using big data to substitute for that experience. From a consumer perspective that appears great at first glance but do consumers really understand what life insurers are looking at such as social media, drug prescriptions and other information. Accordingly, the WG really started looking at life insurance last year, while still maintaining a focus on P&C issues.

Supt. Dwyer stated that the NY DFS issued a circular letter last month relating to insurers use of social media in underwriting and the industry has raised some concerns with it. The WG is examining that letter which states things like if an insurer hires a vendor, the insurer needs to understand what data the vendor is using. That measure is obviously for consumer protection but also for protection of the insurer – if the insurer does not understand how its premiums are set there could be major financial solvency concerns. Supt. Dwyer stated that the Life Insurance Marketing and Research Association (LIMRA) recently made a presentation to the WG, in addition to market conduct exam experts, in an effort to determine if any tweaks need to be made to exams in the big data world. The WG will also look at whether additional regulatory tools are needed to look into big data issues related to life insurance.

Supt. Dwyer noted that at the upcoming NAIC Spring Meeting the WG will hear more on this. The WG has asked for the NAIC's staff resources to look at setting some parameters that states could consider adopting. Ultimately, the WG is trying to look at how life insurers are using big data, and what are the benefits and detriments to consumers. For example, how can a consumer challenge whether or not the information used by the insurer is correct since the consumer did not affirmatively give them the information.

Rep. Lehman asked if an insurer could adjust an existing life insurance premium based on risky behavior it views on a policyholder's social media. Supt. Dwyer stated that she does not believe so and hopes that a responsible insurer would go to social media before issuing the policy and not after. Supt. Dwyer noted that there have been some "glitches" with regard to insurers looking at applicant's drug prescriptions and making assumptions, which is what happened to some people with the drug Narcan. Most insurers are not making those knee-jerk reactions and the expectation should be that if something like a Narcan prescription is discovered, the insurer should follow-up with the applicant to make sure they are not making an assumption. Consumer's ability to challenge some of these issues like that is very important.

DISCUSSION ON REBATE REFORM INITIATIVES

Rep. Lehman asked for the NAIC's thoughts on NCOIL's interest in starting to develop model legislation regarding rebate reform, particularly as more and more carriers start to issue value-added services. Cmsr. Donelon stated that is something that the NAIC should be looking at and part of his legislative package was to address LA's anti-rebate statute.

Supt. Dwyer stated that the NAIC's Innovation and Technology Task Force has a small working group that is looking at coordinating state efforts regarding rebate reforms in an effort to share information so there is a more consistent interpretation of rebate statutes.

Cmsr. Donelon stated that he would welcome a more global perspective with the caveat that some bigger jurisdictions have no anti-rebate laws at all. Cmsr. Rosendale stated that it is important to be careful when defining what a rebate is because the term also has huge ramifications in the drug supply chain, particularly with pharmacy benefit managers.

Rep. Lehman closed by asking what the NAIC's position is regarding the new federal rules that govern lending institution's acceptance of private flood insurance policies. Supt. Dwyer stated that she is Chair of the NAIC's P&C Committee, and Cmsr. White is Vice Chair. That issue will certainly be a strong point of discussion in either that committee or in the catastrophe insurance working group.

Cmsr. Donelon closed by stating that he views the relationship between NCOIL and NAIC to be extremely valuable and he hopes that it will continue to remain strong and vibrant as new leaders begin to emerge in both organizations.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
NASHVILLE, TENNESSEE
MARCH 17, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Sunday, March 17, 2019 at 9:00 a.m.

Representative Edmond Jordan of Louisiana, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)	Rep. George Keiser (ND)
Asm. Ken Cooley (CA)	Sen. Jerry Klein (ND)
Rep. Matt Lehman (IN)	Asm. Kevin Cahill (NY)
Rep. Joseph Fischer (KY)	Asm. Andrew Garbarino (NY)
Rep. Bart Rowland (KY)	Sen. Bob Hackett (OH)
Sen. Dan "Blade" Morrish (LA)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Wieland (MO)	

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Daire Rendon (MI)

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Sen. Jerry Klein (ND) to waive the quorum requirement, the Committee unanimously approved the minutes of its December 7, 2018 meeting in Oklahoma City, OK upon a Motion made by Sen. Dan "Blade" Morrish (LA), NCOIL President, and seconded by Sen. Bob Hackett (OH).

DISCUSSION ON DEVELOPMENT OF MODEL LEGISLATION IN RESPONSE TO THE AMERICAN LAW INSTITUTE'S RESTATEMENT OF THE LAW OF LIABILITY INSURANCE

Rep. Joseph Fischer (KY) stated that this Committee, and NCOIL in general, has been involved with the ALI's Liability Insurance Restatement (Restatement) since May of 2017. For those who may not know, the ALI is a group of distinguished professors, judges, and academics who issue "Restatements" of the law on certain subjects, which are essentially summaries. The Restatements are also reviewed from time to time after completion to determine if any changes should be made. NCOIL's main concern with

this particular Restatement is that in certain areas, it appears that the ALI is stating what they think the law should be rather than what the law is. Rep. Fischer stated that NCOIL certainly respects the ALI's opinion, but legislators have a right to determine what the law is, as do judges. Rep. Fischer stressed again that the ALI is a very respected and important organization and judges do give some deference to what the ALI says so that makes it even more important for legislators to weigh in when issues like this arise.

Rep. Fischer then referenced the two documents he has sponsored. The first document titled "Model Act Regarding Interpretation of an Insurance Policy" is based on Tennessee HB 1977 – enacted on March 22, 2018 – and is meant to set forth in statute the settled law regarding the "plain meaning rule" as applied to interpretation of insurance policies. The second document, titled "Guidance for States Responding to the American Law Institute's Restatement of the Law: Liability Insurance" is meant to serve as exactly what the title states – "guidance." The document recognizes the fact that is in fact difficult to develop corrective model legislation on every issue in the Restatement as each state's statute or common law on the issue may be different. That is why the drafting note indicates that "States should work with stakeholders and the insurance department to amend the appropriate portion of insurance code to reflect the settled law on the issues below in order to avoid the Restatement being construed as the state's settled law on those issues."

Erin Collins, Asst. VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC) reiterated Rep. Fischer's regarding the Restatement's aspirational nature. The Restatement is an issue that NAMIC has been fighting for years and now that the Restatement has been adopted the conversation has shifted to what to do about it in the states. NAMIC has joined forces with the American Property & Casualty Insurance Association (APCIA) to undertake a national project to address the Restatement and both organizations have approached it in such a way as to address it in three ways. First, it is important that whatever solution is arrived at appropriately fixes the problems with the Restatement in that state. Second, it is important to avoid a methodology or vehicle that would go through a legislative process that might alter the intent of the bill. That means it is important where the bill is assigned. This is an insurance issue and it should be assigned to insurance committees and not judiciary or courts committees in which sections of the code could be opened up and altered. Third, whatever vehicle is chosen should appropriately address separation of powers in a state and make sure that it's reflective of that state's constitutional requirements in terms of what a legislature can say to the courts.

Ms. Collins stated that multiple states have coalesced around language that is phrased as a broad disavowal of the Restatement. NAMIC and APCIA believe that approach addresses the three aforementioned points. Ms. Collins stated that multiple bills have been introduced with that approach and hopefully they pass expeditiously. Ms. Collins thanked NCOIL for being involved with this issue in order to ensure that insurance law is developed by legislators and not outside parties. Ms. Collins urged the committee to adopt the model language submitted to them beforehand in a letter submitted by NAMIC and APCIA if NCOIL determines a model law is necessary.

Frank O'Brien, VP of State Gov't Relations at APCIA, congratulated NCOIL for taking the lead on this issue. Mr. O'Brien stated that at the 2017 NCOIL Annual Meeting in Phoenix, AZ, a general session was held during which one of the Restatement's reporters participated and the session was both eye opening and shocking as the

reporter essentially admitted that it was not a Restatement and they had put several provisions in that were aspirational in nature. NCOIL has been very active with the Restatement and has shown its strength. The states that have taken action against the Restatement have been “NCOIL states” and they have shown leadership by broadly stating that the Restatement does not reflect the law of their particular state. OH, AR, ND, and TX have all either taken action or have contemplated action. Other states are also contemplating action. Mr. O’Brien urged NCOIL to continue its leadership role and to move forward with a broad repudiation of the Restatement.

Rep. Fischer stated that in light of the language proposed by NAMIC and APCIA, and the language that has been adopted and introduced in certain states, Rep. Fischer made a motion to table the two documents he has sponsored and stated that he will engage in discussions before the Summer Meeting in July to introduce new language. Rep. Keiser seconded the Motion. The motion carried on a voice vote without objection.

Rep. Matt Lehman (IN), NCOIL Vice President, asked NCOIL staff for a list of states that have passed or introduced the language mentioned by Ms. Collins and Mr. O’Brien.

DISCUSSION ON INSURANCE DEVELOPMENTS IN THE SHARING ECONOMY

Eric Goldberg of The Hartford introduced Iain Boyer, Chief Underwriting Officer at YRisk, and stated that Mr. Boyer is a national expert on the sharing economy, is a frequent speaker on the issue, and has 28 years of experience in the industry. Mr. Goldberg stated that there are aspects of state insurance laws that may need to be revisited in light of emerging types of insurance. NCOIL may be particularly helpful with that in terms of allowing companies to innovate and bring products to market. Mr. Boyer stated that Y-Risk launched in 2016 as an underwriting management company with a focus on the sharing and on-demand economy. In December of last year, Y-Risk was acquired by The Hartford. In terms of the factors that have influenced the rise of the sharing economy, there have been a number of disruptive forces which singlehandedly could have caused a lot of changes but all three of them have occurred rapidly. Those forces include a change in demographics with the rise of millennials, the nature of the economy after the financial crisis, and the rise of technology. With regard to millennials, they have been shaped by technology and they also were brought up during the financial crisis which influenced their ideas of working for one company.

To define the sharing economy, there is an excess in capacity either in services or assets. Cars may sit idle for a period of time; homes may not be used 100% of the time; and depending on the nature of our work we may have free time. The sharing economy is essentially technology firms that enable that excess capacity to be matched; people will put their cars and homes on a platform for use, and people will do the same with their time. Transportation network companies do both since they will provide their time and share their vehicle. Growing up, we were taught to not talk to strangers, don’t meet people on the internet, and never get in a stranger’s car. Now we go on the internet to meet a stranger and get in their car. The reason we are able to do that is because technology allows us to track what’s happening and people are more connected. Years ago, you may have asked your neighbor to drive your child to a soccer game, so the concept of sharing always existed but it existed in micro communities. Technology has enabled hyper connectivity and has caused those micro communities to become very big.

Mr. Boyer stated that access is now more important than ownership and flexibility has value. This is all difficult for the insurance industry because with the rise of collaborative consumption and sharing, there is not a lot of data. There is analogous data but that does not serve the same purpose. Mr. Boyer noted that all of this has occurred very quickly so even though the insurance industry has struggled to keep up, the industry does not have to lose its relevance because insurance is one of the ingredients to creating trust. Accordingly, in the sharing and on-demand economy, insurance can both protect against loss and bridge the trust-gap.

Mr. Boyer stated that the emerging platforms and technologies operate between predefined categories. Insurers have every intention to provide protection to either consumers or companies. Going forward, there needs to be an adjustment to the lines between: personal and commercial; small, medium, and large; and between businesses. There are now three parties involved: the platform, the provider, and the user. Who is ultimately responsible? Is it first party or third party property damage? Is it auto liability or general liability because of something the platform did to match the people together? Commercial entities are providing assets to individuals so is it a personal product or commercial product? Additionally, hypoconnectivity makes the lines around geography less clear because transactions are taking place across jurisdictions.

Mr. Boyer stated that this is not just about how individuals interact. Municipalities struggle to provide the transportation they need for their communities because it's expensive to insert rail lines or bus lines. Municipalities are therefore partnering with on demand and sharing economies to implement the equivalent of last-mile deliveries of goods, for people. As a result, there is a lot of opportunity for those firms but at the same time they need insurance protection that can be difficult to procure. That leads to opportunity because these issues are not going away. As insurance companies work to provide these products, it is important that the industry works collaboratively with legislators and regulators to think about how to properly accommodate the sharing economy.

There are examples of transportation network company legislation, and there has been recent peer to peer legislation introduced in several states. Those are examples of states working to develop a framework so that insurance companies can provide products. Some of the questions that raises are: admitted vs. non-admitted – what are the right ways to deliver those products? Also, how does one satisfy minimum financial responsibility is a question that needs to be thought about. Matching the platforms to the appropriate set of laws can also be difficult. For instance, deciding whether something is short term rental or the shortest possible long term rental has important ramifications.

