

**30 DAY MATERIALS* AND TENTATIVE GENERAL
SCHEDULE
NCOIL SPRING MEETING
MARCH 5 - 8, 2020**

As of February 5, 2020, and Subject to Change



**Charlotte Marriott City Center
Charlotte, North Carolina**

****Pursuant to NCOIL Bylaws Section III.G.1., If a document or substantive amendment to a document is not submitted prior to the 30-day deadline, it shall be subject to a two-thirds vote for Committee consideration and a separate two-thirds vote for adoption. This section of the NCOIL bylaws is intended to provide advance notice of the matters and items on which NCOIL will vote; it is not intended to limit germane amendments that arise during a discussion. Such germane amendments shall not trigger a supermajority vote.***



NCOIL SPRING MEETING
 Charlotte, North Carolina
 March 5 - 8, 2020
 TENTATIVE SCHEDULE

THURSDAY, MARCH 5TH

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

Registration	7:00 a.m.	-	6:00 p.m.
<i>Exhibits Open: 8:00 a.m. – 6:45 p.m.</i>			

Welcome Breakfast	8:15 a.m.	-	9:30 a.m.
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Networking Break	9:30 a.m.	-	9:45 a.m.
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General Session LIBOR's End: What Does it Mean?	9:45 a.m.	-	11:00 a.m.
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Property & Casualty Insurance Committee	11:00 a.m.	-	12:15 p.m.
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The Institutes Griffith Foundation Legislator Luncheon Considering the Economic Impact of the Insurance Industry on the States: An Overview for Public Policymakers (Open to Public Policymakers Only)	12:15 p.m.	-	1:15 p.m.
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NCOIL – NAIC Dialogue	1:15 p.m.	-	2:30 p.m.
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Special Committee on Natural Disaster Recovery	2:30 p.m.	-	3:30 p.m.
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Networking Break	3:30 p.m.	-	3:45 p.m.
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Life Insurance & Financial Planning Committee	3:45 p.m.	-	5:00 p.m.
Joint State-Federal Relations & International Insurance Issues Committee	5:00 p.m.	-	6:00 p.m.
Adjournment	6:00 p.m.		
Reception	6:00 p.m.	-	7:00 p.m.

SATURDAY, MARCH 7TH

Registration <i>Exhibits Open: 8:30 a.m. – 4:30 p.m.</i>	8:00 a.m.	-	4:00 p.m.
Health Insurance & Long Term Care Issues Committee	9:00 a.m.	-	10:45 a.m.
Networking Break	10:45 a.m.	-	11:00 a.m.
General Session What States Preparing for Opioid Lawsuit Funds Can Learn from Tobacco Settlements	11:00 a.m.	-	12:15 p.m.
Luncheon with Keynote Address	12:15 p.m.	-	1:45 p.m.
Legislative Micro Meetings	1:45 p.m.	-	2:15 p.m.
Workers' Compensation Insurance Committee	2:15 p.m.	-	3:30 p.m.
Adjournment	3:30 p.m.		
IEC Board Meeting	3:30 p.m.	-	4:15 p.m.

SUNDAY, MARCH 8TH

Registration <i>Exhibits Open: 8:15 a.m. – 10:00 a.m.</i>	8:00 a.m.	-	10:00 a.m.
Financial Services & Multi-Lines Issues Committee	8:45 a.m.	-	10:00 a.m.
Business Planning Committee and Executive Committee	10:00 a.m.	-	11:00 a.m.
Adjournment	11:00 a.m.		



*****Please note all speakers listed are scheduled to speak as of February 5, 2020. There may be modifications between now and the start of the Meeting.*****

THURSDAY, MARCH 5, 2020

CIP Member & Sponsor Reception
Thursday, March 5, 2020
6:30 p.m. – 7:30 p.m.

FRIDAY, MARCH 6, 2020

Welcome Breakfast
Friday, March 6, 2020
8:15 a.m. – 9:30 a.m.

- 1.) Welcome to Charlotte
The Hon. Mike Causey, Commissioner – North Carolina Department of Insurance
- 2.) **Rep. Matt Lehman (IN) – NCOIL President**
 - a.) President's Welcome
 - b.) New Member Welcome and Introduction
- 3.) Comments from NCOIL CEO
Hon. Tom Considine
- 4.) Any Other Business
- 5.) Adjournment

Networking Break
Friday, March 6, 2020
9:30 a.m. – 9:45 a.m.

General Session
LIBOR's End: What Does it Mean?
Friday, March 6, 2020
9:45 a.m. – 11:00 a.m.

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

*Sam Warren
Head of Advisory
Brean Strategic Advisors*

**Property & Casualty Insurance Committee
Friday, March 6, 2020
11:00 a.m. – 12:15 p.m.**

*Chair: Rep. Richard Smith (GA)
Vice Chair: Rep. Tom Oliverson, M.D. (TX)*

- 1.) Call to Order/Roll Call/Approval of December 13, 2019 Committee Meeting Minutes
- 2.) Continued Discussion on NCOIL E-Scooter Insurance Model Act
***Sen. Jerry Klein (ND) – NCOIL Chairman At-Large – Sponsor
National Association of Mutual Insurance Companies (NAMIC) Representative
Bird Representative
Lime Representative***
- 3.) Presentation from the Insurance Institute for Business & Home Safety (IBHS)
Debra Ballen, General Counsel & Chief Risk Officer – IBHS
- 4.) Discussion on NAIC Casualty Actuarial & Statistical Task Force (CASTF) Initiatives
***The Hon. Nat Shapo, Partner – Katten Muchin Rosenmann LLP; Former Director of the
Illinois Department of Insurance
Brian Fannin, Research Actuary – Casualty Actuary Society (CAS)***
- 5.) Any Other Business
- 6.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon

**Friday, March 6, 2020
12:15 p.m. – 1:15 p.m.**

**Considering the Economic Impact of the Insurance Industry on the States: An Overview for
Public Policymakers**

*James M. Carson, Ph.D.
Daniel P. Amos Distinguished Professor of Insurance
Terry College of Business – University of Georgia*

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

**NCOIL – NAIC Dialogue
Friday, March 6, 2020
1:15 p.m. – 2:30 p.m.**

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

- 1.) Call to Order/Roll Call/Approval of December 12, 2019 Committee Meeting Minutes
- 2.) Update on NAIC Suitability in Annuity Transactions Model Regulation
- 3.) Update on NAIC Pet Insurance Working Group
- 4.) Follow-up Discussion on NAIC Casualty Actuarial & Statistical Task Force (CASTF) Initiatives
- 5.) Update on NCOIL and NAIC Rebate Reform Initiatives
- 6.) Discussion on Rutledge v. PCMA and ERISA Preemption
- 7.) Any Other Business
- 8.) Adjournment

Special Committee on Natural Disaster Recovery
Friday, March 6, 2020
2:30 p.m. – 3:30 p.m.

Chair: Sen. Vickie Sawyer (NC)

- 1.) Call to Order/Roll Call/Approval of December 11, 2019 Committee Meeting Minutes
- 2.) Continued Discussion of NCOIL Private Flood Insurance Model Act
Rep. David Santiago (FL) – Sponsor
Wes Bissett, Senior Counsel, Gov't Affairs – Independent Insurance Agents & Brokers of America (IIABA)
- 3.) Presentation on Natural Disaster Mitigation Efforts
Lynne Grinsell, Asst. VP, Gov't & Industry Affairs – Zurich North America
Gina Schwitzgebel-Hardy, CEO/General Manager - North Carolina Joint Underwriting Ass'n (NCJUA); North Carolina Insurance Underwriting Ass'n (NCIUA)
- 4.) Any Other Business
- 5.) Adjournment

Networking Break
Friday, March 6, 2020
3:30 p.m. – 3:45 p.m.

Life Insurance & Financial Planning Committee
Friday, March 6, 2020
3:45 p.m. – 5:00 p.m.

Chair: Asw. Maggie Carlton (NV)
Vice Chair: Asm. Andrew Garbarino (NY)

- 1.) Call to Order/Roll Call/Approval of December 12, 2019 Committee Meeting Minutes
- 2.) Reforming the Life Insurance Application Process
Porter Nolan, Head of Legal – Ethos

3.) Life Insurance Underwriting 101

Dr. Robert Gleeson, Medical Consultant – American Council of Life Insurers (ACLI)

4.) Introduction of Paid Family Leave Income Replacement Benefits Model Act

American Council of Life Insurers (ACLI) Representative

5.) Any Other Business

6.) Adjournment

Joint State-Federal Relations & International Insurance Issues Committee

Friday, March 6, 2020

5:00 p.m. – 6:00 p.m.

Chair: Sen. Bob Hackett (OH)

Vice Chair: Sen. Roger Picard (RI)

1.) Call to Order/Roll Call/Approval of December 12, 2019 Committee Meeting Minutes

2.) Consideration of NCOIL Insurance Business Transfer (IBT) Model Act

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

American Council of Life Insurers (ACLI) Representative

3.) Consideration of Proposed Amendments to NCOIL Market Conduct Surveillance Model Act

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

4.) Briefing on NCOIL Comment Letter on The Department of Housing and Urban Development's Disparate Impact Rule

The Hon. Tom Considine, NCOIL CEO

The Hon. Nat Shapo, Partner – Katten Muchin Rosenmann LLP; Former Director of the Illinois Dep't of Insurance

5.) Any Other Business

6.) Adjournment

Reception

Friday, March 6, 2020

6:00 p.m. – 7:00 p.m.

SATURDAY, MARCH 7, 2020

Health Insurance & Long Term Care Issues Committee

Saturday, March 7, 2020

9:00 a.m. – 10:45 a.m.

Chair: Asw. Pam Hunter (NY)

Vice Chair: Rep. Deborah Ferguson (AR)

1.) Call to Order/Roll Call/Approval of December 11, 2019 Committee Meeting Minutes

2.) Making the Switch from Fee-for-Service to Managed Care: An Update on North Carolina's Medicaid Transformation

Jean Holliday, Sr. Program Manager, Division of Health Benefits – North Carolina Dep't of Health and Human Services

- 3.) Continued Discussion of NCOIL Short Term Limited Duration Insurance (STLDI) Model Act
Rep. Martin Carbaugh (IN) – Sponsor
- 4.) Discussion on NCOIL Patient Dental Care Bill of Rights Model Act
Rep. George Keiser (ND) – Sponsor; Rep. Deborah Ferguson (AR) – Co-Sponsor
Chad Olson, Director, State Gov't Affairs – American Dental Ass'n (ADA)
National Ass'n of Dental Plans (NADP) Representative
American Council of Life Insurers (ACLI) Representative
- 5.) Discussion on NCOIL Vision Care Services Model Act
Sen. Bob Hackett (OH) – Sponsor
National Ass'n of Vision Care Plans (NAVCP) Representative
American Optometric Ass'n (AOA) Representative
- 6.) Continued Discussion on NCOIL Health Care Sharing Ministry (HCSM) Registration Model Act
Rep. Martin Carbaugh (IN) – Sponsor
Scott Reddig, CEO – Christian Care Ministry
Stuart Lark, Sherman & Howard L.L.C. – General Counsel to Christian Care Ministry
- 7.) Any Other Business
- 8.) Adjournment

Networking Break

Saturday, March 7, 2020

10:45 a.m. – 11:00 a.m.

General Session

What States Preparing for Opioid Lawsuit Funds Can Learn from Tobacco Settlements

Saturday, March 7, 2020

11:00 a.m. – 12:15 p.m.

Moderator: Asw. Pam Hunter (NY)

Adam Kintopf
Director of Strategic Communications
ClearWay Minnesota

Ryan Hampton
Organizing Director
Recovery Advocacy Project

Creighton Drury
CEO
Center on Addiction

Luncheon with Keynote Address

Saturday, March 7, 2020

12:15 p.m. – 1:45 p.m.

Legislative Micro Meetings

Saturday, March 7, 2020

1:45 p.m. – 2:15 p.m.

Facilitator: Hon Tom Considine, NCOIL CEO

Workers' Compensation Insurance Committee

Saturday, March 7, 2020

2:15 p.m. – 3:30 p.m.