Rep. Tom Oliverson, M.D. (TX) asked if there are a set of best practices that certain states are implementing that legislators can look to address the issues Mr. Boyer mentioned relating to the on-demand and sharing economy. Mr. Boyer stated that one of the most important things to do is to develop definitions that fit the platforms. For instance, ride sharing services do not meet certain definitions applicable to Hertz and Avis. Rep. Oliverson agreed and asked if there are specific states that are doing that. Mr. Boyer stated that TNC legislation passed across the country and the peer-to-peer car sharing legislation passed in Maryland are good examples of how to think about and approach these issues.

Mr. Goldberg stated that a couple of western states passed legislation relating to peer-to-peer car sharing services several years ago but it is difficult to look to them as models because the industry changes very quickly. Last year, working with Turo, a good framework was developed in Maryland. Collaboration yields the best results and there is not one particular state that has done that more than others but that it was what led to the solid TNC legislation.

Rep. Oliverson stated that he would like to see this Committee, and NCOIL, take the lead on these issues through perhaps the development of a working group or task force. Mr. Goldberg stated that in his opinion these issues don't lend themselves to an NCOIL Model Law, but they could be an opportunity to work with interested parties and inventory laws that may need to be re-visited in order to accommodate insurance for the sharing economy and The Hartford would be happy to help in doing that.

Rep. Lehman stated that when discussing these issues, it is a good example of the grey colliding with the black and white. There may not be a standard that can be set that says "if you are in the sharing economy, this is what you must do" because each situation is different. In Indiana, there was an unwillingness to compromise on TNC legislation, but a willingness to do so with Airbnb legislation. Good public policy may require putting some parameters in place. With regard to autonomous vehicles, some platforms have said that they are not willing to take on any liability if the car drives off the road because it is only an electronics company – that needs to be figured out and that will depend on how we legislate who is responsible for what. Rep. Lehman agreed with Rep. Oliverson's statement that it is important for NCOIL to have its finger on the pulse of these issues.

Sen. Bob Hackett (OH) stated that TNC legislation is a great example of getting both sides of an issue to work together and develop a workable solution. In Ohio, legislation is being developed regarding peer-to-peer car sharing and everyone is hopeful that both sides will work together just as they did for TNC legislation.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that in California the ruling in *Dynamex Operations West, Inc. v. Superior Court of Los Angeles* was an example of how questions are arising with regard to how the gig economy ties into existing laws on wages and benefits. There is definitely a lot of crossover as you have innovators trying to figure out how to develop products but they are bumping up against insurance laws and other legal obligations. The *Dynamex* decision was very controversial in CA and Asm. Cooley stated that he has a bill pending on that issue with insurance implications. There are a lot of fights yet to come over how the sharing economy intertwines with existing statutes. Notably, the *Dynamex* decision was a unanimous decision from the CA Supreme Court.

Mr. Boyer agreed with Asm. Cooley and stated that it is important to first identify that these are issues public policymakers and interested parties need to be talking about. Next, conversations must be had that acknowledge how well the current insurance statutory and regulatory framework works, but at the same time acknowledging that certain definitions may need to be changed to accommodate the on-demand and sharing economy. Mr. Boyer then discussed the example of the difficulty of providing insurance to people who are renting homes or cars on a short-term basis and determining what is the best vehicle to deliver insurance to that person and at what specific moment in time. One of the issues brought up was that if the requirement is to give any person insured a 30 day cancellation notice that is impossible in those short-term rental situations.

In response to Sen. Hackett's statement, Rep. Jordan stated that it has been very difficult in Louisiana to pass legislation involving taxis and limousines because they don't want to be labeled common carriers because with that designation there is certain liability attached to it. Sen. Hackett stated that issue was also prevalent in Ohio but they worked together to develop a solution. Rep. Jordan stated that he would speak to Sen. Hackett afterwards about that solution.

DISCUSSION ON EFFORTS TO MODERNIZE AND STREAMLINE DATA REPORTING

Robin Westcott, VP of Gov't Affairs & General Counsel at the American Association of Insurance Services (AAIS), stated that AAIS is a national advisory organization that creates forms, loss costs, manuals, and other types of things to assist companies about the centralization of policy language and rating information. AAIS is a non-profit organization and part of what it has done and part of its responsibilities centers around being a statistical agent and collecting data from its member companies to be able to report to insurance departments as well as assist AAIS in developing its products around loss costs.

Advisory organizations are licensed under the National Association of Insurance Commissioners' (NAIC) model rating law which all states have adopted some version of. Traditionally, AAIS has focused on the collection of data and it has some limited antitrust exemptions for that. One of the things that is very hard in this industry is the collection of data and the ability to streamline or share it. When the data calls come out, many companies will have 16 different systems because they have acquired 15 companies in the past 10 years and the integration of that data is very difficult for them as well. The industry still struggles around centralization and the ability to share and collect data and integrate data. Over the years the advisory organizations have lost their way in the ability to assist and be that conduit and it is important to have the ability to judge and take data and understand what is occurring in a marketplace.

Ms. Westcott stated that she applauded and respected the Resolution Encouraging the Adoption of Voluntary Data Call Principles that was adopted by NCOIL in November 2017. Advisory organizations are the right place for the improvement of data calls to happen. As a result, AAIS has created a blockchain around data reporting and data calls for the industry called Open Insurance Data Link (Open IDL). Statistical reporting is something that companies must do and then there are increasing amounts of data calls that come from the regulatory environment to understand and judge what the marketplace, which is of course a fair thing to try and understand and judge.

AAIS has approached this issue differently than the Risk Block Alliance (Alliance) who have about 40 different use cases around how data will go back and forth and exchanged. AAIS has created one use case centered around data calls and data reporting. AAIS has a private permissioned blockchain network where AAIS has worked with IBM on the hyper-ledger platform over the past year to develop an environment where a company can stand up with the nodes inside of the blockchain. The network has a multi-tenant because there are many smaller and mid-size companies that won't be able to stand up their own nodes inside of a blockchain network.

AAIS has worked with taking a thin-stream of statistical data that must be given and working to ensure that companies can do that much more efficiently so that every new data call or every time they have to produce the statistical data the wheel is not being

reinvented. Accordingly, the blockchain is three releases in and it was designed by asking companies and regulators to come to AAIS' design-thinking sessions to help AAIS understand what its needs were and what they are using the data for and how it can be delivered back to them so its very efficient. Some very large companies have participated in those sessions in addition to 8 different regulatory regimes participate, including the NAIC.

From AAIS' perspective, it thinks that there will be many blockchains and AAIS' job will be to get the insurance industry to a place where data can be exchanged and integrated in a more efficient way. Ultimately, that will enable insurtechs to develop products that are much more responsive to the customer's experience and needs. Insurtechs and new products will be able to come into a private-permissioned blockchain environment where the regulator has their node and the ability to interact with data in a secure way. Instead of simply taking large blocks of data and giving it to a regulator, an environment now exists to ask questions about the data. For example, when someone gets "carded" at a bar, the bartender does not need to know anything about that person besides the person's age. Similarly, a credit lender does not need to know your entire credit history which is what they get when they get a credit report – they just need to know that you are a 720 or better. Therefore, imagine an environment where we can ask questions about the data and the data never leaves the privacy of the company's firewall. Insights can be obtained with some transparency but without risk. Another key element of Open IDL is that for the companies that participate, they will get some benchmarking tools back. Currently, when companies submit statistical data and other data they get nothing back and do not know where they stand in relation to the other companies that are writing that business.

Ms. Westcott stated that she has a demo available for anyone that is interested. It looks like a website and information can be plugged in to create a request. The company can then go in and look at it and like it or work collaboratively to perhaps modify the request. Everyone can find value and the data in and of itself can be used and leveraged inside a company in a much greater way to integrate data and streamline the efficiency of sharing data.

Paul Martin, Regional VP – Southwestern Region at NAMIC, stated that there is a balance between the insurer's ability and willingness and need to use data versus the regulatory need for data to ensure that the industry remains between the guardrails. NAMIC has estimated that at any given time in the U.S. there are between 250 and 300 data calls ongoing. Some of those are ongoing while some are quarterly or monthly or annually. Some stem from catastrophe operations. NAMIC believes that there is a place for NCOIL to have some participation in trying to figure out what data calls need to look like moving forward. Some thing that NAMIC would like to see addressed are: a.) ensure that data calls are relevant and that the information being sought by the data calls is actually probative to the issue at hand; b.) ensure that the data call is not overly burdensome. Oftentimes, NAMIC member companies complain about voluminous points of data that are not relevant and they are also costly to comply with; and c.) a need for a sunset provision, particularly since technology is rising at a rapid pace, so that every so often the data calls can be looked to make sure that the things are being asked for.

Ms. Westcott noted that one of the features of Open IDL is an expiration. So as you create data calls you also create time periods within which there will be a response

required. Ms. Westcott agreed with Mr. Martin's statements regarding data calls being burdensome and at times overbroad in asking for information that is not relevant. Blockchain enables data standards to be developed around how we are actually storing data to provide uniformity. One of the greatest outcomes from a blockchain technology is the ability of a company to leverage that as much as the ability of a regulator to simply ask a question and not have voluminous amounts of data in response to that question.

The Honorable Tom Considine, NCOIL CEO, stated that it is not necessarily important for public policymakers to actually understand the nuances of how blockchain functions, as it is very complicated, but it is important to know that it facilitates the exchange of data in a secure way.

RE-ADOPTION OF STATE FLOOD DISASTER AND MITIGATION RELIEF MODEL ACT

Upon a Motion made by Asm. Cooley and seconded by Sen. Jason Rapert (AR), NCOIL Immediate Past President, the Committed voted to re-adopt the NCOIL State Flood Disaster and Mitigation Relief Model Act until the NCOIL Summer Meeting in July while amendments to the Model continue to be developed and considered. The Motion carried without objection by way of a voice vote.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON NATURAL DISASTER RECOVERY
NASHVILLE, TENNESSEE
MARCH 15, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Natural Disaster Recovery met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Friday, March 15, 2019 at 5:15 p.m.

Senator Dan “Blade” Morrish of Louisiana, NCOIL President and Acting Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Rep. Edmond Jordan (LA)
Rep. David Santiago (FL)	Sen. Gary Smith (LA)
Rep. Matt Lehman (IN)	Sen. Vickie Sawyer (NC)
Rep. Mark Abraham (LA)	Rep. George Keiser (ND)
Sen. Ronnie Johns (LA)	

Also in attendance were:

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

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL STATE FLOOD DISASTER MITIGATION AND RELIEF MODEL ACT

Sen. Morrish thanked everyone for attending the meeting and noted that this Special Committee on Natural Disaster Recovery (Committee) is one of his main initiatives as NCOIL President. Sen. Morrish then yielded to Rep. David Santiago (FL), sponsor of the proposed amendments to the NCOIL State Flood Disaster Mitigation and Relief Model Act (Model), which aim to facilitate expansion of the private flood insurance market.

Rep. Santiago stated that the proposed amendments are based on legislation that has been very successful in Florida. The latest numbers reflect that approximately 100,000 policies have switched over or taken on some form of private flood insurance. The legislation created an admitted market and many of Florida’s domestic carriers have implemented endorsements or have sold separate policies. Rep. Santiago stated that he has not heard any complaints since the legislation passed besides some mortgage companies had technical issues as to whether or not they recognized the private flood insurance policies in terms of National Flood Insurance Program (NFIP) compliance. Legislation has been introduced to clean up that process in order to make sure that real estate closings are performed smoothly.

Rep. Santiago noted that he has spoken to the National Association of Mutual Insurance Companies (NAMIC) who have stated that they would prefer a Resolution on this topic rather than model legislation. Rep. Santiago stated that he is interested in discussing a

Resolution moving forward and noted that NAMIC's opposition to the model legislation is centered on rate filing and form approval requirements. Rep. Santiago further noted that he believes it is very important to have form approval requirements when discussing the private flood insurance market. Since the federal government is trying to support acceptance of private flood insurance, it is important to give the public some sense of security that state legislators and regulators review the forms.

Rep. Santiago noted that the federal government has recently stated that private flood insurance policies should meet the minimum requirements of NFIP policies, but stated that since he has been in the business he has seen some creative form writers. An admitted form is the way to go for private flood insurance. Rep. Santiago stated that in Florida, there is both the admitted flood product and the surplus lines product working together and its working properly. Rep. Santiago stated that he has always believed that if you want to be surplus, be surplus. If you want to be admitted, which in many cases provides additional consumer protections, there should be approved forms. They both can coexist successfully. Rep. Santiago closed by stating that he will discuss and consider the Resolution proposed by NAMIC with NCOIL staff over the next few months before the NCOIL Summer Meeting in July.

The Honorable David Maurstad, Chief Executive of the NFIP and Deputy Associate Administrator for Insurance & Mitigation at the Federal Emergency Management Association (FEMA), thanked NCOIL for the invitation and noted that as a former state legislator from Nebraska he understands how important the work is that NCOIL undertakes. Mr. Maurstad stated that as Chief Executive of the NFIP, he oversees all of the business operations of the federal flood insurance program. Mr. Maurstad further stated that he is here today to discuss the NFIP and to ask state legislators to continue their efforts to make our communities more resilient by increasing the number of insured survivors and reducing damage to property after a flood event. FEMA has two moonshot goals of doubling insurance coverage and quadrupling the investment in mitigation by 2022. Those moonshots are now the first two objectives in FEMA's strategic plan.

FEMA is committed to building a culture of preparedness across the nation based on those two aspirations. The Federal Insurance & Mitigation Administration (FIMA) is pressing forward and providing the foundation for a movement across the local, state, and federal governments, private industry, and other stakeholders. Mr. Maurstad stated that as the federal program drives this movement he would like the Committee members to ask themselves what they can do within their state authorities at the state level to achieve more insured survivors and incentivize mitigation. As the NFIP enters its 51st year, it is the largest single peril insurance operation in the world. It provide \$1.3 trillion dollars in flood insurance coverage across the U.S. and insures more than 5 million policyholders in over 22,371 communities across the nation.

Mr. Maurstad stated that he has been in this business for over 30 years and served in private sector, local state capacities, and has never seen more dedicated interest in achieving resilience through insurance than right now. FEMA is pleased that Congress has extended reauthorization of the NFIP through May of 2019 and is actively working with the 116th Congress on reauthorization. FEMA is asking Congress to take bold steps to reduce the complexity of the NFIP and strengthen the NFIP's financial framework. Working with Congress, FEMA continues to stress its 4 principles for reauthorization: a.) create a sound financial framework; b.) increase flood insurance coverage, whether from

public or private sources; c.) improve the customer experience; and d.) secure multi-year reauthorization.

Mr. Maurstad stated that those 4 principles are important because sustained authority is needed to continue to close the insurance gap and move mitigation forward. The impact of the last two storm seasons clearly demonstrated there is more work that needs to be done. For example, when looking at the impact of Hurricane Harvey on Houston in 2017, nearly 1 in 3 homes was under water. When the rain finally stopped, more than 120,000 in Harris County where Houston is located had been damaged by flood waters. Roughly 80% of those homes were uninsured from flood and most of them were outside the high-risk area, mapped in the low to moderate-risk area. Simply put, we need more insured survivors and less disaster suffering and changes are underway that contribute to that successful outcome.

More momentum and growth in the private insurance market is also needed. Frankly, both the NFIP and private markets must grow to close the insurance gap. Only 30% of residents in high-hazard areas and 4% of residents across the country are covered by an NFIP policy. That statistic is concerning given that we know the risk of flooding affects almost every corner of the nation and that every state and 98% of the counties have experienced a flooding event. Wharton published a study that showed that less than 3% of the flood insurance market today is covered by admitted carriers. The private sector should grow in order to see more people covered by flood insurance to reduce disaster suffering. Private market growth is critical to close the insurance gap and hit FEMA's moonshot to double insurance coverage by 2022.

Work over the past year has informed the belief that the path to increased private sector involvement right now is through reinsurance. Reinsurers now know more about the flood risk than they did before and can encourage more insurers to consider offering flood insurance protection. The NFIP is leaning forward to leverage its current authorities to manage risk exposure, shape strong reinsurance and risk transfer programs and build a sound financial framework. Reinsurance and risk-transfer efforts are an important component to success in creating this framework. FEMA is committed to developing a multi-year NFIP reinsurance program that increases the NFIP's capacity to pay claims, strengthens its financial framework and expands the role of private reinsurers and capital markets in managing U.S. flood risk. Exploration of risk transfer in the last 3 years has demonstrated how this can help financially both in the near term and in the long term and play a critical role in the development of a sound financial framework.

Mr. Maurstad stated that while the NFIP has been exploring the reinsurance space and working with Congress on broader reforms, the NFIP has also been re-designing NFIP insurance products as part of its NFIP transformation. Over the next several years, the NFIP is working to reflect industry best practices while creating a simpler policy form that provides more choices to policyholders. The NFIP is also working to make rates more transparent by reducing the complexity of rating and making it easier to understand a property's unique flood risk. Ultimately, the NFIP is re-defining its pricing so that it is fair and risk-based regardless of where one lives in their community or the country. The bottom line is that NFIP is being transformed into a less complex experience that customers value and trust and agents find easier to market and sell.

The NFIP is not only about insuring survivors. Mitigation and reducing risk are the integral parts of its successful insurance operation. Simplifying the conversation with property owners also helps to incentivize mitigation investments. The more intuitive rating variables referenced earlier will clearly communicate risk and highlight mitigation opportunities to individuals and property owners. In the fall of 2018, Congress passed the Disaster Recovery Reform Act that established a consistent stream of funding for pre-disaster mitigation activities. It is important to note that this is a new grant program that will be funded as a 6% set-aside for disaster expenses on an annual basis. This represents a significant increase in dollars available for state mitigation investments from a dependable funding source aimed at building a more resilient infrastructure across the nation.

As FEMA continues to work across its agency and with its stakeholders to develop and launch this landmark, game changing new program, FEMA needs state legislators to speak to their colleagues in the state appropriations arena now to prepare and build capacity to take advantage of this substantial new opportunity. They should know that investment in mitigation is critical to achieving more resilient communities. Mr. Maurstad stated that FEMA will need help to achieve its ambitious goals and stated that NCOIL is a critical partner in creating a culture of preparedness across the nation. State legislators can talk to their colleagues and constituents about being properly insured, especially against flood where we see the most significant gap in insurance coverage.

State legislators can work with their state insurance leadership to advocate for more private and public flood coverage that is easier to access and purchase affordably by more people in their states and territories. It bears repeating that state legislators can urge their colleagues in the state appropriations arena to better understand the critical need for mitigation, and understand the state mitigation programs so they can prepare to take advantage of the significant opportunity from FEMA's new mitigation program to build steady mitigation plans. FEMA needs state legislators' voice and leadership to help FEMA create a whole community of resilience that reduces disaster suffering. The challenge is to learn more about FEMA's movement, become part of the movement, and take action. Working together, Americans can rebuild their lives more quickly and more fully when disaster strikes.

Paul Martin, Regional VP – Southwestern Region at NAMIC, stated that NAMIC and the American Property Casualty Insurance Association (APCIA) have outlined 4 pillars they believe are necessary for a private flood insurance market to flourish: a.) form freedom; b.) rate freedom; c.) underwriting freedom; and d.) the ability to require insureds and policyholders to engage in mitigation activities. NAMIC and APCIA are really excited about the organic growth in the private flood insurance market. NAMIC and APCIA think that it is interesting to see that in some aspects of the disasters you see, private insurance companies are pulling away from certain perils but with flood you actually see the private market stepping up and getting more engaged – that is a very good sign. Mr. Martin stated that NAMIC and APCIA look forward to working with Rep. Santiago on the Resolution and look forward to continuing the conversation.

Ron Jackson, VP – State Affairs at APCIA, reiterated Mr. Martin's statements that flexibility in rates and forms is particularly needed to encourage private flood writings. Those writings have been growing but flexibility is key and that is an issue APCIA looks forward to continuing to discuss. Many member companies were writing private flood insurance in Florida before the 2015 law was enacted upon which the proposed

amendments are based. An insurance journal study of the private flood insurance market as of 2017 looked at Florida specifically and noted that in 2017 there was approximately \$37 million dollars in direct written premium in the private flood admitted market and \$89 million in surplus lines coverage. Mr. Jackson stated that he believes that highlights that flexibility of rate and form incentivizes additional writings and that should be kept in mind as the Committee continues to discuss this issue.

Austin Perez, Senior Policy Representative – Federal Policy & Industry Relations at the National Association of Realtors (NAR), stated that private flood insurance is one of NAR's priorities. NAR agrees that there needs to be an NFIP and Mr. Maurstad and his staff have done a wonderful job over the past couple of years. Mr. Perez stated that he can remember Biggert-Waters being enacted and it was very difficult at that time to reach FEMA but now he talk to FEMA almost every day and NAR and FEMA just signed a memorandum of agreement to work together in order to try and get out more information and educate consumers about the importance of having insurance in order to address natural disasters. Right now, the challenge is if you go through disaster relief you are looking at about a \$5,000 check and an SBA loan on a mortgage on a property that may no longer exist. But insurance helps you recover more quickly and more fully than disaster relief. It is really critical that we not only have an NFIP but also a private market. As stated earlier, less than 3% of the residential market is admitted private flood. NAR and its 1.3 million members are committed to helping the Committee try and grow that market.

Mr. Perez then referenced the recent federal banking regulations regarding private flood insurance and noted that in light of those regulations some have questioned whether any private flood insurance model legislation is still needed. Mr. Perez stated that yes, there is still room for NCOIL to be involved as those regulations only take one issue off the table which is some certainty as to whether the banking regulator is going to accept private flood insurance. The regulations do not deal with the profitability of insurance companies or with decisions to move into a particular state and the conditions are for those purposes. While the regulations are a step in the right direction, they don't really address the underlying issue which is: what is it going to take to get more private flood into this market?

With regard to whether the action taken by the Committee should be in the form of a model law or resolution and what steps the Committee can take to encourage a private market, Mr. Perez stated that other than Florida he is not aware of any other state that has a law specific to private flood. Therefore, the default for every other state are homeowner's insurance regulations but everyone agrees that flood is different and the peril of flood cannot be addressed the way it is for homeowners. For 100 years the private flood market was not writing so they don't have data. So what they use are catastrophe models. To the extent states have restrictions on catastrophe modeling, that might not allow companies the freedom and flexibility that they need in order to set a rate. Also, the private flood market is rating on an individual property-by-property basis vs homeowners which is territorial rating. So when talking about prior approval or filing a rate for every property in an insurance company's portfolio, that is a consideration that has to be taken into account.

Mr. Perez then referenced repetitive loss properties and stated that they represent 2% of the NFIP and more than 25% of claims. That raises questions since in the homeowners market you have cancellation and non-renewal provisions which vary from state to state

but when thinking about the peril of flood it should not be thought of in the same way as the homeowners market. Some of the cancellation and non-renewal provisions might make sense for both homeowners insurance and flood insurance but they may not. States need to be rethinking how they can tailor their current regulatory framework to address the peril of flood which is high-loss, low probability, and a lack of 100 years' worth of data other than what the NFIP has through its experience.

Mr. Perez stated that another aspect of flood insurance that is unique and needs to be considered by states as they consider private flood insurance is that most of the private flood insurance market is through surplus lines. Surplus lines are the first in and trying to prove profitability but the move to an admitted market is needed and it seems that most homeowner's policies consist of admitted coverage. In order to consider how a state's regulatory structure can address the peril of flood, it also needs to be considered how to move from the surplus lines market to the admitted market. NCOIL can help with that. Mr. Perez stressed that NAR's members want options and they don't care if it is on public or private paper as long as it covers the outstanding mortgage and they are getting the best possible rate. If it's the NFIP – wonderful – if it's the private market, even better. What NAR needs is guidance to states so they can start adopting laws specific to the peril of flood and are not based on homeowners policies which really are not designed or suited for that peril.

Lisa Miller, President & CEO of Lisa Miller & Associates, stated that back in 2015, Rep. Santiago and Sen. Jeff Brandeis created a private flood insurance proposal with all of the relevant stakeholders (banks, insurance companies, public adjusters, lawyers). Currently, approximately 100,000 private flood insurance policies have been issued in FL and to put that in perspective, only 975 existed in 2015. The notion that Florida had a private market prior to the law is therefore not quite accurate. Ms. Miller stated that the proposed amendments based on the 2015 FL law have simple concepts. One is rate flexibility so that companies can go into a market and test the rate and see how it works. Another is prior approval of forms. Ms. Miller noted that she believes in providing companies rate and form flexibility but those aspects are really for mature markets.

When you have an emerging market, there is a lot of uncertainty and banks are nervous. Banks love NFIP policies because they know what it is but they are a little nervous about what private forms can do. The bankers that Ms. Miller has spoke with have stated that they will take great comfort if they see on a declarations page "this policy meets all the standards of the NFIP law in the federal code." The only way they can see that on a dec page is if a regulator looks at that form and says it does. A company requesting form freedom is great but probably not wise for a market in its infancy and the private flood insurance market is indeed in its infancy.

Ms. Miller referenced the discussions about the surplus lines market being at around \$90 million and the admitted market being at around \$30 million. The goal is to reverse that. Ms. Miller stated that Florida worked under the adage: "if you build it they will come." Ms. Miller further stated that they are in fact coming as FL has 1.7 million NFIP policies and has written 100,000 private policies in the past 4 years and that is because the companies worked with everyone despite it being contentious. An admitted market is needed and the surplus lines should stay in their swim lane. To have a completely unregulated market as some are suggesting is simply inviting in the surplus lines market. Policymakers have to ask themselves: do we want an unregulated without the consumer protections of an admitted market by deregulating everything that is involved in the

advancement of flood insurance? Or do we want to encourage the admitted market with just a little bit of oversight on the form and get them to come to the party and write product that helps consumers with all of the consumer protections available.