Chair: Rep. Bart Rowland (KY)

Vice Chair: Sen. Paul Utke (MN)

- 1.) Call to Order/Roll Call/Approval of December 12, 2019 Committee Meeting Minutes
- 2.) Innovation in the Workers' Compensation Insurance Marketplace – A Presentation from Pie Insurance
John Swigart, CEO – Pie Insurance
Teri Leon, General Counsel – Pie Insurance
- 3.) Scenarios for the 2030s: Threats and Opportunities for Workers' Compensation Systems
Richard Victor, Ph.D., Sedgwick Fellow – The Sedgwick Institute
- 4.) Any Other Business
- 5.) Adjournment

IEC Board Meeting

Saturday, March 7, 2020

3:30 p.m. – 4:15 p.m.

SUNDAY, MARCH 8, 2020

Financial Services & Multi-Lines Issues Committee

Sunday, March 8, 2020

8:45 a.m. – 10:00 a.m.

Chair: Rep. Edmond Jordan (LA)

Vice Chair: Rep. Jim Dunnigan (UT)

- 1.) Call to Order/Roll Call/Approval of December 11, 2019 Committee Meeting Minutes
- 2.) Supporting and Promoting Innovation in the Insurance Industry
Nicole Gunderson, Managing Director – Global Insurance Accelerator
- 3.) Continued Discussion on Development of NCOIL Insurance Modernization Model Legislation
 - a.) Consideration of NCOIL Insurance E-Commerce Model Act
Rep. Edmond Jordan (LA) – Sponsor
 - b.) Consideration of NCOIL E-Titling Model Act
Del. Steve Westfall (WV) – Sponsor
 - c.) Consideration of NCOIL Rebate Reform Model Act
Rep. Matt Lehman (IN) – NCOIL President – Sponsor
American Council of Life Insurers (ACLI) Representative
Wes Bissett, Senior Counsel, Gov't Affairs – Independent Insurance Agents & Brokers of America (IIABA)
- 4.) Introduction of NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors
Rep. Joe Fischer (KY) – NCOIL Secretary; Rep. Tom Oliverson, M.D. (TX) - Sponsors
National Association of Mutual Insurance Companies (NAMIC) Representative

- 5.) Any Other Business
- 6.) Adjournment

Business Planning Committee and Executive Committee

Sunday, March 8, 2020

10:00 a.m. – 11:00 a.m.

Chair: Rep. Matt Lehman – NCOIL President

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

- 1.) Call to Order/Roll Call/Approval of December 13, 2019 Committee Meeting Minutes
- 2.) 2022 Spring Meeting Location
- 3.) Administration
 - a.) Meeting Report
 - b.) Receipt of Financials
- 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.) 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: Rep. Matt Lehman, IN
VICE PRESIDENT: Asm. Ken Cooley, CA
TREASURER: Asm. Kevin Cahill, NY
SECRETARY: Rep. Joe Fischer, KY

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

National Council of Insurance Legislators (NCOIL)

Insurance Business Transfer Model Act

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

**~~Initial Discussion Draft~~ Based on Oklahoma SB 1101 – The Insurance Business Transfer Act (enacted on May 7, 2018 and amended on May 8, 2019). Draft as of February 5th November 11th, 202019.*

To be discussed and considered during the Joint State-Federal Relations and International Insurance Issues Committee on March 6th December 12th July 11th, 202019

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Section 8.	Fees and Costs
Section 9.	Effective Date

Section 1. Title

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

Section 2. Purpose

This act is adopted to provide options to address the significant limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that provides needed legal finality for such transfers in order to provide for improved operational and capital efficiency for insurance companies, stimulates the economy by attracting segments of the insurance industry to the state, make this state an attractive home jurisdiction for insurance companies, encourages economic growth and increased investment in the financial services sector and increases the availability of quality insurance industry jobs in this state. These purposes are accomplished by providing a basis and procedures for the transfer and statutory novation of policies from a transferring insurer to an assuming insurer by way of an Insurance Business Transfer without the affirmative consent of policyholders or reinsureds. The novation is effected by court order. This act establishes the requirements for notice and disclosure and standards and procedures for the approval of the transfer and novation by the State Insurance Commissioner and a District Court pursuant to an Insurance Business Transfer Plan. This act does not limit or restrict other means of effecting a transfer or novation.

Section 3. Definitions

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

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

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

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

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

E. "Department" means the State Insurance Department.

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

F. "Commissioner" means the State Insurance Commissioner.

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

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

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

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

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

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

Drafting Note: States may wish to remove certain lines of insurance from the scope of an insurance business transfer.

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

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

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

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

Section 4. Court Authority

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

Section 5. Notice Requirements

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

1. To the chief insurance regulator in each jurisdiction in which the applicant:
 - a. holds or has ever held a certificate of authority, and
 - b. in which policies that are part of the subject business were issued or policyholders currently reside;
2. To the National Conference of Insurance Guaranty Funds, the National Organization of Life and Health Insurance Guaranty Associations and all state insurance guaranty associations for the states in which the applicant:
 - a. holds or has ever held a certificate of authority, and
 - b. in which policies that are part of the subject business were issued or policyholders currently reside;
3. To reinsurers of the applicant pursuant to the notice provisions of the reinsurance agreements applicable to the policies that are part of the subject

business, or where an agreement has no provision for notice, by internationally recognized delivery service;

4. To all policyholders holding policies that are part of the subject business, at their last-known address as indicated by the records of the applicant or to the address to which premium notices or other policy documents are sent. A notice of transfer shall also be sent to the transferring insurer's agents or brokers of record on the subject business; and

5. By publication in a newspaper of general circulation in the state in which the applicant has its principal place of business and in such other publications that the Commissioner requires.

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

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

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

Section 6. Application Procedure

A. Application Procedure.

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

a. the name, address and telephone number of the transferring insurer and the assuming insurer and their respective direct and indirect controlling persons, if any,

b. summary of the Insurance Business Transfer Plan,

c. identification and description of the subject business,

d. most recent audited financial statements and statutory annual and quarterly reports of the transferring insurer and assuming insurer filed with their domiciliary regulator,

- e. the most recent actuarial report and opinion that quantify the liabilities associated with the subject business,
- f. pro-forma financial statements showing the projected statutory balance sheet, results of operations and cash flows of the assuming insurer for the three (3) years following the proposed transfer and novation,
- g. officers' certificates of the transferring insurer and the assuming insurer attesting that each has obtained all required internal approvals and authorizations regarding the Insurance Business Transfer Plan and completed all necessary and appropriate actions relating thereto,
- h. proposal for Plan implementation and administration, including the form of notice to be provided under the Insurance Business Transfer Plan to any policyholder whose policy is part of the subject business,
- i. full description as to how such notice shall be provided,
- j. description of any reinsurance arrangements that would pass to the assuming insurer under the Insurance Business Transfer Plan,
- k. description of any guarantees or additional reinsurance that will cover the subject business following the transfer and novation,
- l. a statement describing the assuming insurer's proposed investment policies and any contemplated third-party claims management and administration arrangements,
- m. description of how the transferring and assuming insurers will be licensed for guaranty association coverage purposes.

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

- (1) Guaranty association coverage;
- (2) The financial implications of the transaction including solvency, capital adequacy, cash flow, reserves, asset quality and risk-based capital;
- (3) An analysis of the assuming insurer's corporate governance structure to ensure that there is proper board management oversight and expertise to manage the subject business;

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

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

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

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

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

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

(3) the scope of the report,

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

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

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

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

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

(a) transferring policyholders and claimants,

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

(c) policyholders and claimants of the assuming insurer,

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

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

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

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

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

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

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

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

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

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

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

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

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

7. The Commissioner's review period in paragraph ~~32~~ of this subsection shall recommence when the modification, supplement, amendment or additional information requested in paragraph 5 of this subsection is received.

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

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

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

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

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

4. The Commissioner shall be a party to the proceedings before the court concerning the petition and shall be served with copies of all filings pursuant to

the Rules for District Courts of the State. The Commissioner's position in the proceeding shall not be limited by his or her initial review of the Plan.

5. Following the filing of the petition, the applicant shall file a motion for a scheduling order setting a hearing on the petition.
6. Within fifteen (15) days after receipt of the scheduling order, the applicant shall cause notice of the hearing to be provided in accordance with the notice provisions of Section 5 of this act. Following the date of distribution of the notice, there shall be a sixty-day comment period.
7. The notice to policyholders shall state or provide:
 - a. the date and time of the approval hearing,
 - b. the name, address and telephone number of the assuming insurer and transferring insurer,
 - c. that a policyholder may comment on or object to the transfer and novation,
 - d. the procedures and deadline for submitting comments or objections on the Plan,
 - e. a summary of any effect that the transfer and novation will have on the policyholder's rights,
 - f. a statement that the assuming insurer is authorized, as provided in this section, to assume the subject business and that court approval of the Plan shall extinguish all rights of policyholders under policies that are part of the subject business against the transferring insurer,
 - g. that policyholders shall not have the opportunity to opt out of or otherwise reject the transfer and novation,
 - h. contact information for the Insurance Department where the policyholder may obtain further information, and
 - i. information on how an electronic copy of the Insurance Business Transfer Plan may be accessed. In the event policyholders are unable to readily access electronic copies, the applicant shall provide hard copies by first-class mail.
8. Any person, including by their legal representative, who considers himself, herself or itself to be adversely affected can present evidence or comments to the court at the approval hearing. However, such comment or evidence shall not

confer standing on any person. Any person participating in the approval hearing must follow the process established by the court and shall bear his or her own costs and attorney fees.

C. Approval of the Insurance Business Transfer Plan.

1. After the comment period pursuant to paragraph 6 of subsection B of this section has ended the Insurance Business Transfer Plan shall be presented by the applicant for approval by the court.
2. At any time before the court issues an order approving the Insurance Business Transfer Plan, the applicant may withdraw the Insurance Business Transfer Plan without prejudice.
3. If the court finds that the implementation of the Insurance Business Transfer Plan would not materially adversely affect the interests of policyholders or claimants that are part of the subject business, the court shall enter a judgment and implementation order. The judgment and implementation order shall:
 - a. order implementation of the Insurance Business Transfer Plan,
 - b. order a statutory novation with respect to all policyholders or reinsureds and their respective policies and reinsurance agreements under the subject business, including the extinguishment of all rights of policyholders under policies that are part of the subject business against the transferring insurer, and providing that the transferring insurer shall have no further rights, obligations, or liabilities with respect to such policies, and that the assuming insurer shall have all such rights, obligations, and liabilities as if it, ~~instead of the transferring insurer,~~ were the original insurer of such policies,
 - c. release the transferring insurer from any and all obligations or liabilities under policies that are part of the subject business,
 - d. authorize and order the transfer of property or liabilities, including, but not limited to, the ceded reinsurance of transferred policies and contracts on the subject business, notwithstanding any non-assignment provisions in any such reinsurance contracts. The subject business shall vest in and become liabilities of the assuming insurer,
 - e. order that the applicant provide notice of the transfer and novation in accordance with the notice provisions in Section 5 of this act, and
 - f. make such other provisions with respect to incidental, consequential and supplementary matters as are necessary to assure the Insurance Business Transfer Plan is fully and effectively carried out.

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

- a. deny the petition, or
- b. provide the applicant leave to file an amended Insurance Business Transfer Plan and petition.

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

D. Implementation of Insurance Business Transfer Plan.

The Commissioner shall ~~have the authority to~~ promulgate rules that are not inconsistent with to effectuate the provisions of the Insurance Business Transfer Act.

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

Section 7. Ongoing oversight by Insurance Commissioner

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

Section 8. Fees and Costs

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

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

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

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

Section 9. Effective Date

This act shall become effective _____.

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



PRESIDENT: Rep. Matt Lehman, IN
VICE PRESIDENT: Asm. Ken Cooley, CA
TREASURER: Asm. Kevin Cahill, NY
SECRETARY: Rep. Joe Fischer, KY

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

National Council of Insurance Legislators (NCOIL)

E-Titling Model Act

**Sponsored by Del. Steve Westfall (WV)*

**Draft as of November 11th, 2019. To be discussed and considered by the Financial Services & Multi-Lines Issues Committee on March 8th December 11th, 2020*

Section 1. Title

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

Section 2. Purpose

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

Section 3. E-Titling Process

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

- (a) The use of an electronic signature in association with any title transaction satisfies any signature required under law, except that an electronic signature on an odometer disclosure by or on behalf of an insurance company must utilize a secure authentication system identifying a specific individual with a degree of certainty equivalent to Level 2 as described in NIST Special Publication 800-63-3, Revision 3, *Digital Identity Guidelines*, June 2017.
- (b) Notarization is not required for any power-of-attorney form or any other form submitted in association with either a title application or odometer disclosure pursuant to subsection (a).

- (c) The use of electronic signature pursuant to subsection (a) is not contingent upon the establishment or existence of an electronic vehicle titling system.
- (d) The Department of Motor Vehicles, or appropriate State Agency, shall provide for third-party real-time, single inquiry access to the electronic vehicle titling system so as to facilitate access to title information.

Section 4. Rules

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

Section 5. Effective Date

This Act shall take effect _____.

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

MARKET CONDUCT SURVEILLANCE MODEL LAW

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

**To be discussed and considered during the Joint State-Federal Relations and International Insurance Issues Committee on March 6th~~December 12th~~, 2020~~19~~*

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

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Section 1. Short Title

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

Section 2. Purpose/Legislative Intent

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

- Processes and systems for identifying, assessing and prioritizing market conduct ~~problems~~ issues and allegations that, if existing, violate the laws or regulations of this state and may have a substantial adverse impact on consumers, policyholders and claimants;
- Market conduct actions by a commissioner to substantiate such market conduct problems and a means to remedy significant market conduct that rises to a level of material violations of state law or regulations and harms consumers; and
- Procedures to communicate and coordinate market conduct actions among states to foster the most efficient and effective use of resources.
- Notwithstanding any provisions in this code to the contrary, nothing in this act shall authorize a market conduct examination of the insurer's cybersecurity protection measures which is otherwise provided for in domiciliary state financial examinations consistent with the NAIC's coordinated approach to examinations, unless a separate cybersecurity market conduct examination is precipitated by a cybersecurity breach.

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

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

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

Section 3. Definitions

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

(b) "Complaint" means a written or documented oral communication to the Insurance Department primarily expressing a grievance, meaning an expression of dissatisfaction. For health companies, a grievance is a written complaint submitted by or on behalf of a covered person.

(c) "Comprehensive Market Conduct Examination" means a review of one or more lines of business of an insurer domiciled in this state that is not conducted for cause. The term

includes a review of rating, tier classification, underwriting, policyholder service, claims, marketing and sales, producer licensing, complaint handling practices, or compliance procedures and policies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 4. Domestic Responsibility and Deference to Other States

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

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

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

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

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

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

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

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

(e) If the Insurance Commissioner to whom the examination responsibility was delegated pursuant to paragraph (a) of this Section or the report of a market conduct examination

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

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

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

Section 5. Market Analysis Procedures

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

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

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

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

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

(b) If the analysis compels the Commissioner to inquire further into a particular insurer or practice, the following continuum of market conduct actions may be considered prior to

conducting a targeted, on-site market conduct examination. The action selected shall be made known to the insurer in writing. These actions may include, but are not limited to:

- (1) Correspondence with Insurer
- (2) Insurer Interviews
- (3) Information Gathering
- (4) Policy and Procedure Reviews
- (5) Interrogatories
- (6) Review of Insurer Self-Evaluation (if not subject to a privilege of confidentiality) and compliance programs, including membership in a best-practice organization

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

- (c) The Commissioner shall select a market conduct action that is cost effective for the Insurance Department and the insurer, while still protecting the insurance consumer.
- (d) The Commissioner shall take those steps reasonably necessary to eliminate requests for duplicate information provided as part of an insurer's annual financial statement, the annual market conduct statement of the National Association of Insurance Commissioners, or other required schedules, surveys, or reports that are regularly submitted to the Commissioner, or with data requests made by other states if that information is available to the Commissioner, unless the information is state specific, and coordinate market conduct actions and findings with other states.
- (e) Causes or conditions, if identified through market analysis, that may trigger a targeted examination, are:
 - (1) Information obtained from a market conduct annual statement, market survey or report of financial examination indicating potential fraud, that the insurer is conducting the business of insurance without a license or is engaged in a potential pattern of material-unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts].
 - (2) A number of material and confirmed complaints against the insurer or a confirmed complaint ratio sufficient to indicate potential fraud, conducting the business of insurance without a license, or a potential pattern of unfair trade practice in violation of [cite statutory reference for the Unfair Trade and Claims Practices Acts]. For the purposes of this section, a confirmed complaint ratio shall be determined for each line of business.

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

(4) Patterns of material violations of Insurance [Code/Law] and administrative regulations promulgated thereunder that cause consumer harm.

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

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

Section 6. Protocols for Market Conduct Actions

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

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

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

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

Section 7. Protocols for Targeted Market Conduct Examinations

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

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

- (e) (1) Prior to commencement of a targeted on-site market conduct examination, market conduct surveillance personnel shall prepare a work plan and proposed budget. Such proposed budget, which shall be reasonable for the scope of the examination, and work plan shall be provided to the company under examination. Additionally, a summary of all actions taken along the continuum of regulatory response shall be documented and provided to the targeted company. Upward deviations from estimated budgets shall be limited to 10%, should rarely occur and only with substantial documentation as to necessity for the same.
- (2) Market conduct examinations shall, to the extent feasible, utilize desk examinations and data requests prior to a targeted on-site examination.
- (3) Market conduct examinations shall be conducted in accordance with the provisions set forth in the NAIC Market Regulation Handbook and the NAIC Market Conduct Uniform Examinations Procedures (or procedures, adopted by regulation, that are substantially similar to the foregoing NAIC products).

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

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

- (1) The name and address of the insurer(s) being examined;
- (2) The name and contact information of the examiner-in-charge;
- (3) The reason(s) for and the scope of the targeted examination;
- (4) The date the examination is scheduled to begin;
- (5) Identification of any non-insurance department personnel who will assist in the examination, if known at the time the notice is prepared;
- (6) A time estimate for the examination;
- (7) A budget and work plan for the examination and identification of reasonable and necessary costs and fees that will be included in the bill, if the cost of the examination is billed to the company; and
- (8) A request for the insurer to name its examination coordinator.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Require disclosure of contract examiners' recommendations;

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

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

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

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

(H) ~~Limit~~ ~~Prohibit~~ market conduct surveillance personnel ~~to~~ ~~from~~ performing duplicative work or review of materials submitted in prior market conduct examinations in this state or in other states' examinations to the extent such review will expedite the subsequent examination.

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

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

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

Section 8. Confidentiality Requirements

(a) Except as otherwise provided by law, market conduct surveillance personnel shall have free and full access to all books and records, employees, officers and directors, as practicable, of the insurer during regular business hours. An insurer utilizing a third-party model or product for any of the activities under examination shall cause, upon the request of market conduct surveillance personnel, the details of such models or products to be made available to such personnel. All documents, whether from a third party or an insurer, including but not limited to working papers, third party models or products,

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

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

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

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

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

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

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

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

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

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

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

Section 9. Market Conduct Surveillance Personnel

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

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

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

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

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

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

Section 10. Immunity for Market Conduct Surveillance Personnel

(a) No cause of action shall arise nor shall any liability be imposed against the Commissioner, the Commissioner's authorized representatives or an examiner appointed by the Commissioner for any statements made or conduct performed in good faith while carrying out the provisions of this Act, unless those statements are made with reckless disregard for the truth or recklessly disclose confidential or proprietary information.

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

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

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

Section 11. Fines and Penalties

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

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

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

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

The Commissioner shall collect and report market data to the NAIC's market information systems, including the Complaint Database System, the Examination Tracking System, and the Regulatory Information Retrieval System, or other comparable successor NAIC products as determined by the Commissioner. In addition to complaint data, the accuracy

of insurer-specific information reported to the NAIC to be used for market analysis purposes or as the basis for market conduct actions shall be reviewed by appropriate personnel in the Insurance Department and by the insurer.

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

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

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

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

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

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

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

Section 13. Coordination with Other States Through the NAIC

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

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

Section 14. Additional Duties of the Commissioner

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

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

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

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

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

Section 15. Effective Date

This Act shall take effect [insert chosen date].

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National Council of Insurance Legislators (NCOIL)

Rebate Reform Model Act

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

**Discussion Draft as of ~~February 5th~~ ~~November 11th~~, ~~2020~~19. To be discussed and considered during the NCOIL Financial Services & Multi-Lines Issues Committee on March 8th ~~December 11~~, ~~2020~~19*

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Permissible Gifts and Prizes

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

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

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

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

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

Section 4. Permissible Value-Added Service or Activity

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

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

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

Section 6. Rules

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

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

Section 7. Effective Date

This Act is effective immediately.

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National Council of Insurance Legislators (NCOIL)

Private Flood Insurance Model Act

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

**Discussion Draft as of November 11th, 2019. To be discussed during the Special Committee on Natural Disaster Recovery on March 6th, 2020~~December 11th, 2019.~~*

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

For purposes of this Act:

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

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

Section 4. Rates

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

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

Section 5. Forms

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

Section 6. Duties of Insurer

(a) Authorized insurers must notify the [State entity for regulating insurance] of plans to sell private flood insurance products in accordance with the state’s rate filing laws at least 30 days before writing flood insurance in this state; and

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

Section 7. Duties of Producer

A producer must:

- (a) notify the applicant of the existence of the NFIP and private market alternatives for flood insurance coverage;
- (b) inform the applicant that a homeowner's property insurance policy, unless endorsed for flood insurance coverage, does not include coverage for the peril of flood; and
- (c) inform the applicant that unless flood insurance is purchased, the applicant has declined flood coverage.

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

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

Section 8. Other Provisions

- (a) With respect to the regulation of flood coverage written in this state by authorized insurers, this section supersedes any other provision in the State Insurance Code in the event of a conflict.
- (b) If federal law or rule requires a certification of a private flood insurance policy by the [state entity for regulation of insurance] as a condition of qualifying for federal disaster assistance, the Executive of the [state entity for regulation of insurance] may provide the certification, and such certification is not subject to review under the State's Administrative Procedures Act.
- (c) An authorized insurer offering flood insurance may request the [state entity for regulation of insurance] certify that a policy, contract, or endorsement provides coverage for the peril of flood which equals or exceeds the flood coverage offered by the NFIP.
- (d) The authorized insurer or its producer may reference or include a certification under paragraph (c) in advertising or communications with an producer, a lending institution, an insured, or a potential insured only for a policy, contract, or endorsement that is certified under this subsection. The authorized insurer may include a statement that notifies an insured of the certification on the declarations page or other policy documentation related to flood coverage certified under this subsection.

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

Section 9. Rules

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

Section 10. Effective Date

This Act shall take effect _____.

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National Council of Insurance Legislators (NCOIL)

Private Primary Residential Flood Insurance Model Act

**This document is submitted as a strike-all amendment to the NCOIL Private Flood Insurance Model Act, the current version of which is dated November 11th, 2019 and sponsored by Rep. David Santiago (FL). This document is a result of discussion and compromise between the American Property Casualty Insurance Association (APCIA), the National Association of Mutual Insurance Companies (NAMIC), the American Bankers Association (ABA), the Independent Insurance Agents and Brokers of America (IIABA), the National Association of Professional Insurance Agents (PIA), the Wholesale & Specialty Insurance Association (WSIA), and the Reinsurance Association of America (RAA). The drafting note at the end of Section 10 of this document was requested for inclusion by NAMIC.*

**This document will be discussed together with Rep. Santiago's Model during the Special Committee on Natural Disaster Recovery on March 6th, 2020.*

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

For purposes of this Act:

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

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

(c) “Primary residential flood insurance” means an insurance policy covering losses from flood to residential property, other than commercial property, written in this State by any insurer authorized to do business that is not written to apply coverage in excess of the coverage provided under another flood insurance policy, whether issued by a private insurer or the National Flood Insurance Program.

Section 4. Rates

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

(b) An insurer shall file with the [State entity for regulation of insurance] all rates and any change to such rates within 30 days after the effective date. The notice of a rate change 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.

Drafting Note: A “use and file” rate filing is used in this section. A State may choose to apply a “file and use” standard instead.