Rep. Matt Lehman (IN), NCOIL Vice President, stated that the private flood insurance market is starting to emerge, but he has some concerns. If the industry wants to fill a vacuum that is low-risk, what will happen when it becomes high-risk and it wants to vacate the market? Rep. Lehman stated that he believes the perfect model to copy is the Terrorism Risk Insurance Act (TRIA) where the industry said there was no way it could cover another \$100 billion dollar loss so the federal government said it will pick that up but not the first "x" amount of dollars. The cost of terrorism insurance is \$25 on a smaller risk so why could that model not be adapted into a flood program?

Rep. Lehman asked Mr. Maurstad if that idea has been discussed at the federal level. Mr. Maurstad stated that idea has not been seriously discussed and he personally believes that since 2005, the NFIP has been trying to prove itself. The program has been dedicated to improve and transform over that period of time. During the reauthorization process, there is some discussion of modernizing "part A" of the National Flood Insurance Act which would allow the program more flexibility to be creative and implement some different pooling mechanisms. However, the bandwidth has been lacking to go out and design a new program.

Mr. Perez stated that NAR hired Milliman to evaluate how much you could bring flood insurance down, cost-wise, if you were to add earthquakes and other natural disasters and therefore have an all-perils policy that covered everything. The idea being that while some perils are paying in and the floods are paying out it would sort of be a wash. What was discovered is that a program like that would bring down the cost for about 2% of those currently with flood insurance. They would pay about \$300 less. The other 98% would have to add coverage on top of their homeowner's policy and the cost of that would be \$600. That raises the question about cross-subsidization. Mr. Perez also noted that there has never been a terrorism loss and flood is a different peril than terrorism. Accordingly, you get into some sticky issues when you go down that road of some sort of natural disaster insurance program. That is not to say that it is something that could not be considered but Congress would have to make a deliberate choice and it would not be an easy choice.

Ms. Miller stated that another model to consider is that the NFIP would eventually become a residual market. Florida, for example, has Citizens Property Insurance Corporation (Citizens) which has shrunk over the years as the admitted market has increased and it is a nice balance. The surplus lines market is out there for the high-risk homes.

Rep. George Keiser (ND) stated that with regard to the growth of the private flood insurance market, regardless of whether it is in the surplus lines or admitted market, what percentage of that growth is simply a transfer from the NFIP; what is new; and were the best properties taken from the NFIP? Ms. Miller stated that one of the leading property insurance companies in Florida ran its entire book of business through a sophisticated flood model and they recognized that 97% of that book would be eligible, according to their underwriting guidelines, for flood. They opened their flood insurance endorsement program in July and they wrote 30% of their book since then and maybe only a handful of policies were NFIP policies. Also, the endorsement is only about \$100.

Mr. Perez stated that the cherry-picking argument is one heard on the Hill very often. First, there are no cherries in the NFIP. Second, NAR's experience has been that private flood companies go after the highest risk because it is really difficult to make a profit off a \$500 low-risk policy. Portfolios of risk are being created that includes some low-risk and some high-risk and the interesting thing is that it is the admitted market going after the low-risk and the surplus lines going after the high-risk. Overall, NAR has not experienced cherry-picking from the NFIP.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that we often find ourselves in a situation where we are trying to think through problems and what we have not recognized is the tools and the toolkits have been changing. If you keep on thinking about the problems with the same tools, you will keep on coming up with the same solutions. At the national level, you are dealing with a type of commonplace disaster that people have dealt with for time immemorial and it is easy to assume that the same solutions always applied are the solutions available. We now live in an era where we see the rise of different tools in the marketplace such as big data, the interconnectedness of things, the availability of satellites not just to place things on the ground but to understand elevations so we can now say that an earthquake causes the Santa Monica mountains to jump 6 inches.

Asm. Cooley stated that traditionally, insurers have a basic problem with the geographic concentration of risk and flood fits that problem. Insurers have a problem with their book of business because if you need actuarially sound rates to cover the known degree of peril it is hard to find a lot of money to give back to the realtors and homeowners in mitigation within the rate that was set based upon an agreed understanding of the peril. It is also hard to broaden coverage in that sense. Therefore, the idea of TRIA presents the option of what if there was a methodology at the national level to develop a postflood disaster means of financing to backstop the private sector. If you had something like that then you could start expanding coverage because you know when a disaster strikes there is some help with the payment of claims.

Asm. Cooley stated that there are a lot of things out there that could feed into a conversation about a lot of perils regarding whether there is an opportunity to use post-disaster financing to change the dynamics of the frontline peril. We see it in California where it has taken pools about as far as they can go to deal with the peril of earthquake. In 1989, the California Residential Earthquake Recovery Fund was enacted but it ended up being repealed in about three years because it was deemed to not be actuarially sound. However, getting that idea out there led to the development of the California Earthquake Authority (CEA). But even the CEA is bumping into issues because in order to preserve itself it has to keep rates up which effects the extent to which they are able to write business. If there was some post-disaster financing around it, the economics of that system might change. To move in the direction of TRIA would be a major move from where the NFIP is today but you can see how a larger conversation might begin with realtors, homeowners, and local governments regarding how to apply new tools to come up with new solutions to this problem.

Mr. Perez stated that the CEA has a make-available requirement just like TRIA and it has not been effective. Asm. Cooley pointed to California AJR 6 (2015) which was a Resolution that recognized the need for federal legislation that would establish guarantees of post earthquake financing for prequalified, actuarially sound state earthquake insurance programs, including the CEA, and urged the President and

Congress to enact that legislation. Mr. Perez stated that another thing to consider is whether a make-available requirement is not enough because a lot of property owners are going off of their personal experience and if you tell them they have a 1 in 4 chance of being flooded every 30 years but they have never experienced a flood they assume they are low-risk. So going down that road must involve talking about expanding mandatory purchase to broader areas over more perils which is a very challenging concept to get buy-in from consumers.

Mr. Perez noted that NAR's members had difficulty understanding the Milliman research and the way that he broke through in explaining it is that if you are just talking about floods and earthquakes, there is a true-risk premium on both of them. So the only way to subsidize and bring down the average cost of the floods is to charge more for the earthquakes so it's a cross-subsidization scheme. From NAR's perspective, if you bring in millions of homeowners at only a \$25 surcharge that is one thing; but it was found that for 98% of the homeowners in the country, it would be closer to \$600 and that is a subsidized rate.

Asm. Cooley stated that the issue is that if you actually had a national pool in place to backstop the system in the case of huge natural disasters, and all of the private carriers in the country could rely upon that, then they could build into their rates a more affordable rate to cover the more garden variety of things for which they would be on the hook. If you can drop the basic rate because you are no longer worried about that catastrophic event because you know there will be help coming, then you can get greater market penetration. Mr. Perez stated that he does not disagree but he is just raising some policy and political considerations in terms of somebody having to pay for it. If you are subsidizing one risk either other policyholders or taxpayers will have to pay for it.

Sen. Vickie Sawyer (NC) stated that as an insurance agent who has written through the NFIP and held her customer's hand as she was navigating a claim through the NFIP, and also as a legislator that just voted to spend \$800 million dollars in hurricane recovery relief in North Carolina after Hurricanes Michael and Florence, she has a lot of interest in this subject. Sen. Sawyer asked Mr. Maurstad what FEMA's timeline is for NFIP reform, not only with the front end delivery when agents write it but on the claims process.

Mr. Maurstad stated that changes have already been made to the claims process over the last 3 to 4 years. Litigation issues have been reduced as have appeals. The information the NFIP is receiving now has been very positive in response to surveys issued to policyholders asking how their claims experience has been. Accordingly, Mr. Maurstad stated that he believes they have made great strides in terms of claims process reform but is of course welcome to hearing suggestions for further improvements. With regard to improving the policy itself, that is still a ways out because the development stage is still underway which will then be followed by the rulemaking stage since the terms and conditions of the policies are part of the regulations pursuant to the statute. With regard to pricing reform, that is also still in the early development stage but the hope is to have a new rating structure sometime next year as it has not been changed since the 1970s.

Sen. Gary Smith (LA) stated that he and his colleagues in Louisiana have been observing Florida's private flood insurance market and they would like to learn more

about said market. Sen. Smith asked Ms. Miller whether Florida's private flood insurance market consists of all admitted policies and approved forms. Ms. Miller stated that Florida has 6 million property insurance policies and about 60 to 65 companies write 90% of that. Citizens has about 500,000 policies and Florida domestic companies write the rest. Ms. Miller stated that of the approximately 30 companies that are writing private flood insurance in Florida, they are writing it because the statute was put on the books that gave them parameters and ground rules which provided them certainty and they knew what they had to do to "get in the game". They then found that they could write it as an endorsement to their property policy and for less than an NFIP policy. Accordingly, it can be written with one adjuster, one deductible and it is covered by the guaranty fund. That is a great testament to "if you build it they will come." Thus far in Florida, no cherry-picking is occurring and there have been no complaints regarding arduous form approval concepts.

Sen. Morrish asked Mr. Maurstad if that NFIP still has rules in place which prohibit those who leave the NFIP for the private market from returning to the NFIP. Mr. Maurstad stated that you can come back to the NFIP but you cannot come back with the same discounts or subsidies you had before you left, if you had any.

CONSIDERATION OF RESOLUTION RECOGNIZING SEPTEMBER 1ST – 7TH 2019 AS "NATURAL DISASTER RESILIENCY WEEK"

As sponsor, Sen. Morrish introduced a Resolution Recognizing September 1st - 7th 2019 as Natural Disaster Resiliency Week. Upon a Motion made by Rep. Mark Abraham (LA) and seconded by Rep. Edmond Jordan (LA), the Committee voted to waive the quorum requirement. The motion carried on a voice vote without opposition.

Upon a Motion made by Sen. Ronnie Johns (LA) and seconded by Sen. Smith, the Committee voted to adopt the Resolution. The motion carried on a voice vote without opposition.

ADJOURNMENT

There being no further business, the Committee adjourned at 6:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
NASHVILLE, TENNESSEE
MARCH 16, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Sheraton Grand Nashville Downtown Hotel in Nashville, Tennessee on Saturday, March 16, 2019 at 1:30 p.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Rep. George Keiser (ND)
Rep. Matt Lehman (IN)	Rep. Tom Oliverson, M.D. (TX)
Rep. Edmond Jordan (LA)	
Sen. Paul Wieland (MO)	

Other legislators present were:

Rep. Deborah Ferguson (AR)	Rep. Tracy Boe (ND)
Rep. Roy Takumi (HI)	Sen. Bob Hackett (OH)
Rep. Daire Rendon (MI)	

Also in attendance were:

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

MINUTES

After a motion was made by Rep. George Keiser (ND) and seconded by Sen. Paul Wieland (MO) to waive the quorum requirement, the Committee unanimously approved the minutes of its December 8, 2018 meeting in Oklahoma City, OK upon a Motion made by Rep. Matt Lehman (IN), NCOIL Vice President, and seconded by Rep. Edmond Jordan (LA).

MARIJUANA IN THE WORKPLACE: WHAT DO STATES NEEDS TO KNOW AS THE LEGALIZATION OF MARIJUANA INCREASES?

Chester McPherson, Senior Division Executive – External & Gov't Affairs at the National Council on Compensation Insurance (NCCI), first stated that his presentation is not meant to provide legal advice but rather to provide updates on certain issues. NCCI is a licensed rating organization and advisory organization in the workers' compensation space. NCCI is the largest collector and provider of workers' compensation data services and it works with about 40 states in assistance to set and establish loss costs or full rates in the workers' compensation arena. Mr. McPherson stated that a number of states have been working to legalize marijuana. Last year, Vermont became the ninth state to legalize recreational marijuana and interestingly it was the first state to do so

through the legislative process as opposed to a ballot measure. Louisiana has also passed legislation related to marijuana through the legislative process. Mr. McPherson stated that in Michigan in 2018, the legalized use of recreational marijuana was enacted through a ballot initiative. Also, in 2018, Missouri, Utah, and Oklahoma permitted the legalized use of medicinal marijuana through ballot initiatives. However, in 2018, a ballot measure to legalize recreational marijuana failed in North Dakota.

Mr. McPherson stated that Idaho, Nebraska and Kansas are the only states that do not permit the use of marijuana in any form. Those 3 states represent about 6.6 million U.S. residents out of about 327 million total U.S. residents so you can see almost the entire country lives in a state where there is access to marijuana whether it is medical, recreational or some form of limited use through CBD oils. Ten states plus the District of Columbia permit recreational use of marijuana.