Section 5. Forms

The [State entity for regulating insurance] may require, through the application of the State’s existing regulatory system:

- (a) that an insurer file the forms for primary residential flood insurance coverage;
- (b) that an authorized insurer may issue an insurance policy, contract, or endorsement;
and,
- (c) for residential properties required to have flood insurance that are in a Special Flood Hazard Area designated by the Federal Emergency Management Agency, that the coverage at least meets the private flood insurance requirements as specified in 42 U.S.C. § 4012a(b) and applicable federal regulations in document 84 FR 4953, effective July 1, 2019.

Drafting Note: In the interest of facilitating the growth of the private flood market, the intent of this section is to ensure that States do not impose greater filing requirements for private flood insurance form filings than the State requires for other property lines of insurance. However, States may also wish to consider further streamlining the filing requirements for personal and commercial flood insurance to enhance insurers’ ability to develop private flood policies and endorsements that would provide consumers with choices when compared to the protection provided by the National Flood Insurance Program.

Section 6. Duties of Insurer to Provide Regulatory Notice of Intent to Transact Residential Primary Flood Insurance

- (a) Authorized insurers must notify the [State entity for regulating insurance] of plans to sell primary residential flood insurance products in accordance with the State’s rate filing laws but at least 30 days before writing such flood insurance in this State; and
- (b) File a plan of operation and financial projections or material revisions to such plan.

Section 7. Notice to Consumers

- (a) If an consumer currently has coverage under the National Flood Insurance Program, before placing the consumer applicant with private flood insurance, the consumer must be informed that the coverage under the National Flood Insurance Program may be

provided at a subsidized rate and that the full-risk rate for flood insurance may apply to the property if the applicant later seeks to reinstate coverage under the program. The insurance producer, surplus lines broker, or the insurer upon its election or if there is no producer or broker must provide such notice.

(b) This section (7.) only applies if the applicant lives in a Special Flood Hazard Area. This section automatically sunsets if federal legislation is enacted allowing the insured to switch between private flood insurance and NFIP coverage without risk of penalty.

Section 8. Cancellation and Nonrenewal Notice

(a) Notice of cancellation or nonrenewal, other than for nonpayment of premium, as allowed by State statute, shall be made and provided in compliance with [applicable State law] but at least 45 days before the cancellation or nonrenewal of private flood insurance coverage to the insured.

(b) Notwithstanding (a) above, notice of cancellation for nonpayment of premium, or fraud or misrepresentation in the application, shall be made and provided in compliance with [applicable State law].

Drafting Note – The notice described must meet the delivery and other requirements established under [insert reference to the provisions of the State code addressing cancellation and nonrenewal notice requirements]. This section is intended for States that have cancellation and nonrenewal notice requirements, for other than nonpayment of premiums, that mandate the delivery of such notices fewer than 45 days before cancellation or nonrenewal of a policy but is not necessary in other States.

Section 9. Surplus Lines Placements

[Applicable State diligent effort law] does not apply to flood coverage under an insurance policy issued by an eligible surplus lines insurer.

Drafting Note – States may wish to consider sunseting this section after a specified period of time.

Section 10. Other Provisions.

(a) [Residual Market Mechanism] Participation. Writing private flood insurance does not constitute participation in the property insurance market for purposes of determining participation in the [insert name of State residual market program] under [insert citations of State law requiring insurers writing property insurance in the State to participate in the residual risk pool].

Drafting Note: Appropriate reference should be made to FAIR plans, wind and beach pools, and related entities.

- (b) Filings Open to Inspection. All rates, supplementary rate information, and any supporting information filed under this Act shall be open to public inspection upon disposition, except information marked confidential, Trade Secret, or proprietary by the insurer or filer in accordance with (statutory reference for confidentiality requirements). Copies may be obtained from the commissioner upon request and upon payment of a reasonable fee.
- (c) It is the intent of the legislature that nothing in this law is intended to restrict the use of existing filings by an insurer or limit ability of private insurers to provide flood insurance coverage of any type not addressed herein.

NAMIC Requested Drafting Note: Because the peril of flood is both parcel specific and frequently catastrophic, policymakers should consider the following additional flexibility provision:

Notwithstanding any other law or regulation, and consistent with the purpose of encouraging a robust private flood insurance market, private flood insurer may consider, without restriction, claim history or loss experience, including weather-related loss or catastrophe losses, of a policyholder or of a previous property owner.

Section 11. Rules

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

Section 12. Effective Date

This Act shall take effect _____.

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National Council of Insurance Legislators (NCOIL)

Insurance E-Commerce Model Act

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

**Draft as of ~~February 5th, November June 11th~~, ~~202019~~. To be discussed during the Financial Services & Multi-Lines Issues Committee on ~~March 8th December July 11th~~, ~~202019~~*

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Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

As used in this Chapter, the following definitions apply:

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

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

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

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

Section 4. Electronic delivery of insurance documents and notices

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

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

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

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

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

- (a) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means.
- (b) The types of notices and documents to which the party's consent would apply.
- (c) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn.
- (d) The procedures a party must follow to withdraw consent, which can be no more burdensome than providing consent, to have a notice or document delivered by electronic means and to update the party's electronic mail address.
- (e) The right of a party to have any notice or document delivered, upon request, in paper form.

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

Section 5. Change in hardware or software requirements

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

- (1) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.
- (2) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

Section 6. Applicability

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

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

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

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

Section 7. Contracts and policies not affected

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

Section 8. Withdrawal of consent

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

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

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

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

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

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

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

Section 10. Alternative method of delivery required

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

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

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

The insured's consent to electronic delivery shall not preclude the insurer from delivering a notice or document by any other delivery method permitted by law.

Section 11. Limitation of liability

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

Section 12. Posting Policy on Internet

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 13. Receipt of Claim Payments by Electronic Transfer

All claims brought by insureds, workers' compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer or, if offered by the insurer and the claimant consents, electronic transfer of funds to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or her/his attorney, or upon direction of the claimant to one specified; ~~However, the check or draft shall be made jointly to the claimant and the employer when the employer has advanced the claims payment to the claimant, the check or draft shall be paid jointly to the claimant and the employer; or, if consented by all parties, the electronic payment shall be paid to the trust account.~~ The check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer. The electronic payment shall be held in trust 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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IMMEDIATE PAST PRESIDENTS:
Sen. Jason Rapert, AR
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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 ~~March 7th~~ ~~December~~ ~~July 11th~~, ~~2020~~ ~~19~~. ~~Initial~~ ~~draft~~ as of ~~February 5th~~ ~~November~~ ~~June 11th~~, ~~2020~~ ~~19~~ based on Indiana HB 1631 (signed into law on May 6, 2019)*

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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].

Drafting Note: States are not required to offer short term limited duration insurance plans. For states that choose to offer such plans, this Model is intended to serve as a framework that can be adjusted accordingly to meet each state's needs.

Section 3. Definitions

For purposes of this Act:

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

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

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

(de) “Short Term Insurance Plan” means a policy of health insurance that:

(1) may be renewed for the greater of:

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

(ii) the maximum period permitted under federal law;

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

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

Section 4. Renewal and Underwriting

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

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

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

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

Section 5. Coverage Requirements

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

- (1) Ambulatory patient services;
- (2) Hospitalization;
- (3) Emergency services; and
- (4) Laboratory services

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

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

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

- (1) The preferred provider plan includes essential community providers in accordance with PPACA.
- (2) The preferred provider plan is sufficient in number and types of providers (other than mental health and substance abuse treatment providers) to assure covered individuals' access to all health care services without unreasonable delay.
- (3) The preferred provider plan is consistent with the network adequacy requirements that:
 - (i) apply to qualified health plan issuers under 45 CFR 156.230(a) and 45 CFR 156.230(b); and
 - (ii) are consistent with subdivisions (1) and (2).

Section 7. Disclosure Requirements

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

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

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

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

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

Section 8. Tiering/Rating

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

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

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

Section 10. Rules

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

Section 11. Effective Date

This Act shall take effect [_____].

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National Council of Insurance Legislators (NCOIL)

Health Care Sharing Ministry Registration Model Act

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

**Discussion Draft as November 11th, 2019. To be discussed during the Health Insurance & Long Term Care Issues Committee on March 7th, 2020~~December 11th, 2019~~*

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Section 9.	Rules
Section 10.	Effective Date

Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

“Health care sharing ministry” is defined by 26. U.S.C. § 5000A(d)(2)(B).

Section 4. Notice Requirements

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

NOTICE

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

Drafting Note: This notice should be harmonized to reflect any existing notice requirement that may exist for health care sharing ministries in the given state.

Section 5. Registration and Reporting Requirements

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

(1) An application for registration on a form promulgated by the Insurance Commissioner which must include:

(a) The responsible director or manager of the health care sharing ministry plans;

(b) Contact address for the health care sharing ministry; and

(c) Contact phone number for the responsible director or manager.

(2) A copy of the certification letter issued to the Health Care Sharing Ministry by the Centers for Medicare & Medicaid Services;

(3) A copy of the current annual audit required pursuant to 26 U.S.C. § 5000A(d)(2)(B);

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

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

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

(a) Total number of enrolled members;

(b) Distribution of members by age; and

(c) Distribution of members by sex.

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

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

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

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

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

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

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

(a) Total number of enrolled members;

(b) Distribution of members by age; and

(c) Distribution of members by sex.

(5) A copy of the current annual audit required pursuant to 26 U.S.C. § 5000A(d)(2)(B);

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

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

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

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

(1) 1-30 days late – [\$250]

(2) 31-60 days late – [\$500]

(3) 61-90 days late – [\$1,000]

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

Section 6. Posting Requirements

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

Section 7. Anti-Fraud Protections

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

Section 8. Enforcement

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

Section 9. Rules

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

Section 10. Effective Date

This Act shall take effect [_____].

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National Council of Insurance Legislators (NCOIL)

Draft Model Act Regarding Vision Care Services

**Sponsored by Sen. Bob Hackett (OH)*

**Discussion Draft as of November 11th, 2019. To be ~~discussed~~introduced during the Health Insurance & Long Term Care Issues Committee on March 7th, 2020~~December 11th, 2019~~.*

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

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

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

(1) An optometrist licensed under Chapter XXX;

(2) A physician authorized under Chapter XXX.

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

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

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

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

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

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

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

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

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

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National Council of Insurance Legislators (NCOIL)

Patient Dental Care Bill of Rights

**Sponsored by Rep. George Keiser (ND); Co-Sponsored by Rep. Deborah Ferguson (AR)*

**Discussion Draft as of November 11th, 2019. To be discussed~~introduceed~~ during the Health Insurance & Long Term Care Issues Committee on March 7th, 2020~~December 11th, 2019.~~*

Contents:

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

A. Definitions *

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Fair and Transparent Network Contracting Act

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

Section I. Responsible Leasing Requirements when Leasing Networks

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

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

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

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

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

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

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

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

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

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

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

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

This act shall not apply to:

1. A provider network contract for dental services provided to beneficiaries of the state sponsored health programs such as Medicaid and CHIP;
2. Situations in which access to a provider network contract is granted to a contracting entity or dental carrier operating under the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A listing of all affiliates of the contracting entity shall be made available to the provider, in writing or electronic form, prior to access being granted; or,
3. Electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

Section II. Penalties

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

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

C. Prior Authorizations/Claim Payments Act

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

Section I.

Authorized Service(s) Claim Denial Prohibited/Exceptions

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

1. Benefit limitations such as annual maximums and frequency limitations not applicable at the time of the prior authorization are reached due to utilization subsequent to issuance of the prior authorization;
2. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;
3. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care;
4. If, subsequent to the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time required disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used; or
5. The denial of the dental service contractor was due to one of the following:
 - a. another payor is responsible for payment,
 - b. the dentist has already been paid for the procedures identified on the claim,
 - c. the claim was submitted fraudulently or the prior authorization was based in whole or material part on erroneous information provided to the dental service contractor by the dentist, patient, or other person not related to the carrier, or
 - d. the person receiving the procedure was not eligible to receive the procedure on the date of service and the dental service contractor did not know, and with the exercise of reasonable care could not have known, of their eligibility status.

Section II. Penalties

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

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

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

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

Section I

Post-Payment of Claim/Payment Recovery Limitations

1. Other than recovery for duplicate payments, dental benefit plans or dental services contractors, whenever engaging in overpayment recovery efforts, shall provide written notice to the dentist that identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.
2. Dental benefit plans or dental services contractors shall provide dentists with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for dentists to follow to challenge an overpayment recovery.
3. Dental benefit plans or dental services contractors shall not initiate overpayment recovery efforts more than [Insert desired limit; suggest 12-18 months or emulate prevailing insurer limit on filing claims] after the original payment for the claim was made. No such time limit shall apply to overpayment recovery efforts which are:
 - a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;
 - b. required by, or initiated at the request of, a self-insured plan; or
 - c. required by a state or federal government plan.
4. Waiver Prohibited. The provisions of this section cannot be waived by contract. Any contractual arrangement in conflict with the provisions of this section or that purports to waive any requirements of this section is null and void.

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

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

Section I.

Method of Payment Option

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

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

1. Notify the dentist if any fees are associated with a particular payment method; and
2. Advise the dentist of the available methods of payment and provide clear instructions to the dentist as to how to select an alternative payment method.
3. Notify the dentist if the dental benefit plan is sharing a part of the profit of the fee charged by the credit card company to pay the claim.

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

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

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

F. Transparency of Patient Premiums Invested in Dental Care Act

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

1. A health care service plan that issues, sells, renews, or offers a specialized health care service plan contract covering dental services shall file a Medical Loss Ratio (MLR) with the [state insurance authority] that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418).
2. The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. All terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), Part 158 (commencing with 158.101) of Title 45 of the Code of Federal Regulations, and Section 1367.003.
3. If data verification of the health care service plan's representations in the MLR annual report is deemed necessary, the [state authority] shall provide the health care service plan with a notification 30 days before the commencement of the financial examination.

4. The health care service plan shall have 30 days from the date of notification to submit to the [state authority] all requested data. The director may extend the time for a health care service plan to comply with this subdivision upon a finding of good cause.
5. The [state authority] shall make available to the public all of the data provided to the department pursuant to this section.
6. Exempts Health care service plans for health care services under Medicaid CHIP or other state sponsored health programs

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

National Council of Insurance Legislators (NCOIL)

Electric Scooter Insurance Model Act

**Sponsored by Sen. Jerry Klein (ND)*

**Discussion Draft as of February 5th, 2020~~November 11th, 2019~~. To be discussed during the Property & Casualty Insurance Committee on March 6th, 2020~~December 13, 2019~~.*

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

Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

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

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

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

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

Section 4. Insurance Requirements

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

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

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

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

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

- a. insurance maintained by the independent contractor; or
- b. insurance maintained by the electric scooter company; or
- c. Any combination of paragraphs (a) and (b) of this Section; or
- d. Other applicable insurance.

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

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

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

- a. Insurance maintained by the independent contractor; or
- b. Insurance maintained by the electric scooter company; or
- c. Any combination of paragraphs (a) and (b) of this Section; or
- d. Other applicable insurance

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

F. The provisions of this act shall not create a private cause of action.

G. The Insurance Commissioner shall have authority to waive the requirements of this section upon determination of insufficient availability of applicable insurance products.

Section 5. Rules

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

Section 6. Effective Date

This Act shall be effective _____.

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National Council of Insurance Legislators (NCOIL)

Model Act Concerning Statutory Thresholds for Settlements Involving Minors

**Sponsored by Rep. Joe Fischer (KY) and Rep. Tom Oliverson, M.D. (TX)*

**Discussion Draft as of February 5th, 2020. To be discussed during the Financial Services & Multi-Lines Issues Committee on March 8th, 2020.*

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Procedures for Settling Claims Involving Minors
Section 4.	Effective Date

Section 1. Title

This Act shall be known and cited as the “[State] Statutory Thresholds for Settlements Involving Minors Act.”

Section 2. Purpose

The purpose of this Act is to set forth standards and procedures for settling claims involving minors.

Section 3. Procedures for Settling Claims Involving Minors

(1) A person having legal custody of a minor may enter into a settlement agreement with a person against whom the minor has a claim if:

- (a) A [conservator or guardian ad litem] has not been appointed for a minor;

- (b) The total amount of the claim, not including reimbursement of medical expenses, liens, reasonable attorney fees and costs of suit, is \$25,000 or less if paid in cash or if paid by the purchase of a premium for an annuity;
 - (c) The moneys paid under the settlement agreement will be paid as set forth in subsections (3) and (4) of this section; and
 - (d) The person entering into the settlement agreement on behalf of the minor completes an affidavit or verified statement that attests that the person has made a reasonable inquiry and that:
 - (i) To the best of the person's knowledge, the minor will be fully compensated by the settlement; or
 - (ii) There is no practical way to obtain additional amounts from the party entering into the settlement agreement with the minor.
- (2) The attorney representing the person entering into the settlement agreement on behalf of the minor, if any, shall maintain the affidavit or verified statement completed under subsection (1)(d) of this section in the attorney's file for two years after the minor attains the age of 21 years.
- (3) The moneys payable under the settlement agreement must be paid as follows:
- (a) If the minor or person entering into the settlement agreement on behalf of the minor is represented by an attorney and the settlement is paid in cash, by direct deposit into the attorney's trust account maintained pursuant to rules of professional conduct adopted under [State Attorney Trust Accounting Rules] to be held for the benefit of the minor. The attorney shall deposit the moneys received on behalf of the minor directly into a federally insured savings account that earns interest in the sole name of the minor, and provide notice of the deposit to the minor and the person entering into the settlement agreement on behalf of the minor. Notice shall be delivered by personal service or first-class mail.
 - (b) If the minor or person entering into the settlement agreement on behalf of the minor is not represented by an attorney and the settlement is paid in cash, directly into a federally insured savings account that earns interest in the sole name of the minor. Notice of the deposit to the minor shall be delivered by personal service or first-class mail. The minor or person entering into the settlement agreement on behalf of the minor shall open the federally insured savings account and provide the person or entity with whom the minor has settled the claim with information sufficient to complete an electronic transfer of settlement funds within 10 business days of the settlement;
 - (c) If paid by purchase of an annuity, by direct payment to the provider of the annuity with the minor designated as the sole beneficiary of the annuity.

- (d) If the minor is a [ward of the state] and the settlement is paid in cash, directly into a trust account, or subaccount of a trust account, established by the [department responsible for wards of the state, or similar state mechanism] for the purpose of receiving moneys payable to the ward under the settlement agreement and that earns interest for the benefit of the ward.
- (4) The moneys in the minor's savings account, trust account or trust subaccount established under subsection (3) of this section may not be withdrawn, removed, paid out or transferred to any person, including the minor, except as follows:
- (a) Pursuant to court order;
 - (b) Upon the minor's attainment of 18 years of age; or
 - (c) Upon the minor's death.
- (5) If a settlement agreement is entered into in compliance with subsection (1) of this section, the signature of the person entering into the settlement agreement on behalf of the minor is binding on the minor without the need for further court approval or review and has the same force and effect as if the minor were a competent adult entering into the settlement agreement.
- (6) A person acting in good faith on behalf of a minor under this section is not liable to the minor for the moneys paid in settlement or for any other claim arising out of the settlement.
- (7) Any person or entity against whom a minor has a claim that settles the claim with a minor in good faith under this section shall not be liable to the minor for any claims arising from the settlement of the claim.

Section 4. Effective Date

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

NAMIC Statement in Support of NCOIL model “Statutory Settlement Thresholds involving Minors”

Among other parties, liability settlement sometimes includes those alleged or purported injuries to minors. Many are amicably resolved by settlement especially in the low severity range as an equitable and expeditious agreement between the parties. Because a minor is under the age of majority which is generally 18 years of age in most states, they do not have the legal capacity to enter into a contractual arrangement for settlement.

Consequently, states have incorporated systems either through their probate or other processes to allow court approvals for settlements which would allow an amount to be paid to a minor’s estate and legally remove the insurers continuing obligation or liability for the claim. Most states require legal custodians of the child be appointed as well as a *Guardian Ad Litem* or Friend of the Court, usually an attorney, to independently review settlements and approve of the same while not directly representing the minor but looking out for its best interests. The parents may have retained counsel to negotiate the settlement as well. Legal custodians may be required to obtain bonding or other surety to protect their fiduciary duty to look out for the child’s best interests.

All of the costs associated with these proceedings are usually if not always submitted to the insurer including the *Guardian Ad Litem* fees which can run in the thousands of dollars even for a routine small dollar settlement. While it is stipulated that in certain circumstances, either party to a settlement may deem it necessary and prudent for a court to review a settlement involving a minor, it does not follow logic that ALL settlements of that nature must achieve such judicial scrutiny. When both the insurer and the policyholders agree, there ought to be a system by which settlements may be expedited without further delay and unnecessary intervention by the courts.

Some states have allowed for threshold dollar amounts that preclude or do not require court approval if not surpassed in a settlement. These may range from \$2,500 to \$25,000 with \$10,000 being a common amount. This usually means the threshold amount after attorney fees, costs and medical expenses are deducted. State determinations vary as to threshold amounts, level of court involvement and process for obtaining releases regardless of amount.

However, many if not most of these statutes have not kept pace with inflation and the realities and value or usage of the funds. The corpus of these low severity settlements is routinely utilized even with court approval for the benefit and welfare of the child as it is being reared. Consequently, for these amounts, there is an inordinate cost for procuring

only to have the court on its own *sua sponte* allow the funds to be utilized and spent for the child. Due to both the unnecessary mandatory court action and increasing costs, a legislative remedy to allow flexibility to both insurers and their policyholders is warranted.

It is NAMIC's position that model legislation on settlements involving minors may serve to:

- 1) Expedite settlement dollars to policyholders of all ages
- 2) Remove legal and administrative costs and delays in the settlement of claims involving minors
- 3) Maintain requirements for parties' duty to the minor regarding truthful statements via affidavit or verified statement

Proposed Paid Family Leave Income Replacement Insurance Law

**Proposal submitted for discussion by the American Council of Life Insurers (ACLI).
To be introduced for discussion during the Life Insurance & Financial Planning
Committee on March 6th, 2020 and throughout 2020.*

The State's Insurance Code is amended to enact the following:

Title AA, Accident and Sickness Insurance, [Section X, Disability Income Insurance] is amended by adding the following sections –

Article Z. Paid Family Leave Income Replacement Benefits

An insurance company licensed to issue disability income insurance policies in accordance with this title may also offer paid family leave benefits providing wage replacement caused by absences that are not based upon an insured's status as disabled. Such benefits may be offered either through a rider to a policy of disability income insurance or as a separate policy and must: (1) comply with the relevant sections of this title, and (2) [comply with any state disability income insurance filing requirements – cite state insurance code].

§ 100. Short Title

This Article shall be known and may be cited as the "Paid Family Leave Income Replacement Benefits Act".

§ 101. Purpose

[State] is a family-friendly state, and providing the workers of [State] with access to paid family leave insurance will encourage an entrepreneurial atmosphere, encourage economic growth, and promote a healthy business climate. Many workers need to take time off work for family reasons, including bonding with a new child or caring for an ill family member. Increasingly, employers in [State] want to make paid leave benefits available to workers who need time off for these reasons. Employers recognize workers will be healthier and more productive workers when able to take care of family responsibilities without a complete loss of income, and believe that offering paid family leave benefits to their employees will improve recruitment opportunities and reduce turnover in the workplace. Disability insurers currently offer income replacement benefits to workers who need time off from work because of their own disabling medical condition. Disability insurers have extensive experience, claims staff, systems, and expertise that can be used to provide fully insured paid family leave benefits for employees either through employer-sponsored group insurance policies or voluntarily purchased employee policies. It is in the best interests of [State's] workers and employers to permit disability insurers to expand their fully insured benefits in [State] to include paid family leave benefits.