New Mexico was one of the first states where NCCI saw courts addressing the issue of whether or not an employer has to reimburse for the use of medical marijuana. Within the workers' compensation space, one of the key issues that is of concern is whether the medical treatment is considered reasonable and necessary, and whether it is legal under state law, and that is the question that states and courts are wrestling with as it relates to the reimbursement of medical marijuana. The New Mexico court of appeals ruled in a number of cases (*Vialpando v. Ben's Automotive Services and Redwood Fire & Casualty* (2014); *Maez v. Riley Industrial*; *Lewis v. American General Media* (2015)) that the employer must reimburse for the use of medical marijuana within a workers' compensation context. Subsequently, New Mexico adopted a fee schedule related to medical marijuana which provides for reimbursement of medical marijuana in New Mexico and that became effective January 1, 2016.

In 2015, the Minnesota Department of Labor promulgated regulations that made the use of medical marijuana reimbursable as a form of workers' compensation treatment. In a 2016 Connecticut case, *Petrini v. Marcus Dairy, Inc.*, the workers' compensation commission ruled that the use of medical marijuana is reimbursable because it constitutes a necessary and reasonable medical treatment. That decision was appealed but the parties ultimately settled and the original ruling of the workers' compensation commission remains settled CT law. Last week in New Hampshire in *Appeal of Andrew Panaggio*, the court ruled delicately that a carrier does not affirmatively have to reimburse for medical marijuana but within the ruling the court did seem to suggest that it could be reimbursable. That ruling is still being analyzed.

Mr. McPherson then discussed some 2019 legislative activity relating to reimbursement issues, coverage issues, and overall the payment of medical marijuana. Hawaii HB 1534 and SB 1523 just recently died during session but those bills would have allowed for reimbursement of medical marijuana within the workers' compensation space. Kansas SB 195 contains a provision for the safe, legal use of medical cannabis but it is not clear if it will pass and how it will impact the workers' compensation space. Maine HB 697 contains a provision to provide for reimbursement in workers' compensation cases. Maryland SB 854 indicates that if an employee is taking or using medical marijuana and gets injured on the job while using medical marijuana, then that employee would not be entitled to receive workers' compensation benefits. New Jersey A 4097 and A 4505 contain provisions to provide for the reimbursement of medical marijuana in workers' compensation cases. New York also has pending legislation on that issue (AB

2824/S2054) and Vermont HB 14 would also permit workers' compensation payment in the medical marijuana space.

A number of states have made it clear through legislation that medical marijuana is not reimbursable in the worker's compensation space: Florida (SB 8-A – 2017); North Dakota (HB 1156 – 2017); and Louisiana (HB 579 – 2018). The Maine Supreme Court ruled in *Bourgoin v. Twin Rivers Paper Co.* (2018), that employers are not required to cover reimbursement for marijuana. However, there is currently a bill pending in Maine that would permit reimbursement so it remains to be seen how that will play out. In *Hall v. Safelite Group, Inc.* (2018), the Vermont Department of Labor ruled that even though medical marijuana is legal it should not be construed to require employers to reimburse for that coverage. There is also a bill in VT, HB 14, that would allow for reimbursement. Mr. McPherson stated that as states consider these issues NCCI will continue to monitor them. Mr. McPherson encouraged everyone to visit NCCI's website where it has information available that covers a plethora of issues related to marijuana for employers, legislators, employees, and insurers.

Michael Correia, Director of Gov't Relations for the National Cannabis Industry Association (NCIA), stated that he is not here to discuss the pros and cons of cannabis legalization as the voters have already spoken on the issue. The question that needs to be asked is how you want implementation to work. There are 47 states that have cannabis laws that disagree with the federal government. NCIA's approach is to allow this conversation to be had at the state level. There are many issues that need to be worked out and NCIA's focus is that the conversation should be done with policymakers at the state level rather than the federal level. The states that are anticipated to introduce ballot initiatives related to legalizing marijuana are CT, HI, IL, MN, NH, NJ, NM, NY, RI, and VT.

With regard to the federal level, Mr. Correia stated that this is the first time in 6 years where we have had Democrats control the House so this will be the first time where the legislative process will be able to be fleshed out in terms of bills going through committees and receiving votes so we can have an idea of what Congress is thinking. Last month, the House Financial Services Committee held a hearing on issues related to cannabis and banking. Last week, a bill was introduced related to cannabis and banking and there are over 120 co-sponsors. NCIA cares about legalization and the light at the end of the tunnel, but the main focus is being able to have Congress pass legislation that pushes it back to the states. There are two bills that address that issue, one of which is the States Act sponsored by Senator Elizabeth Warren (MA) and Senator Cory Gardner (CO).

Mr. Correia noted that President Trump has stated that if something was to move through Congress he could support the concept of pushing these issues back to the states and offering them protection on these issues. Mr. Correia further noted that with regard to the 2020 election, many Democrats are going to be taking a very progressive view on this issue. Mr. Correia stated that he is hopeful that the discussions on these issues will move forward and that something can make its way to the President's desk that addresses some of the issues.

Erin Collins, Asst. VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC, like many others, is investigating what the cannabis industry and boom means for the insurance industry in particular and to

communities at large. NAMIC is looking at the issues in the context of three main areas. First, the impact of medical marijuana and the question being asked relates to carriers being in violation of federal law if they are forced to reimburse for medical marijuana. Questions are being asked regarding whether those carriers would be subject to RICO. There are many who would say that would never happen, however, Jeff Sessions did issue a memo last year indicating that they should enforce the laws of Congress vociferously as it relates to marijuana so it remains to be seen what the exposure is.

Second, in the instance of an assigned risk pool, especially in the workers' compensation area, if there are dispensaries or other cannabis oriented businesses that fall into the assigned risk pool, a workers' compensation carrier or other carrier may be assigned that risk without being able to determine if that is something that they are willing to undertake as a business practice in the context of a violation of federal law. Ms. Collins stated that when discussing cannabis, NAMIC begins and ends with the notion that as an industry, it should not be forced to do something illegal. NAMIC is taking appropriate steps in advocacy to try to work towards that initiative but NAMIC knows that this conversation will be coming to a head at the federal level. The third area is the effect on the homeowner's line and the auto line. In the homeowners context we have to ask the question about whether or not marijuana is property. There have been several cases where individuals have been growing marijuana in their homes, one of which involved an individual having several plants stolen from her home which caused her to file a claim for almost \$50,000. NAMIC has seen that those types of cases are determined by whether the judge decides that state law or the federal controlled substances act is the prevailing statute.

In the auto space, NAMIC is seeing an impact in states that have legalized marijuana. There have been studies from the Insurance Institute for Highway Safety (IIHS) and others that show an increase in collision claims resulting after the legalization of marijuana. Another issue in the auto space is that we don't really know what "impairment" means as it relates to marijuana, nor is there a way to test for that. Ms. Collins applauded the Committee for examining these issues and stated that it will likely have to continue doing so for quite some time as new issues develop.

Frank O'Brien, VP of Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated APCIA is neutral with regard to the public policy question of whether states should legalize recreational or medical marijuana. Having said that, this is a very active area and Mr. O'Brien noted that he will be in Rhode Island next week testifying on many of the issues mentioned by Ms. Collins. Mr. O'Brien stated that we are currently in a very difficult catch-22 situation. Marijuana is a schedule 1 drug at the federal level and a federal crime and APCIA is very concerned about its exposure for participating in "touch the plant" activities. APCIA is pleased to see that Congress is finally starting to wrestle with these issues and looks forward to it finally resolving said issues because as with any other business, the marijuana industry needs the risktransfer mechanism.

On the insurance side of things, one of the main issues is impairment standards. Right now there is no recognized impairment standard and no recognized test to measure impairment such as a breathalyzer being used to measure blood alcohol levels. That presents a problem and one of APCIA's concerns is a growing trend in the states to give marijuana a special status. APCIA would like to see a situation where impairment is impairment and APCIA is concerned about moving away from safety-related

requirements and a safety-related culture particularly in safety-sensitive positions. One thing that APCIA would like to see that it is working with federal officials on is the development of some sort of impairment standard and some sort of impairment test. Mr. O'Brien stated that these issues are going to have a lot of attention going forward and one of the things APCIA is concerned about is any type of mandate from state legislators to insurers to either cover marijuana or somehow give it a special status. So far that has not occurred but APCIA remains concerned about it.

Rep. Matt Lehman (IN), NCOIL Vice President, stated that an issue that he believes is going to emerge in Indiana is that it does not have any laws relating to medical or recreational marijuana but Ohio does. Rep. Lehman stated that his community is 6 miles from Ohio and it draws a lot of its workforce from Ohio. Rep. Lehman described the scenario of someone from Ohio having a legal prescription for marijuana and they are injured in Indiana and it turns out there is marijuana in their system and the policy written in Indiana excludes any illegal behavior. Rep. Lehman asked Mr. McPherson if issues like those are being considered by NCCI and other organizations. Mr. McPherson stated that NCCI is not an insurer so it does not insure the risk, it just collects the data and shares it with state departments of insurance. Since this is such a new issue, NCCI does not have marijuana-specific data currently because it does not have a national drug code due its classification as a schedule 1 substance. However, NCCI is working to develop its data call for next year to see whether or not NCCI could obtain information from insurers who cover marijuana or reimburse for marijuana in the workers' compensation space.

Rep. Lehman stated that the situation he described seems to be putting people into a box and it may result in the individual described in his hypothetical not having any coverage due to a perfectly legal prescription in his state. Mr. O'Brien stated that is one of the issues that will be discussed in Rhode Island next week because RI is surrounded by a number of states that have legalized marijuana. This is also not only an issue in the workers' compensation space, but also the criminal space, as the head of the RI State Police is addressing the issue during his first week on the job. Mr. O'Brien stated that some of these issues are going to need to be resolved by the courts. The Massachusetts Supreme Court is looking at the issue and there are a number of state legislatures that are considering statutes on this issue, MA and RI being among them. Unfortunately, right now, the situation Rep. Lehman described and the issues surrounding it is a mess.

Mr. Correia stated that regardless of your views on cannabis, there are many policy issues that need to be worked out and states are dealing with that now. Congress needs to change this and they are not willing to do so until they feel that the states can handle it.

Rep. Daire Rendon (MI) stated that Michigan legalized recreational marijuana a few years ago and it still has not gotten its hands around it. In Michigan, trucking, lumber, and farming are huge industries and it is becoming difficult to find people to get into those industries and they are good paying jobs. Rep. Rendon stated that her constituents in those industries are worried sick about how marijuana laws are going to impact their ability to move their goods and still be able to provide a service and not have their liability compromised. Mr. O'Brien stated that those concerns relate to his comments made earlier regarding safety-related requirements. APCIA believes that

Congress needs to resolve this and we need to fish or cut bait on this issue. The catch22 needs to be eliminated. Once that it is done, the states are then going to have to decide what type of regulatory structure they are going to put in place, and how it will be enforced. Many different policy decisions are going to have to be made by the states and they will be laboratories of democracy.

Mr. Correia stated that he believes the most important thing to determine is what impairment is so policy can be implemented. If a person crashes a truck and they are under the influence of alcohol, they will either show visible effects of being under the influence or the breathalyzer will tell you. With cannabis, you can consume it on Friday and it would still be in your system if you got into an accident on Monday.

Rep. George Keiser (ND) stated that in ND, medical marijuana is allowed as is alcohol and both are statutorily excluded from coverage if you are under the influence of either. Rep. Tom Oliverson, M.D. (TX) stated that one of the problems that must be dealt with is the fact that unlike any other intoxicant which is legal in the U.S., marijuana is the only one that is simultaneously being reported to have medicinal properties. You don't see the legal recreational use of Vicodin and you don't see the medicinal use of alcohol unless you are recovering from alcoholism and you are in a detox facility. Rep. Oliverson stated that as a physician it frustrates him that the advocates have been fairly disingenuous because they have essentially stated that they'll "take" medical marijuana being legalized but ultimately what they really want is full-fledged legalization. That muddies the waters. Is it a drug to treat disease or is it an intoxicant for recreational purposes? That represents a problem on the regulatory side of things because if I am on a drug that is prescribed to me that impairs me, that is different compared to smoking it in a bar and then driving home.

DISCUSSION ON DEVELOPMENT OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL

Rep. Lehman stated that the initial discussion draft of the NCOIL Workers' Compensation Drug Formulary Model is based off of a bill he sponsored in Indiana last year that was signed into law last March. Rep. Lehman stated that throughout the past several years, interest from state legislatures in workers' compensation drug formularies has grown significantly as they are seen as a way to: ensure that the treatment provided injured workers is related to and the most appropriate for their work-related injury; combat the opioid crisis; and lower prescription drug costs. Rep. Lehman noted that In Indiana, they decided to utilize the Official Disability Guidelines (ODG) Workers' Compensation Drug Formulary Appendix A as published by MCG Health, but that does not necessarily mean that is what should be included in an NCOIL Model. It's possible that the Model might not even name a specific formulary but could rather direct states to develop their own formularies as some states have done.