§ 102. Definitions

As used in this Article:

1. “Armed forces of the United States” includes members of the National Guard and Reserves.
2. “Child” means a person who is (i)(a) under 18 years of age; or (b) 18 years of age or older and incapable of self-care because of a mental or physical disability; and (ii) a biological, adopted, or foster son or daughter; a stepson or stepdaughter; a legal ward; a son or daughter of a domestic partner; or a son or daughter of a person to whom the employee stands in loco parentis.
3. “Family Leave” is any leave taken by an employee from work for reasons enumerated in Section 103.
4. “Family Member” may include a child, spouse, or parent as defined in this Section or any other person defined as a “family member” in the policy of insurance.
5. “Health care provider” shall mean a person licensed under the public health law of the [State].
6. “Parent” means a biological, foster, or adoptive parent, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.
7. “Serious health condition” means an illness, injury, impairment, or physical or mental condition, including transplantation preparation and recovery from surgery related to organ or tissue donation, that involves inpatient care in a hospital, hospice, or residential health care facility, continuing treatment or continuing supervision by a health care provider as defined in the insurance policy. Continuing supervision by a health care provider includes a period of incapacity which is permanent or long term due to a condition for which treatment may not be effective and where the family member need not be receiving active treatment by a health care provider.

§ 103. Family Leave Benefits:

Family leave benefits may be provided for any leave taken by an employee from work to:

- (a) participate in providing care, including physical or psychological care, for a family member of the employee made necessary by a serious health condition of the family member;

(b) bond with the employee's child during the first twelve months after the child's birth, or the first twelve months after the placement of the child for adoption or foster care with the employee;

(c) address a qualifying exigency as interpreted under the Family and Medical Leave Act, 29 U.S.C. § 56 2612(a)(1)(e) and 29 C.F.R. §§ 825.126(a)(1)-(8), arising out of the fact that the spouse, child, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces of the United States;

(d) care for a family service member injured in the line of duty; or

(e) take other leave to provide care for a family member or other family leave as specified in the policy of insurance.

§ 104. Explanation of Family Leave Reasons

The policy of insurance shall set forth the details and requirements with regard to each of the covered family leave reasons.

§ 105. Benefit Period

The policy of insurance shall set forth the length of family leave benefits that are available for each covered family leave reason, which will in no event be less than [two weeks] during a period of fifty-two consecutive calendar weeks. Fifty-two consecutive calendar weeks may be calculated by (i) a calendar year; (ii) any fixed period starting on a particular date such as the effective or anniversary date; (iii) the period measured forward from the employee's first day of family leave; (iv) a rolling period measured by looking back from the employee's first day of family leave; or (v) any other method that is specified in the policy of insurance.

§ 106. Waiting Period

The policy of insurance shall set forth whether there is an unpaid waiting period and, if so, the terms and conditions of the unpaid waiting period, which may include, but are not limited to: (i) whether the waiting period runs over a consecutive calendar day period, (ii) whether the waiting period is counted toward the annual allotment of family leave benefits or is in addition to the annual allotment of family leave benefits, (iii) whether the waiting period must be met only once per benefit year or must be met for each separate claim for benefits, and (iv) whether the employee may work or receive paid time off or other compensation by the employer during the waiting period.

§ 107. Amount of Family Leave Benefits/Other Income

(a) The policy of insurance shall set forth: (i) the amount of benefits that will be paid for covered family leave reasons; (ii) the definition of the wages or other income upon which

the amount of family leave benefits will be based; and (iii) how such wages or other income will be calculated.

(b) If the family leave benefits are subject to offsets for wages or other income received or for which the insured may be eligible, the policy shall set forth: (i) all such wages or other income that may be set off and (ii) the circumstances under which it may be offset.

§ 108. Permissible Limitations, Exclusions, or Reductions

Eligibility for family leave benefits under this Article may be limited, excluded, or reduced, but any limitations, exclusions, or reductions shall be set forth in the policy of insurance. Permissible limitations, exclusions, or reductions may include, but are not limited to, any of the following reasons:

(a) for any period of family leave wherein the required notice and medical certification as prescribed in the policy has not been provided;

(b) for any family leave related to a serious health condition or other harm to a family member brought about by the willful intention of the employee;

(c) for any period of family leave during which the employee performed work for remuneration or profit;

(d) for any period of family leave for which the employee is eligible to receive from his or her employer, or from a fund to which the employer has contributed remuneration or maintenance;

(e) for any period of family leave in which the employee is eligible to receive benefits under any other statutory program or employer-sponsored program, including, but not limited to, unemployment insurance benefits, worker's compensation benefits, statutory disability benefits, statutory paid leave benefits, or any paid time off or employer's paid leave policy;

(f) for any period of family leave commencing before the employee becomes eligible for family leave benefits under the policy; or

(g) for periods of family leave where more than one person seeks family leave for the same family member.

§ 109. Payment of Family Leave Benefits

Family leave benefits provided under this Article shall be paid periodically and promptly [If Applicable: {as provided for in Section "X" of (State) Insurance Code}] except as to a contested period of family leave and subject to any of the provisions of Section 108 of this Article.

§ 110. The Insurance Policy

(a) Premiums for policies or riders providing paid family leave benefits in accordance with [State's] disability income insurance law shall be calculated in accordance with applicable provisions of the [State's] insurance law, including Subsection (X) of such law.

(b) Policies of insurance issued pursuant to this Article may offer coverage for paid family leave benefits or may offer paid family leave benefits as a rider to a policy of disability income insurance.

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October 11, 2019

Office of the General Counsel
Rules Docket Clerk
Department of Housing and Urban Development
451 7th Street, SW, Room 10276
Washington, D.C., 20410-00001

Re: Docket No. HUD-2019-0067
FR-6111-P-02 HUD's Implementation of the FHA's Disparate Impact Standard

Dear Sir or Madam:

The National Council of Insurance Legislators (NCOIL)¹ welcomes the opportunity to comment on the Department of Housing and Urban Development's (HUD/Department's) new proposed and revised implementation of the Fair Housing Act's (FHA's) disparate impact standard ("Rule").

INTRODUCTION/SUMMARY

We appreciate the Department's diligent revisions to the Rule. Sections (b), (c), and (d) establish standards consistent with the decision of the Supreme Court in *Inclusive Communities Project, Inc.* We focus on to whom these standards should apply, and recommend that section (e) fully exempt the business of insurance from the Rule, as its inclusion conflicts with prior Congressional action in the very area addressed by the Rule.

The Department's publication of the Rule explained that the Oct., 2017 report of the Secretary of the Treasury "explicitly recommended that HUD reconsider applications of the Disparate Impact Rule, especially in the context of the insurance industry." Fed. Reg. Vol. 84, No. 160 (Aug. 19, 2019) at 42856.

¹ NCOIL is a legislative organization comprised principally of legislators serving on State insurance and financial institutions committees around the nation. NCOIL writes Model Laws on insurance, and works to both preserve the State jurisdiction over insurance as established by the McCarran-Ferguson Act seventy-four years ago and to serve as an educational forum for public policy makers and interested parties. See <http://ncoil.org/history-purpose/>

The Department responded in Section (e) by restating the McCarran-Ferguson Act’s “invalidate, impair, or supersede” standard. This preemption rule already applies under current law when there is no relevant Federal “Act specifically relat[ing] to the business of insurance”²—which is usually the case, since McCarran delegated most policy choices regarding insurance regulation to the States.³

Congress does, however, from time to time pass substantive legislation specific to insurance regulation. The first time this happened was in McCarran itself, with respect to a few discrete issues, including the area covered by the Rule and section (e): insurer discrimination practices.

McCarran instituted Federal Trade Commission (FTC) enforcement of the Robinson-Patman Anti-Discrimination Act—previously thought not to attach to insurance—after a three year moratorium, but only to the extent the States did not legislate. This constituted what sponsors described as an “invitation to the States to legislate in good faith,” in order to “afford the public protection...against discrimination.”

The States correctly interpreted this carrot-and-stick mechanism as Congress’s mandate to them to enact statutes implementing Robinson-Patman unfair discrimination standards—requiring cost-based pricing, which, with respect to insurance, means actuarially justified rates—for the regulation of insurer discrimination practices.

Unlike most insurance code provisions, the resulting unfair discrimination laws did not result from State-by-State, independent policy judgments pursuant to Congress’s structural direction in McCarran that primary, independent State insurance policymaking “is in the public interest,” 15 U.S.C. 1011.

Instead, the historical record abundantly demonstrates that the States implemented McCarran’s substantive Federal policy regulating insurer discrimination practices in an unusually uniform manner, specifically adopting laws prohibiting “unfairly discriminatory” rates—all under Congress’s demanding, watchful eye and ticking deadline.

Robinson-Patman’s anti-discrimination standards—which are economic, not social—were made specific to insurance and insurer discrimination practices by McCarran, and in turn further to Congress’s intent, State insurance unfair discrimination statutes. By contrast, the

² See Rule, Section (e) (“Business of insurance laws. Nothing in this section is intended to invalidate, impair, or supersede any law enacted by any state for the purpose of regulating the business of insurance.”); 15 U.S.C. 1012(b) (“No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance...unless such Act specifically relates to the business of insurance.”).

³ See 15 U.S.C. 1011 (“Congress hereby declares that the continued regulation...by the several States of the business of insurance is in the public interest, and that silence on the part of the Congress shall not be construed to impose any barrier to the regulation...of such business by the several States.”); 15 U.S.C. 1012(a) (“The business of insurance...shall be subject to the laws of the several States which relate to the regulation...of such business.”).

FHA's social anti-discrimination standards are not specific to insurance and insurer discrimination practices.

Robinson-Patman, unlike the FHA, does not recognize disparate impact liability for protected social classes. The former statute's standard must control any administrative disparate impact rulemaking since Congress—by incorporating Robinson-Patman standards in McCarran—regulated insurer discrimination practices without recognition of disparate impact liability for protected social classes in an “Act specifically relat[ing] to the business of insurance.”

We respectfully request that the Department reconsider and exempt the business of insurance from the Rule's application of FHA social class disparate impact liability, in deference to the cost-based pricing, Robinson-Patman unfair discrimination standard implemented by the States—in the form of their unfair discrimination statutes—pursuant to McCarran's mandate.

I. McCarran And Robinson-Patman

After the Supreme Court held insurance to be interstate commerce in June, 1944, *see U.S. v. Southeastern Underwriters Assn.*, 322 U.S. 533 (1944), Congress and the National Association of Insurance Commissioners (NAIC) engaged in substantial dialogue before, during, and after McCarran-Ferguson's passage on March 9, 1945.⁴

NAIC prepared an early draft of this maiden Federal insurance regulatory legislation for Congress.⁵ The NAIC draft exempted insurance from the Robinson-Patman Anti-Discrimination Act.⁶ Robinson-Patman requires cost-based pricing by prohibiting “discriminat[ing] in price between different purchasers of commodities of like grade and quality.” 15 U.S.C. 13(a).

The proposed exemption met strong opposition, with Members arguing that “[i]t is unfair to legalize the practice of rate discrimination.” 91 Cong. Rec. 1091 (Feb. 14, 1945) (Rep. Bailey).⁷

⁴ The NAIC was at the time the only State association dedicated to insurance regulation; NCOIL was formed in 1969.

⁵ *See, e.g.*, Cong. Rec. A 4403 (Nov. 16, 1944) (Sen. Hatch) (“I wish to ask to have printed in the...Record...the report of the subcommittee on Federal legislation...of the National Association of Insurance Commissioners...a press release...of the executive committee...[and] the text of the proposed legislation recommended by the [NAIC].”).

⁶ *See* Interim Report, NAIC Subcommittee on Federal Legislation, 1945 NAIC Proc. 158 (“The commissioners...asked for outright exemption from the Robinson-Patman Act.”); H.R. Rep. 143, 79th Cong., 1st Session, Feb. 13, 1945 (“Nothing contained in the...Act of June 19, 1936, known as the Robinson-Patman Antidiscrimination Act, shall apply to the business of insurance.”).

⁷ *See also*, 91 Cong. Rec. 1027-1028 (Feb. 12, 1945) (Rep. Cochran) (“If you look at section 3 of the bill you will find that it exempts all the business of insurance companies...from the...Robinson-Patman Act...I will not vote for the bill as...reported...unless section 3 is stricken.”); 91 Cong. Rec. 1092 (Feb. 14, 1945) (Rep.

Members also noted the awkwardness of applying Robinson-Patman—a statute regulating commodities—directly to insurance.⁸ It was thus suggested that, “If the Members wish a bill of the character of the Robinson-Patman Act to cover insurance...a special bill should be introduced which should cover it more equitably and more accurately than the Robinson-Patman Act, which was not written with insurance in mind.” 91 Cong. Rec. 1090 (Feb. 14, 1945) (Rep. Gwynne).