Rep. Lehman then provided a brief background on how the bill operates with regard to the interaction between employers, employees, and physicians and the prescription of certain drugs. Essentially, except during a medical emergency, the bill prohibits workers' compensation reimbursement for drugs specified in the ODG Workers' Compensation Drug Formulary Appendix A published by MCG Health as "N" drugs. Rep. Lehman stated that he looks forward to hearing comments on the initial discussion draft and looks forward to further discussing this issue at the Summer Meeting in July and perhaps

beforehand during an interim committee conference call with the goal of ultimately adopting a Model for states to consider.

Abbie Hudgens, Administrator of the Tennessee Bureau of Workers' Compensation, stated that TN adopted a similar workers' compensation drug formulary to Indiana's. Ms. Hudgens stated that TN chose to enact a workers' compensation drug formulary because TN has a problem with opioid use. Several years ago, TN had 1,600 people die from opioid overdoses and that provided an impetus both for workers' compensation and the state as a whole. The workers' compensation drug formulary was part of the 2013 reform which was a large reform for the entire TN worker's compensation system. In that statute was a requirement to have treatment guidelines and TN considered the formulary as part of the treatment guidelines. The statute did not spell out the exact parameters of the formulary but rather said that the Administrator would, in consultation with the medical advisory committee, make a decision on the formulary. Accordingly, several months were spent getting input from several different organizations and rules were ultimately developed. The rules did go before the government operations committee before being finalized. The decision was ultimately made to go with the ODG workers' compensation drug formulary.

Ms. Hudgens noted that they did include provisions in the regulations providing for an expedited hearing so if someone was trying to get prescribed an "N" drug and there was a delay about getting it approved, a hearing can be conducted and currently the average is 1.7 days before an answer is given. Interestingly, once people got used to the formulary, now there is only about 1 hearing per quarter. Another provision in the regulations was an absolute requirement that all compound drugs had an "N" rating and had to be reviewed. That provision was implemented because it was identified when reviewing TN statistics that compounded drugs were raising the price of drugs in TN. Ms. Hudgens stated that the most astounding percentage in TN was that compound drug usage went down 90% upon implementation of the formulary.

The reduction in opioids is more difficult to quantify because the state has implemented an aggressive program relating to opioid use and abuse called Tennessee Together. The program states that for acute care you cannot have more than a 3 day fill. Also, in other states they call it a prescription drug monitoring program (PDMP) but in TN it is called a Controlled Substance Monitoring Database Program (CSMD) and its very rigid in that it is not discretionary – doctors must put prescriptions in the system within one day and they must consult the CSMD before they write a prescription. Ms. Hudgens stated that all of these things together have helped TN, and for workers' compensation specifically, the formulary has been effective.

There are a couple of things that are very important to know as to why the formulary has been effective and what some difficulties are. One of the biggest difficulties is getting the word out and helping doctors understand what's coming. Ms. Hudgens stated that a fairly long lead-in time was given in TN before the formulary was effective and that was helpful, but the biggest issue is education in order to try and get the attention of physicians. Additionally, it was important to get assistance from other states. TN relied mainly on 4 other states that had a formulary in addition to the International Association of Industrial Accident Boards and Commissioners (IAIABC) and the Southern Association of Workers' Compensation Administrators (SAWCA). States are sort of one big family when it comes to workers' compensation and that is an important aspect for this committee to consider moving forward with this issue.

Ms. Hudgens stated that morphine equivalents certainly did decrease upon implementation of the formulary. There was also some concern in TN about what would happen to someone who was in some sort of difficulty and they did not get their drugs in time so a feature called a first-fill was implemented which provides those people the ability to get a 7 day prescription regardless. Ms. Hudgens stated that overall, the formulary has worked very well in TN.

Brian Allen, VP of Gov't Affairs at Mitchell, stated that he has been involved in some way in the development of most of the formularies adopted across the country. Mitchell provides a full continuum of services within the workers' compensation system, starting with first reports of injury up to the time the claim is settled, managed pharmacy care, building solutions for pharmacies, and utilization review. Accordingly, Mitchell has experienced workers' compensation drug formularies from many different angles. Mr. Mitchell stated that Texas adopted workers' compensation reform legislation in 2005 but it took until 2011 until the formulary was actually implemented for a number of reasons. From 2011 to 2014, the number of injured workers receiving "N" drugs fell by 83%, and "N" drug prescriptions fell by 85%. Interestingly, other drug prescriptions fell 14% which was believed to be caused by the formulary guiding physicians on more appropriate medications so there was less defensive prescribing going on and more focus on what really works. Additionally, after Texas implemented its formulary, no more changes were made to their pharmacy rules; no changes were made to the fee schedule and no legislative changes dealing with how to prescribe opioids were made. That means there was a stagnant legislative and regulatory environment so the data was very telling. One thing that Texas found was that in 2009 they had over 15,000 people on over 90 morphine equivalents per day and that number fell to less than 500 in 2015.

Mr. Allen stated that Ohio, which has a proprietary formulary, released a study last year which stated that the number of injured workers meeting or exceeding the threshold for being clinically dependent on opioids decreased 59% since 2011. Mr. Allen noted that there are different types of formularies and two are commercially available: ODG, and the American College of Occupational and Environmental Medicine (ACOEM) guidelines. ACOEM has been used in CA and NY. OH, WA, and AR developed their own formularies, with AR utilizing its School of Pharmacy to develop the formulary. Nebraska is currently considering a targeted formulary related only to opioids and that is pending in the legislature.

Mr. Allen then discussed some features that Mitchell believes are key ingredients to workers' compensation drug formularies. Formularies should be evidence based and there should be some proven science behind it. The focus must be on outcomes. If you are not building a formulary that is focused on what is going to be right for the injured workers and what is going to drive good outcomes, you probably should not be building a formulary. It really is all about delivering the best care possible to the injured worker and making sure they get better faster and get back to work or at least achieve the highest level of functionality that they can. Formularies can also control some cost-driving outliers such as physician dispensing, compounded medications, and brand name drugs with generic equivalents. Formularies also should be easy to use. If a physician cannot understand it, it is not going to be used. The formulary should also be accessible to providers and users at little or no cost, and there must be simple utilization review processes along with a dispute resolution procedure.

Ken Eichler, VP of Gov't Affairs at ODG by MCG Health, stated that formularies are actively used in every state. The question is not whether or not to allow them, but rather whether you want to look behind the curtain and legislate and regulate to protect injured workers. The goal of workers' compensation formularies and guidelines is to "do no harm" while improving quality of care and outcomes. The formularies the Committee is discussing are evidence based and they started in Texas and that was because the state asked for an extrapolation from the guidelines into a table for easy lookup by clinical practitioners. The Centers for Disease Control (CDC) and Prevention states that improving the way opioids are prescribed through clinical practice guidelines, which is the basis for formularies, can ensure patients have access to safe, effective treatment while reducing the number of people who misuse, abuse, or overdose from these powerful drugs. The CDC also stresses the importance about informing agencies, providers, and medical/professional organizations about evidence-based practices that can improve patient outcomes.

Mr. Eichler stated that there are two main types of formularies, one of which is the group health commercial model. There, the bottom line is "you get what you pay for." If you buy a stripped-down Hyundai, you will get stripped down drug-coverage. If you buy a top of the line Rolls Royce with every bell and whistle, you will get the best coverage you can and your drugs will be covered. In group health you have covered and non-covered, and tiered drugs. It's black and white and if you don't pay for it you don't get it. Workers' compensation, however, allows for any treatment – and drugs are no more than another form of treatment – that is medically appropriate and causally related to the injury. Prescription benefits for all are available regardless of cost. Preferred drugs generally do not require prior authorization vs. non-preferred drugs which simply require prior authorization with substantiation of the medical necessity. It is important to have legislation with formularies because legislation ensures increased transparency and equal benefits for all instead of individual organizations setting different benefits for different employees. Workers' compensation should be administered level-handedly.

With regard to ODG's formulary, there are currently over 355 drugs which converts to over 45,000 NDC codes – the codes assigned by manufactures. As of March 1, 2019, there were over 168 preferred drugs recommended as first line, and 187 non-preferred drugs requiring substantiation of medical necessity for authorization as a safeguard for injured workers. The goal is to expedite prescriptions for injured workers and expedite improved outcomes. Mr. Eichler stated that during meetings in Indiana with regard to the formulary, labor spoke up saying they supported a formulary because there were so many jobs in Indiana and so many workers that couldn't go back to work simply because they were prescribed opioids, muscle relaxers, and other drugs that created safety-sensitive issues. Therefore, formularies are a labor issue to help people get back to work and allow them to have quality of life. Formularies will also empower medical providers and streamline communications; expedite case specific authorizations and medical reviews (most states are legislating 2 to 3 days as compared to Ms. Hudgens' statement earlier regarding an average of 1.7 days); and decrease transactional processes, friction & costs for all. Formularies are already integrated into most PBM & industry systems, processes and procedures nationwide, thereby minimizing implementation efforts and costs.

Mr. Eichler noted that the preferred drug list does not preclude prescribing of all drugs, it just buckets them into those that may require pre-authorization and basic substantiation. Formularies decrease the adversarial relationship with patients and physicians, enabling

physicians to “just say no” when indicated without fear of backlash. There are documented positive life altering results in multiple states with improved outcomes, function and return to work. There is also a documented decrease in use and abuse of opioids, and with the ODG formulary, there is no cost to the state for posting a complementary “stakeholder use” formulary drug list on the website. There are also measurable outcomes to document program results and benchmark adherence.

Mr. Eichler stated that the entire process is very simple once the formulary is implemented, and it really does not differ that much from what happens without a formulary except it provides stopgaps for authorization. A patient should never have a negative experience of going to the pharmacy and being denied because that negative touchpoint is going to be a downturn in the overall attitude of the claimant and a bad touchpoint for the claim. Mr. Eichler stated that there is a lot of data and research on formularies from organizations such as the Workers’ Compensation Research Institute (WCRI), SAWCA, IAIABC, and NCCI. NCCI actually prices out the impact of formularies for states. NCCI also prepared a study at the request of some states and it shows the potential cost savings. Formularies are not about cost savings but cost savings represents a decrease in the number of drugs prescribed which translates into improved quality of life.

Mr. Eichler stated that Texas is the most closely studied and cited state that has implemented a formulary because Texas does the best job in the country with regard to collecting data as they have the resources and budget to do it. Importantly, Texas currently has more medical providers participating in the workers’ compensation system than ever before and Texas is an opt-in state. Also, in Texas no non-preferred drugs are in the top 10 most-prescribed medications. There are a significant amount of opioids that are preferred drugs that are short-acting so the formulary enables patients to get the right drugs quickly and to avoid the bad drugs. Further, in Texas, the total opioid prescription costs for non-preferred drugs combined with those on the preferred list dropped from \$43.2 million in 2009 to \$18.5 million in 2015. Mr. Eichler closed by noting that there is complementary state stakeholder access to ODG’s formulary on its website.

Joe Guerriero, Sr. VP for MDGuidelines at ReedGroup, stated that ReedGroup is a trusted provider of clinical content, leading edge software, absence management outsourcing services and data analytics to employers, insurers and healthcare organizations. ReedGroup serves over 3,000 clients in multiple sites across the globe including many Fortune 100 companies. ReedGroup is a subsidiary of Guardian Life Insurance Company. The MDGuidelines/ACOEM platform is used by virtually all major group disability insurance carriers as well as many workers’ compensation carriers. Of particular note, in addition to work in the workers’ compensation systems in CA, NY, NV, and TX, ReedGroup’s guidelines and drug formulary are used exclusively in the workers’ compensation programs of the Veterans Administration, the Department of Defense, and Federal Occupation Health. Mr. Guerriero thanks the Committee for inviting ReedGroup to comment on the important work of the Committee.

Mr. Guerriero stated that in the summer of 2014, he was approached by a number of stakeholders in the workers’ compensation industry about the possibility of having ReedGroup publish a drug formulary. Chief among those stakeholders was Dr. Robert Goldberg, MD, FACOEM and Chief Medical Officer at HealtheSystems, a FL-based PBM company. Since there were a handful of formulary options already available for use in the workers’ compensation system, Mr. Guerriero stated that he pushed back and

asked why ReedGroup should go through the time and effort of building a formulary. The replies were all pretty much the same – “the industry should do better on behalf of injured workers”; “what is presently being used in the market may not be medically responsible”; “and that ReedGroup now had the “platform upon which to build a medically responsible, patient-centric formulary.” The platform being referred to was the clinical practice guidelines from the ACOEM which ReedGroup had acquired a year earlier. The ACOEM clinical practice guidelines are both highly respected and widely-used, and would later serve as the foundation for the drug formulary ReedGroup launched in 2015.