Congress responded in McCarran—a “special bill...written with insurance in mind”—by crafting a mechanism to force the States to implement a national regulatory policy prohibiting unfair discrimination by insurers: A three year moratorium, after which Robinson-Patman would apply to insurance if the States had not prohibited unfair discrimination.⁹

II. McCarran as Substantive Federal Policy Directing State Unfair Discrimination Laws

The moratorium was designed to compel the States to pass unfair discrimination laws. Senator O’Mahoney, broker of the final McCarran-Ferguson bill, described it as “an invitation to the States to legislate in good faith.” 91 Cong. Rec. 1487 (Feb. 27, 1945). *See also id.* 1478 (Sen. McCarran) (“[T]he states are advised and warned that they have a moratorium of 3 years during which they may bring themselves into compliance by way of regulation.”); *id.* 1483 (Sen. Radcliffe) (“[T]he States would have certain opportunities to regulate....If they should attempt to enact any laws which would permit...unjust discrimination, this bill would intervene and prevent.”).

Congress thoroughly monitored the States’ compliance efforts. Senator McCarran explained that his Judiciary Committee “survey[ed]...the status of accomplishments and plans of the States” in response to the “feeling in the Congress that the Federal legislature has a positive responsibility to see to it that there is adequate regulation of insurance...by the...States.” Pat McCarran, “Insurance as Commerce—After Four Years,” 23 Notre Dame L.Rev. 299, 303, 306 (1948).

Kefauver) (“I doubt...Members...should...permanently exempt insurance from...the...Robinson-Patman Act.”).

⁸ *See* 91 Cong. Rec. 1090 (Feb. 14, 1945) (Rep. Gwynne) (“[S]ection 3 is not necessary...but it was inserted, I suppose, to make it clear that the Robinson-Patman Act should not apply to insurance....The Robinson-Patman Act was passed with the intent that it should regulate and control the sale of commodities. It was not meant to cover insurance.”).

⁹ *See* 15 U.S.C. 1013(a) (“Until June 30, 1948,...the Robinson-Patman Anti-Discrimination Act...shall not apply to the business of insurance.”); 15 U.S.C. 1012(b) (“[A]fter June 30, 1948,...the Act of October 15, 1914, as amended, known as the Clayton Act [Robinson-Patman amended the Clayton Act]...shall be applicable to the business of insurance to the extent that such business is not regulated by State law.”). The bill as passed in 1945 set a Jan. 1, 1948 date for expiration of the moratorium, later changed to June 30, 1948 in a 1947 amendment, *see* footnote 12 and accompanying text.

According to Senator McCarran, “adequate regulation” specifically included: “Will the regulations afford the public protection...against discrimination...?” *Id* at 310.

Our review of NAIC’s published Proceedings from 1945-1947 demonstrates the States’ paramount focus on complying with McCarran-Ferguson, including making a record of dozens of pages of reports submitted by NAIC’s Subcommittee on the Robinson-Patman Act.¹⁰

The NAIC concluded that, while Robinson-Patman’s applicability to insurance before 1945 was unclear, absent State legislative action, McCarran’s incorporation by reference of the earlier statute “implie[d] that after...1948...the Robinson-Patman Act will apply to the business of insurance.” Report of NAIC Robinson-Patman Act Subcommittee, 1947 NAIC Proc. 183-184.¹¹

This required a specific policy response: uniform passage of unfair discrimination laws. *See* Report of NAIC Robinson-Patman Act Subcommittee, 1947 NAIC Proc. 187-188 (explaining the “only way by which states may accomplish the ouster” of Robinson-Patman was “through the passage of rate regulatory laws” that “included...anti-discrimination sections,” and recommending the “enactment in each State—either as an integral part of the rating law or independently—of statutes...prohibiting unfair rate discriminations.”).

The States quickly passed model NAIC rating laws including unfair discrimination prohibitions in their legislative sessions following McCarran’s enactment. Congress,

¹⁰ *See, e.g.*, 1947 NAIC Proc. 153-172 (Reports of All-Industry Committee On Robinson-Patman Act; Report of the Subcommittee On The Robinson-Patman Act To The All-Industry Committee; Supplementary Report Of The Subcommittee On The Robinson-Patman Act; Supplemental Report); 1947 NAIC Proc. at 177-195. The three year moratorium in 15 U.S.C. 1012(b) is best known for its complex applicability to the Sherman Act, which is beyond the scope of, and not relevant to, the substance of this comment letter. Because McCarran’s far simpler applicability to Robinson-Patman, and the resulting unfair discrimination statutes are well-settled law and were far less controversial than McCarran’s interaction with the Sherman Act, the role of Robinson-Patman in McCarran-Ferguson implementation is largely forgotten to history. The NAIC Proceedings and other contemporaneous authorities, however, as demonstrated herein, are replete with analysis of Robinson-Patman’s inclusion in McCarran-Ferguson and the importance of the State unfair discrimination statutes as a necessary policy response.

¹¹ *See also id.*, at 1947 NAIC Proc. 161 (“Our conclusion is that since Section 1 of Robinson-Patman amends the Clayton Law, it is included within the proviso of Section 2(b) of Public Law 15 [McCarran]. Being within the proviso, the price discrimination...subsection[] appl[ies] to insurance ‘to the extent’ that there is no state law regulating the specific activities prohibited by these sections.”); Address of NAIC President Robert E. Dineen, 1947 NAIC Proc. 297 (“Many observers feel that despite the uncertainty as to whether or not insurance constitutes ‘goods’ or ‘commodities’ as those words are used in the Robinson-Patman Act [citations omitted], the very fact that the Robinson-Patman Act is specifically mentioned in U.S. Public Law 15 [McCarran] is a clear indication that Congress intended its provisions to apply to the insurance business.”); Memorandum of NAIC Casualty and Surety Rating Bill and Fire and Inland Marine Rating Bill Drafting Committee, 1946 NAIC Proc. 127 (“[T]he Robinson-Patman Act, a portion of which will be applicable to the insurance business after January 1, 1948, expressly prohibits price differentials by reason of volume or size unless supported by adequate cost figures.”); Supplemental Report of NAIC Robinson-Patman Act Subcommittee, 1947 NAIC Proc. 170 (“[I]nsurance cannot afford to proceed on the assumption that the Robinson-Patman Act is inapplicable and run the risk of the federal penalties, namely, action by the Federal Trade Commission, suits for treble damages, and in some cases criminal prosecution.”).

satisfied by the response to its “invitation to the States to legislate in good faith,” extended the moratorium from Jan. 1 to June 30, 1948, providing the States more time to pass McCarran-compliant legislation.¹²

III. State Unfair Discrimination Laws Implement A Federal Policy of Cost-Based Pricing

As Congress intended, the State unfair discrimination laws implemented as national regulatory policy the same basic anti-discrimination standard as Robinson-Patman: cost-based pricing and equal economic treatment of similarly situated consumers. *See* New York Superintendent/NAIC President Robert Dineen, Remarks, Sept. 21, 1948 (explaining that “the rationale of” the “Robinson-Patman Act, the All-Industry [NAIC Model] Bills and the New York rating law” is “generally the same, namely, that where varying prices on the same articles are quoted to different buyers...the seller should be able to establish that the variations in price are fair and reasonable.”).¹³

The State rating laws explicitly recognize that they implement substantive Federal unfair discrimination public policy pursuant to a Congressional mandate. *See, e.g.*, 24-A Me. Rev. Stat. § 2301 (“The purpose of this chapter is to promote the public welfare by regulating insurance rates, in accordance with the intent of Congress as expressed in Public Law 15—79th Congress [McCarran], to the end that they shall not be excessive, inadequate or unfairly discriminatory.”); *Karlin v. Zalta*, 154 Cal.App.3d 953, 967 (1984) (“There ensued precipitate state action to implement the McCarran Act and by 1950 every state had enacted rate regulatory legislation.”).¹⁴

¹² *See* Sen. Rep. 407 (July 1, 1947) (“This bill extends the so-called moratorium provision of Public Law 15...from January 1, 1948, until June 30, 1948. The committee is informed and is satisfied that an effort has been exerted by the insurance industry, the insurance commissioners, and the States in dealing with the matter of State regulation...[I]t would appear most desirable to extend this moratorium period an additional 6 months.”).

¹³ Quoted in Stone and Campbell, “Insurance and the Robinson-Patman Act,” 1949 Ins. L.J. 553, 564 (1949). *See also* Speech of NAIC president James McCormack, 1946 Proc. 212-213 (“[N]o state legislation should prevent the economic non-discriminatory rating of risks....There should be no unfair discriminations.”); Hanson et al, “Monitoring Competition: A Means of Regulating the Property and Liability Insurance Business,” at 440 (1974 National Association of Insurance Commissioners) (NAIC treatise describing the “parallel...between the state insurance prohibitions against unfairly discriminatory rates and the Robinson-Patman Act [which]...prohibits sellers from discriminating in price between different purchasers....[I]f the costs are the same, the seller cannot discriminate price....This is akin to the unfairly discriminatory concept in the insurance laws.”).

¹⁴ *See also* 18 Del. C. § 2501 (“The purpose of this chapter is to promote the public welfare by regulating insurance rates...in accordance with the intent of Congress as expressed in Public Law 15-79th Congress [McCarran]...and to the end that they shall not be excessive, inadequate or unfairly discriminatory.”); *Pac. Fire Rating Bur. v. Ins. Co. of N. Am.*, 83 Ariz. 369, 371 (1958) (“Because the federal antitrust laws were, by Public Law 15...made inapplicable to insurance only to the extent that the business was regulated by state law, each state proceeded to enact a rate law.”); *Ins. Co. of N. Am. v. Com’r. of Ins.*, 327 Mass. 745, 748 (1951) (“During the period of delay thus afforded [McCarran moratorium], model laws were prepared by the [NAIC]....These have now been adopted with few changes in almost every State.”).

The State unfair discrimination statutes establish an economic, cost-based pricing standard—which, with respect to insurance, means actuarially justified rates—for the regulation of insurer discrimination practices. “[U]nfair discrimination’ is a word of art used in the field of insurance which, ‘[i]n a broad sense...means the offering for sale to customers in a given market segment identical or similar products at different probable costs.’ [Citations omitted.]” *Polan v. State of New York Ins. Dept.*, 3 A.D.3d 30, 33 (N.Y. App. 2003).¹⁵

This regime differs fundamentally from the FHA: Courts distinguish the economic unfair discrimination standard specific to insurance from social standards applied under general civil rights laws. *See, e.g., Thompson v. IDS Life Ins. Co.*, 274 Or. 649, 654 (1976) (“The Insurance Commissioner is instructed to eliminate unfair discrimination, whereas the Public Accommodations Act prohibits *all* discrimination. The reason for the different standards...is that insurance...always involves discrimination...based on statistical differences and actuarial tables. The legislature specifically intended...to only prohibit *unfair* discrimination in the sale of insurance policies.” [Emphasis in original.]).

IV. McCarran’s Discrimination Standard—Specific to Insurance And Not Recognizing Disparate Impact—Controls Over the FHA’s Discrimination Standard, Which is Not Specific to Insurance.

With little Federal substantive law specific to insurance regulation, McCarran’s “invalidate, impair, or supersede” standard—governing Federal Acts not specific to insurance and State insurance regulatory laws—is the most common way that Federal statutes are applied to insurance.

The Rule, however, pertains to subject matter (insurer discrimination practices) governed by a Federal statute specific to insurance (McCarran-Ferguson). The FHA, a statute not specific to insurance, protects social classes and recognizes disparate impact. By comparison, protected social class disparate impact liability has not been found cognizable under the economic statute made applicable to insurance under McCarran: The Robinson-Patman Anti-Discrimination Act.