Mr. Guerriero stated that the key thing to think about when discussing drug formularies is that the drug formulary in and of itself is basically just, in the traditional sense, a list of drugs. With the assistance of the physicians and Pharm.D’s at HealthSystems, and the research team that builds the ACOEM guidelines at the University of Utah’s Rocky Mountain College of Occupation and Environmental Medicine, ReedGroup began building a formulary based on the premise that determining the clinical appropriateness of drug therapy is not merely a matter of sorting the good apples from the bad.

ReedGroup believed that whether or not a drug is appropriate depends as much on the patient and the specifics of their injury as it does the risk-benefit profile of the drug itself. Even ibuprofen, a drug that in many instances is a safe option for pain management, can have serious or even fatal adverse effects if prescribed at excessive doses or for the wrong patient. As Dr. Goldberg stated during the early stages of building the formulary, “there is nothing wrong with a red delicious apple, but if you try baking it in a pie, it will fall apart.” His point was that decisions regarding prescription drug therapy must be made in the right context, or the outcome may be less than optimal. With that in mind, ReedGroup constructed its ACOEM-based formulary in a manner that ties drug recommendations to the injured or ill workers’ condition and phase of treatment. Mr. Guerriero stated that ReedGroup’s approach towards a drug formulary is that the most responsible drug formulary that one can look at adopting or including in overall legislation is one that really takes to heart the relationship between the doctor and patient that is sacrosanct.

Robert Nydam, Project Director at MAXIMUS, stated that one of the main things that MAXIMUS does is provide healthcare dispute resolution services to government entities across the country both at the state and federal level. Since the inception of the Medicare Part D prescription drug program, MAXIMUS has run the appeals program. MAXIMUS also administers the independent medical review (IMR) program associated with workers’ compensation in CA. With regard to the CA IMR program, as of January 1, 2018, CA adopted a prescription drug formulary for workers’ compensation. Accordingly, there is now data available a year into the program. It is still too early to draw any conclusions but what MAXIMUS has seen thus far is that in 2016 and 2017 the number of healthcare appeals in workers’ compensation associated with opioids ran about 13% of IMR appeals. In 2018, that number went up slightly to 14% but the takeaway is that when you first introduce a formulary you can expect some new friction as you have to give folks time, especially on the provider side, to adjust.

Mr. Nydam stated that it is important to understand what a formulary is and is not. At its most basic level, it is a list of drugs and to be successful a formulary really must be part of a system. A set of evidence-based guidelines alongside a formulary is essential. A good analogy is that if you have a recipe and all you have is a list of ingredients but no

instructions on how to cook the meal, the meal will probably not taste good. Another aspect to consider when introducing a formulary is that MAXIMUS believes it is vital for states to have a dispute resolution process in place. A formulary is going to provide you with a path of what is true and proper for the large majority of patients but there are going to be exceptions and you need to have a process for those exceptions to be presented and considered; if not, the risk is that someone's unique clinical situation is not going to get the attention that it deserves. A dispute resolution program also provides those in the provider community who may have concerns about the introduction of a formulary the opportunity to be heard.

Sen. Bob Hackett (OH) stated that he is a strong supporter of the formulary but what made OH successful with it was that the prescriptive authority of physicians was lowered. Mr. Allen stated that OH was ground zero for the opioid epidemic and noted that the formulary coupled with the prescriptive authority was important. Mr. Allen noted that Texas did not change its prescribing authority and only implemented the formulary which shows that there are different options for different states depending on the state's needs. There is no silver bullet to combat the opioid crisis. Sen. Hackett stated that OH first started with acute pain provisions only and then introduced chronic pain provisions later. Mr. Allen stated that typically happens and a good analogy is that of a lake filled with people addicted to opioids. You can't drain the lake until you dam the river feeding the lake so you have to go after acute pain first to slow it down and then you have time to go after chronic pain.

Mr. Eichler stated that ODG has heard from state legislators that when drafting a formulary bill it is important not to create conflicts in the prescribing laws because it will end up in a legal battle and that will undermine the formulary. The formulary can give recommendations but it does not control medical provider licensure and accordingly it has to defer on that.

Rep. Lehman closed by stating that the discussion held today was very valuable and hopefully by the Summer Meeting in July a new version of the Model can be ready and discussed for the Committee to agree upon.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON NATURAL DISASTER RECOVERY
INTERIM COMMITTEE CONFERENCE CALL
JUNE 3, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Natural Disaster Recovery held an interim meeting via conference call on Monday, June 3, 2019 at 10:00 a.m.

Senator Dan “Blade” Morrish (LA), NCOIL President and Acting Chair of the Committee, presided.

Other members of the Committees present were:

Rep. David Santiago (FL)
Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)

Sen. Vickie Sawyer (NC)
Sen. Thomas Alexander (SC)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Jennifer Webb (FL)
Del. Courtney Watson (MD)

Also in attendance were:

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

DISCUSSION ON COMMITTEE COURSE OF ACTION REGARDING THE PRIVATE FLOOD INSURANCE MARKET

Senator Dan “Blade” Morrish (LA) – NCOIL President and Acting Chair of the Special Committee on Natural Disaster Recovery (Committee)– thanked everyone for joining and noted the importance and timeliness of the Committee’ meeting. Sen. Morrish stated that the Committee had a very productive inaugural meeting at the NCOIL Spring Meeting in Nashville, Tennessee. In addition to thoroughly discussing the proposed amendments to the existing NCOIL State Flood Disaster and Mitigation Relief Model Act (Model) that aim to facilitate expansion of the private flood insurance market, the Committee voted without objection to adopt a Resolution Sen. Morrish sponsored Recognizing September 1st to 7th, 2019 as “Natural Disaster Resiliency Week” which several states have adopted.

Sen. Morrish stated that the purpose of the Committee’ meeting today is to consider how the Committee would like to proceed regarding the proposed amendments to the Model concerning the private flood insurance market which are sponsored by Florida Representative David Santiago (FL). Sen. Morrish asked Rep. Santiago to comment on the proposed amendments.

Rep. Santiago thanked everyone for joining and noted that during the Committee's meeting in Nashville there was some conversation regarding converting the proposed amendments to the Model to a Resolution. Rep. Santiago stated that he neither accepted or rejected that course of action, and after speaking with NCOIL staff he thought it would be best for the Committee to decide whether to proceed with the proposed amendments or develop a Resolution. Rep. Santiago noted that he offered the proposed amendments to the Model, which are based on existing Florida law, mainly because the Florida law is working well and is worthy of having the country examine.

Sen. Morrish stated that if the Committee decides to move forward with the proposed amendments to the Model, he is not sure that they have been vetted completely. Sen. Morrish asked Rep. Santiago for his thoughts on which course of action he would like the Committee to take. Rep. Santiago stated that in conversations with industry representatives, his major sticking point with their proposals is that they do not want to have prior approved form requirements. Rep. Santiago stated that he believes the prior form approval requirement in Florida is a main reason why its private flood insurance market has been so successful and able to work with the National Flood Insurance Program (NFIP) and mortgage lenders as they review the private flood insurance product. Form approval or some type of form consensus would help the marketplace feel comfortable that at least some legislative or governmental body has looked at the product to make sure that it at least meets the minimum standards of the NFIP. Rep. Santiago stated that such a process has worked in Florida and he would welcome the opportunity to talk to Committee members at the NCOIL Summer Meeting to present facts and figures about the flourishing Florida private flood insurance market. Rep. Santiago also noted that Florida does not regulate the private flood insurance market rates and he is not opposed to that being mirrored in any model legislation.

Sen. Morrish stated that from his perspective, if the Florida private flood insurance market is indeed flourishing, then clearly something was done right and Florida's laws should be examined by the Committee. Rep. Santiago stated that the non-admitted flood insurance market in Florida is also flourishing so it is important to note that everything can co-exist: the NFIP, the admitted market with form approval, and the non-admitted market. Sen. Morrish stated that it will be important to work closely with the NFIP as the issue of leaving the NFIP to go to the private flood insurance market and not being able to return to the NFIP still exists. That issue certainly needs to be addressed at the federal but should also be part of the Committee's discussions. Sen. Morrish then asked if any other legislators present would like to comment.

Indiana Representative Matt Lehman, NCOIL Vice President, thanked Sen. Morrish and Rep. Santiago for their leadership on this issue and noted that the issue of private flood insurance market reform is a heavy lift. Rep. Lehman stated he embraces more private market involvement in this area as the NFIP has failed in his opinion. Rep. Lehman noted that industry has said that in order for the private flood insurance market to work most effectively things like rate and underwriting freedom should be implemented, similar to how the commercial lines market operates. Rep. Lehman further stated that the proposed amendments currently use the word "may" instead of "shall" in several places, which is fine, but may result in the model, if adopted, not having much teeth. Rep. Lehman also stated that the requirement in the proposed amendments for an agent to provide written evidence of a signed rejection of flood coverage would be the only such requirement in personal lines insurance today. It is done with terrorism and cyber coverage, but not with any personal lines. Rep. Lehman stated that such a requirement

may be an undue burden on agents and asked for feedback on how the agent community has reacted in Florida. It is important to protect against possible errors & omissions issues for agents who are trying to get clients into the private flood insurance market.

Rep. Santiago stated that he does not recall the legislation passed in Florida containing the agent duties mentioned by Rep. Lehman, but his recollection is that on Florida forms there is a stipulation in bold text stating that typical homeowner policies do not cover flood events. Rep. Santiago also stated that he is certainly open to conversations about any amendments to the agent section of the proposed amendments, and that he does not recall the agent community in Florida opposing the legislation. Rep. Santiago further stated that changes to Florida forms were made this year to clear up certain discrepancies that were arising between the aforementioned statement that the homeowner policy does not cover flood and the fact that private flood insurers were in fact covering flood as an addendum.

Rep. Lehman stated that in Indiana, agents go through homeowners policies to with prospective insureds to make clear that flood coverage is excluded. However, the requirement in the proposed amendments for agents to provide written evidence of explaining to the applicant the NFIP and private market alternatives to flood insurance coverage may be difficult to comply with. Rep. Santiago stated Rep. Lehman's point is worth examining. Rep. Lehman further stated that there have also been a lot of problems with floodplains. There are situations where a garage must have flood coverage because it is in the floodplain, but the house is in the floodplain and therefore needs coverage. A policy for the house that included the garage could have been obtained for less than a garage-only policy, but the bank would not allow it citing legal restrictions. Local governments should be given more flexibility in situations like that. Rep. Lehman closed by stating that he likes the much of the substance of the proposed amendments but believes some things will have to be tweaked. Rep. Santiago agreed.

Texas Representative Tom Oliverson, M.D., stated that after Hurricane Harvey it was realized that so many people did not realize they did not have flood coverage. Rep. Oliverson stated that he understood the points made by Rep. Lehman regarding putting a burden on agents, but the most critical thing is for people to be informed at the time they are purchasing coverage for their property whether they have coverage for flood. In Texas, it was important to close that loophole to no longer have situations where people simply were not aware they did not have flood coverage. Therefore, going forward in Texas, there will be disclosure requirements as to whether a homeowner policy includes coverage for flood, and if not, how to obtain such coverage.

Sen. Morrish stated that based on the conversation thus far he believes the Committee should proceed with developing the proposed amendments to the Model rather than developing a Resolution. Sen. Morrish stated that he realizes that it may be a heavy lift, but it would be ideal to have the amendments completed and voted upon by the NCOIL Annual National Meeting in December. Rep. Santiago stated that he supports that plan.

The Honorable Tom Considine, NCOIL CEO, stated that executing that plan within that timeframe should not be a problem but requested that the Committee not make a formal decision on which course of action to take until it hears from interested parties present. Sen. Morrish agreed.

Ron Jackson of the American Property Casualty Insurance Association (APCIA) stated that APCIA is happy to participate in these discussions as the issue of the growth of the private flood insurance market is indeed a popular one. Mr. Jackson noted that the language in the proposed amendments relating to prior form approval and catastrophe modeling are sticking points for APCIA. APCIA's members write a significant amount of flood coverage including the vast majority of the companies listed on the Florida's Office of Insurance Regulation's website. Mr. Jackson stated that APCIA does not necessarily agree that the increased flood writings in Florida are occurring because there is prior approval of forms. Rather, the rate flexibility facilitated the growth. If you look at the vast majority of the business in Florida on a nationwide basis on the private side residing in the surplus lines market really speaks to the need for both rate and form flexibility to drive the issuance coverage for the risk of flood. APCIA looks forward to discussing those issues further.

Rep. Santiago stated that as a retail insurance agent in Florida, whenever he pitched private flood insurance to a consumer so many questions arise. Rep. Santiago stated that in discussion with industry on these issues, he has no problem with rating freedom, but having some type of either form approval or form filing is needed. Rep. Santiago stated that industry stated it would work on providing some type of form filing language prior to the NCOIL Summer Meeting in July. Rep. Santiago stated that he is open to such language that states the coverage meets or exceeds NFIP standards.

Wes Bissett of the Independent Insurance Agents and Brokers of America (IIABA) thanked Sen. Morrish and Rep. Santiago for bringing this issue forward as the IIABA believes it is important to bolster the private flood insurance market. With regard to whether the Committee should move forward with the proposed amendments or develop a Resolution, Mr. Bissett stated that IIABA does not have a strong position as it believes the vehicle is far less important than the substance of what a model law or resolution might say. With regard to the proposed amendments, IIABA has very strong concerns with Section 4 – Duties of an Agent – as it is vague, subjective, troubling and unclear as to how a typical agent could meet the burdens imposed. Mr. Bissett stated that IIABA is certainly willing to discuss amendments to that section. Sen. Morrish thanked Mr. Bissett for his comments and stated that it is his understanding that everything in the proposed amendments are subject to change as it is important to arrive at the best possible final work product.

Dennis Burke of the Reinsurance Association of America (RAA) stated that RAA supports NCOIL seeking to facilitate consumer choice in flood insurance coverage but opposes the proposed amendments. Mr. Burke noted that RAA supported passage of the Florida legislation, which the proposed amendments are based on, but opposes the that legislation as a national model because the legislation is Florida-centric and not appropriate on a nationwide basis. Mr. Burke stated that RAA looks forward to working with NCOIL throughout the process to address any issues. With regard to form approval, RAA's members do not file forms since they are reinsurers but it is important to be aware that one of the form approval issues dealt with an early bank regulator proposal that would have had the insurance department certify that the forms were as broad as the NFIP. That regulation is no longer on the table as banking regulators have finalized their proposal and the rule does not require regulator certification anymore. It would be helpful for the Committee to discuss that rule. The market largely developed with an "as broad as" endorsement and the current regulation permits that. NFIP

reauthorized for 2 weeks, not 2 years. Mr. Burke closed by stating he looks forward to working on these issues with NCOIL going forward.

Paul Martin of the National Association of Mutual Insurance Companies (NAMIC) stated that when discussing the issue of the lack of private flood insurance with NAMIC members, the real issue being discussed is a lack of capital in the flood market. NAMIC believes that capital is already coming and will continue to come with or without any reaction by NCOIL because the market continues to develop organically. NAMIC is not hearing anyone say, on this line of insurance or any other line of insurance, is that if form approval was required more capital would come into the marketplace. Mr. Martin stated that there may be capital coming into the Florida marketplace with form approval, but NAMIC believes that is a form or correlation, not causation. Mr. Martin noted that in earlier meetings with Rep. Santiago, industry pointed out that the private flood insurance market is nascent, still developing, and growing organically across the country with or without any type of model laws. At some point, as the market grows, there may very well be a need for a model law but NAMIC does not believe that point in time has arrived yet. NAMIC would prefer to see a Resolution outlining some best practices to encourage states to remove any regulatory barriers that may exist currently and to let the market flourish organically. As the market matures, then it would be an opportune time to discuss development of a model law based on more market experience.

Rep. Santiago stated that he understands that there may not be any causation between form approval and capital entry, but it is important to keep in mind that form approval is a form of consumer protection.

John Ashenfelter of State Farm first stated that State Farm is supportive of the Committee moving forward with the development of a Resolution rather than a model law. Mr. Ashenfelter stated that it is important to be reminded of the NFIP's huge debt of \$20 billion dollars. If that type of burden was placed on the private market it would be significant and would probably cause some carriers to face insolvency issues. Therefore, unless there is rate, form, and underwriting freedom, along with a very strong emphasis on loss mitigation measures, the likelihood of a hit upon the guaranty funds for property and casualty is significant, especially due to the increased prevalence of flood events – both coastal and inland.

Mr. Ashenfelter stated that he believes the Model in its current form already has a disclosure requirement for those writing homeowners insurance to disclose whether the policy covers flood. Many states have adopted that sound disclosure provision which protects consumers. Mr. Ashenfelter agreed with Mr. Bissett and Rep. Lehman's statements that obtaining a rejection is burdensome for agents especially in today's market where an agent may be able to write the policy via online or via the telephone. Mr. Ashenfelter noted that the proposed amendments require approval of the flood modeling that is used which can be very complicated and detrimental to ensuring the adequacy of rates. When models are in flux and dynamic as they are year to year based upon the events that have occurred, getting behind the curve on modeling because of an approval process could be very damaging for rate adequacy for private flood insurance.

Mr. Ashenfelter stated that he believes what will probably start to be seen is that the surplus lines market - where many form, approval, and underwriting restrictions do not exist - will be where the private flood insurance market can thrive. Mr. Ashenfelter stated that while it would be very beneficial if all 50 states adopted the NCOIL flex-rating

model, many states have not done so. Also, with regard to underwriting, restrictions such as being stuck on a risk in perpetuity could be disastrous in a flood situation particular in states like Florida which has seen multiple flood events in one year. Mr. Ashenfelter closed by reiterating that State Farm is supportive of the committee moving forward with a resolution in part because there are so many difference among the states, and in part because a resolution gets across the point that the private flood insurance market is important to the overall health of the country in terms of protection from flooding events, knowing that not everyone can insure it in light of the significant losses the flood market has faced through the NFIP.

Amy Bach of United Policyholders (UP) stated that it is important to remember that the NFIP was in the black for most of its existence until Hurricane Katrina. Additionally, there are only about 5 million households in the NFIP and therefore it should be a goal shared by everyone to increase the number of homes with non-compulsory flood insurance coverage. Ms. Bach stated that form regulation is something that should not be thrown out the window. While a competitive flood insurance market is important in order to give consumers options outside of the NFIP, the states need to have some baseline below which a basic flood insurance policy cannot fall beneath. Situations that would result in short-term flood insurance policies and products being purchased that people believe give them protection but really don't should be avoided. Ms. Bach stated that one of the most important things that NCOIL can do is to seek to ensure a baseline for what flood insurance coverage must contain. To abandon that in the interest of stimulating competition could result in significant blowback from constituents.

The Honorable Ted Nickel, former Wisconsin Insurance Commissioner and National Association of Insurance Commissioners (NAIC) President, stated that it would be a mistake for NCOIL to not seize the moment and continue the work it is doing with regard to developing model legislation that would facilitate growth of the private flood insurance market. Cmsr. Nickel stated that as a former regulator, consistency is always ideal and that is why it is important for NCOIL to continue its work and work out any issues to develop a model that states can adopt. States can then always take the model and tailor it to the needs of their markets.

Cmsr. Nickel stated that he believes it is important to be upfront with a model law and have a framework in place rather than having a wild-west atmosphere resulting in state legislators and regulators have to corral it all. Cmsr. Nickel stated that it would be ideal for NCOIL to continue its work and have something ready for adoption by the NCOIL Annual Meeting in December. Cmsr. Nickel further stated that it would be great to have more direct writers in the marketplace, and he has heard from his own agents that they would love to have more direct writers and more options for consumers. Ultimately, this is about protecting consumers and enabling them to have more options to purchase flood products at prices they can afford. The private flood insurance market can meet those goals.

Lisa Miller, President of Lisa Miller & Associates and former Florida Deputy Insurance Commissioner, stated that in June of last year several interested parties who were involved in passing the Florida private flood insurance legislation met and adjusted that legislation into the proposed amendments that are currently before this Committee. Ms. Miller stated that she recently met with catastrophe model representatives which resulted in making some suggested changes to the proposed amendments which she will send to Rep. Santiago for consideration.

Ms. Miller stated that with regard to the discussion about agent requirements, Florida started with a requirement for agents to have a conversation with a customer of that customer was in a special flood-hazard area. There was significant pushback to that which was troubling because many believed that the requirement would separate the profession into two buckets: those that are meeting their responsibilities as an agent and leading their communities in understanding risk; and those that are scared of such requirements. Ms. Miller stated that she is hopeful she can work with IIABA and stated that requirements are not burdens but rather responsibilities and many agents take those professional responsibilities very seriously. Ms. Miller further stated that she believes the proposed amendments have a chance to make a difference in the marketplace and that prior form approval would give regulators the ability to better protect consumers.

ANY OTHER BUSINESS

Sen. Morrish then announced the appointment of North Carolina Senator Vickie Sawyer as Chair of the Committee for the remainder of the year. Sen. Morrish stated that he is very excited to have Sen. Sawyer Chair the Committee as she is a very active and dedicated legislator.

Sen. Sawyer thanked Sen. Morrish and stated that she is looking forward to this opportunity. Sen. Sawyer stated that as a retail insurance agent and as a state Senator from a state that has been hit hard by flood events these issues are very important to her.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
OKLAHOMA CITY, OK
DECEMBER 6, 2018

The National Council of Insurance Legislators (NCOIL) Business Planning and Budget Committee met at the Renaissance Oklahoma City, on Thursday, December 6 at 5:15 p.m.

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

MEMBERS OF THE COMMITTEE PRESENT:

Sen. Jason Rapert (AR)
Sen. Dan "Blade" Morrish (LA)
Rep. Steve Riggs (KY)

OTHER LEGISLATORS PRESENT;

Asm. Ken Cooley (CA)
Rep. Martin Carbaugh (IN)
Sen. Gary Dahms (MN)
Rep. Tom Oliverson (TX)
Rep. Joe Schmick (WA)
Sen. Paul Utke (MN)

ALSO PRESENT:

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

Rep Lehman called the meeting to order.

A motion was made by Rep. Riggs and seconded by Sen. Rapert to approve the minutes of the Salt Lake City on July 12th.

Penna went over the budget showing support and revenue of \$1,152,000 and expenses of \$1,060,524.10 for an excess of \$91,475.90.

Sen Rapert made a motion to adopt the 2019 budget that Asm Cooley seconded. The motion carried on a voice vote.

UPDATED BUDGET MODEL

Rep Lehman stated that he sits on the legislative council in Indiana which approves spending. And routinely CSG and NCSL cost his state between \$425,000 for one organization and \$250,00 for the other. NCOIL last raised dues increased in 2002 and he believes that NCOIL should increase dues to \$20,000, beginning in 2020 because the organization has moved in a direction that has become more efficient in how it works. It

is laser focused on insurance. Also, raising the dues enhances the organizations' significance.

Lehman told the story of Y2K and Amish lanterns. They cost suppliers \$3 to make and were selling for \$10 and no one was purchasing them. The price was raised to \$20 each and they sold out because of the perception of value. He stated he sees good things happening at NCOIL and a dues increase gives states more of a reason to participate, and if NCOIL lost 25 percent it would still break even. He then introduced the stipend concept and turned it over to Commissioner Considine to introduce.

Commissioner Considine stated that we've discovered dues are too low. Even when we have contributing states there is a lack of legislator participating because they have to pay out of own pocket or use campaign funds, where permissible and other organizations like NCSL provide stipends. We like the idea of increased value and increase participation of dues funding 2 legislators per state per meeting. This would create a much more vibrant participation and an upward spiral among all levels from commissioners, state trades and participants. That of course leads to a larger audience and great cross-section of participation.

Rep. Riggs stated he loves the concept. It gives the states some money back to send participants. He asked how we thought it would affect states that send more legislators.

Rep. Lehman stated he thought that it would not affect states that come more often because we're not talking about spending big dollars and many interested legislators will not get the stipend. Might go ranking from minority party

Rep. Oliverson stated that if 3 legislators come to every meeting from the House and 3 from the Senate they could rotate who gets the stipend and the total cost will be less for everyone.

Rep. Riggs wanted to make sure that it was explained to the states and Rep. Lehman stated that we would be sending a letter with the 2019 dues – which remain the same amount at \$10,000 - stating this is effective with the 2020 dues.

Sen. Rapert stated he appreciate efforts and is supportive of the dues increase if it brings more legislators in to participate. Not every state has a problem sending legislators. He noted that he and Rep. Ferguson consistently come to NCOIL meetings. NCOIL has been showing new value and breathed life back into the organization. He has seen the organization grow. The purpose of this not to build coffers but to offer more services and develop more members and it's a great and noble goal. He cautioned that there might be a few impediments to come and weigh through compliance issues but he supports it.

Sen. Morrish is supportive and stated it best serves NCOIL. Even with a 20 percent decrease will still see more legislators.

Rep. Lehman noted that the scholarship program still exists and will be available to draw more legislators to participate.

Asm. Cooley stated that this is a program of innovation. He stated he had her the church sermon when he was 18 that asked did anyone know the last 7 words of the church?

The answer – “We’ve never done it that way before”. Part of a healthy organization is to promote value and innovate; this strengthens the role of NCOIL.

A motion was made by Asm. Cooley and seconded by Rep. Carbaugh and carried on a voice vote.

There being no other business the committee adjourned at 5:46.