McCarran’s specific direction regarding regulation of insurer discrimination practices—under which protected social class disparate impact liability is not cognizable—must control over the FHA because the latter statute is not specific to insurer discrimination practices. “It is a commonplace of statutory construction that the specific governs the

¹⁵ *See also Ins. Com'r v. Engelman*, 345 Md. 402, 413 (1997) (“Unfair discrimination, as the term is employed by the Insurance Code, means discrimination among insureds of the same class based upon something other than actuarial risk.”); *Life Ins. Assn. v. Com'r. Of Ins.*, 403 Mass. 410, 416 (1988) (“The intended result of the [risk classification] process is that persons of substantially the same risk will be grouped together, paying the same premiums, and will not be subsidizing insureds who present a significantly greater hazard.”).

general.” *NLRB v. SW General, Inc.*, 137 S.Ct. 929, 941 (2017) (Internal citation and punctuation omitted).¹⁶

Section (e) of the Rule would run contrary to this canon and compound the error by codifying, for insurer discrimination practices, just McCarran’s “invalidate, impair, or supersede” standard—which is designed to apply only absent a relevant “Act specifically relat[ing] to...insurance,” 15 U.S.C. 1012(b), *supra*.

The Department itself has conceded the priority of McCarran over the FHA in the context of regulating insurer discrimination practices. In an Oct. 4, 1977, HUD memo, prepared to develop a “detailed work plan on insurance redlining,” and shared with the NAIC, 1978 NAIC Proc. Vol. I at 637, HUD’s Redlining Staff explained that “The role of the federal government...is somewhat limited with this industry given the McCarran-Ferguson Act,” *id.* at 640.¹⁷

Recognizing that no Federal law other than McCarran regulated insurer discrimination practices, the HUD Redlining Staff approvingly described “current federal legislative initiatives”—including “Pending Title VIII amendments [which] might make insurance companies covered by the Fair Housing Act[,] thus prohibiting discriminatory practices.” *Id.* at 641. These proposed bills failed, however, and Title VIII, the FHA, still contains no language specifically covering insurers.

Further, Congress has repeatedly considered, but never passed, amendments to McCarran regulating insurer discrimination practices by protected social class.¹⁸ Thus McCarran’s original statutory incorporation by reference of Robinson-Patman remains controlling Federal policy regarding insurers.¹⁹ Since Robinson-Patman is not a statute that recognizes protected social class disparate impact liability, a Federal disparate impact standard for insurer discrimination practices cannot be created by administrative rulemaking that implements a statute—the FHA—that is not specific to insurance.

¹⁶ See also *Radzanower v. Touche Ross & Co.*, 426 U.S. 148, 153 (1976) (“It is a basic principle of statutory construction that a statute dealing with a narrow, precise, and specific subject is not submerged by a later enacted statute covering a more generalized spectrum.... ‘The reason and philosophy of the rule is, that when the mind of the legislator has been turned to the details of a subject, and he has acted upon it, a subsequent statute...treating the subject in a general manner, and not expressly contradicting the original act, shall not be considered as intended to affect the more particular or positive provisions....’ [Citation omitted.]”).

¹⁷ HUD’s staff Memo also concluded that a Federal agency specific to insurance—the Federal Insurance Administration, not HUD—“was the most obvious agency to begin considering” how to address redlining. *Id.* at 640.

¹⁸ See, e.g., Insurance Competition Improvement Act, S. 2474, 1980.

¹⁹ State insurance codes prohibit direct (but not indirect, disparate impact) discrimination by insurers against protected social classes. See, e.g., NAIC Property and Casualty Model Rating Law (No. 1780), Section 4 (“Rates shall not be excessive, inadequate, or unfairly discriminatory....[R]ating plans [may] establish standards for measuring variations in hazards or expense provisions....[and] may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses. No risk classification, however, may be based upon race, creed, national origin or the religion of the insured.”).

CONCLUSION

The Treasury Report, cited in the Rule’s publication, asked “whether the disparate impact rule...is consistent with McCarran-Ferguson and existing state law [and]...whether such a rule...is reconcilable with actuarially sound principles.” Treasury Report to the President, Oct. 2017, 110. NCOIL—pursuant to its mission of “preserv[ing] the state jurisdiction over insurance as established by the McCarran-Ferguson Act”²⁰—is uniquely qualified to comment on this question.

While our organization protects State legislators’ discretionary authority as primary regulators—granted under McCarran’s unique structural regime wherever no Federal “Act specifically relates to...insurance”—we understand that State unfair discrimination statutes were passed in conscientious response to McCarran’s substantive mandate.

McCarran, an “Act specifically relate[d] to...insurance,” applies Robinson-Patman cost-based pricing standards to insurer discrimination practices. Including insurance in the Rule would undermine the States’ diligent efforts to implement McCarran’s Federal insurance regulatory policy under which insurer discrimination practices are not subject to disparate impact liability.

Absent contrary direction from Congress specific to insurance, McCarran’s economic discrimination standard specific to insurance must control. We therefore respectfully suggest that, because the FHA is not specific to insurance, exempting insurers from the Rule’s disparate impact discrimination standard for protected social classes is not just appropriate, but necessary.

Thank you for your consideration. Please contact the undersigned, at 732.201.4133, or tconsidine@ncoil.org, should you require further information.

Very truly yours,



Thomas B. Considine
Chief Executive Officer
National Council of Insurance Legislators

²⁰ <http://ncoil.org/history-purpose/>.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
NCOIL ANNUAL MEETING – AUSTIN, TX
DECEMBER 13, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the JW Marriott on Friday, December 13, 2019 at 12:14 p.m.

NCOIL President, Sen. Dan “Blade” Morrish, LA, Chair of the Committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Rep. Matt Lehman, IN, Vice President
Asm. Ken Cooley, CA, Treasury
Asm. Kevin Cahill, NY, Secretary
Rep. Deborah Ferguson, AR
Sen. David Livingston, AZ
Rep. Joe Fischer, KY
Rep. Martin Carbaugh, IN

Rep. Edmond Jordan, LA
Rep. George Keiser, ND
Sen. Jerry Klein, ND
Sen. Neil Breslin, NY
Asm. Andrew Garbarino, NY
Asw. Pam Hunter, NY
Rep. Tom Oliverson, TX

OTHER LEGISLATORS PRESENT:

CT Sen. Matt Lesser
CO Rep. Matt Gray
CO Sen. Jack Tate
IN Rep. Andy Zay

MN Sen. Gary Dahms
MN Sen. Paul Utke
MT Rep. Bruce Grubbs

ALSO PRESENT:

Commissioner Tom Considine, NCOIL CEO
Paul Penna, Executive Director, NCOIL Support Services
Will Melofchik, General Counsel, NCOIL
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services

QUORUM

A motion was made by Sen. Klein and seconded by Rep. Keiser to waive the quorum that carried on a voice vote.

MINUTES

A motion was made by Rep. Keiser and seconded by Sen. Dahms to approve the minutes of the July 13th, 2019 Committee Meeting minutes.

FUTURE LOCATIONS

Commissioner Considine discussed options for both Scottsdale and Seattle for the 2021 Annual Meeting from November 17th – 20th. Still no action from Washington to join as a

contributing state. He suggested the Kierland Westin in Scottsdale, which is 15 minutes from downtown, but no location downtown can accommodate NCOIL's banquet needs.

Sen. Morrish directed staff to pursue the Scottsdale location.

ADMINISTRATION

Commissioner Considine noted that there were 353 registrants for the Annual Meeting, 57 legislators and participants from 33 states. 16 first time legislators, 10 legislators participated via full and 3 partial ILF scholarships. 4 Commissioners participated, and 9 insurance departments were present.

Paul Penna gave the 2019 third quarter unaudited financial report through September 30, 2019 showing revenue of \$906,136.47 and expenses of \$737,990.19 for an excess of \$168,146.28.

Rep. Keiser made a motion to accept the administration report that was seconded by Asm. Cooley. It carried on a voice vote.

RESOLUTION HONORING SEN. LARKIN

Sen. Morrish acknowledged Asm. Cahill to discuss the Resolution honoring Sen. Larkin's life. Cahill said Larkin was a character beyond words. They shared portions of their districts and Larkin would inject you into his speeches and stories. After returning from an NCOIL meeting, Larkin would tell other NY legislators how the New York delegation ran the whole meeting. Cahill noted that Larkin's contribution to New York and the country, including his military service, was commendable and reminded everyone that near the end of his career he worked to renovate the National Purple Heart Hall of Fame into a renowned center because of his work. Cahill concluded that while they did not agree on much politically, he was a great politician and he holds many fond and happy memories of him. He moved the resolution and acknowledged his New York colleague, Asm. Garbarino.

Asm. Garbarino noted that he served a few years with Sen. Larkin and he was a great storyteller that everyone wanted to sit next to at events. It was really an honor to serve with him.

Assemblyman Garbarino seconded the resolution which passed on a voice vote. A copy of the resolution will be forward to Sen. Larkin's family.

CONSENT CALENDAR

Sen. Morrish asked if any member had an item to take off the consent calendar. Since no member did, Asm. Cooley made a motion to accept the consent calendar and Rep. Carbaugh seconded the consent calendar. The motion carried on a voice vote.

OTHER SESSIONS

Sen. Morrish discussed the general sessions including the Griffith Foundation and Michael McCord for the Legislator Luncheon "A Primer on Microinsurance" and the

corresponding general session – Microinsurance Explosion: Lessons from Abroad and their Impact on the US Market.

The Start Up CEO was a fascinating look at the process of research and development of drug pricing in this country.

Sen. Morrish thanked TX Commissioner Kent Sullivan for speaking at the Welcome Breakfast and Tom Workman as the keynote luncheon speaker.

There were 3 interesting and timely General Sessions –

- 1) The Gig Gap – Does Insurance Come With That?;
- 2) Insuring the Previously Unimaginable: A Discussion on the Active Shooter Insurance Coverage Landscape; and
- 3) The US Healthcare System in Flux: Judicial Repeal of the ACA? Medicare for Whom?

NOMINATING COMMITTEE REPORT

Sen. Morrish gave the Nominating Committee report and stated that the existing 3 officers will move up with IN Rep. Lehman serving as President, CA Asm. Cooley as Vice President, NY Asm. Kevin Cahill as Treasurer and the addition of KY Rep. Joe Fischer as Secretary. Rep. Carbaugh made a motion to accept that was seconded by Asm. Garbarino. The motion carried on a voice vote.

OTHER BUSINESS

Cmsr. Considine asked the committee to continue utilizing the services of Collins & Co for 2019. They have done so for several years. They are a fine a professional group but made improvements to practices and will continue at the same rate. A motion was made by Rep. Smith and seconded by Asm. Cahill. The motion carried on a voice vote.

Sen. Morrish noted that pursuant to NCOIL bylaws, as chair of the relevant committee in their states that attended the NCOIL meeting and Executive Committee, CT Sen. Matt Lesser and MN Sen. Gary Dahms are automatically added to the Executive Committee.

Asm. Garbarino noted that MN Sen. Utke has been a diligent participant for a few years at NCOIL and nominated him as a member of the Executive Committee. Rep. Lehman seconded the motion which carried on a voice vote.

Sen. Morrish called on John Ashenfelter to discuss IEC topics. The IEC suggested two topics for discussion at a future NCOIL meeting:

Value of a Competitive and Profitable Insurance Industry to Every State's Economy. This is suggested as a Griffith Foundation session for legislators and regulators.

What Can States Do To Accelerate Natural Disaster Recovery? Consider public policy proposals relating to:

- creation of Disaster Recovery Zones to facilitate shared purchasing;

- address specific regulatory requirements that slow down insurers' efforts to adjust and pay claims quickly and efficiently

Sen. Morrish thanked Rep. Oliverson, his staff and the Texas Department of Insurance for their help in making this meeting successful.

Rep. Keiser asked to be recognized and stated that NCOIL should examine the relationship between property & casualty insurance on homeowners and appraisers being employees or 100% provider and there is a conflict of interest. Constituents in his state are raising it as an issue, and though he is not sure if it an issue in other states, he would appreciate this discussion at a future NCOIL meeting about the value of an independent appraiser because that relationship has become really close and should be examined. Sen. Morrish thanked him for the suggestion and asked staff to take it under advisement.

Sen. Morrish recognized Rep. Lehman as new NCOIL President, who honored Sen. Morrish for his year as President.

Lehman was recognized to make a few comments – that when he came to his first NCOIL meeting in Boston in 2010 and has attended every meeting since then, Sen. Morrish and Rep. Keiser were among the first legislators to make him feel welcome. Under his leadership with the new dues structure, NCOIL has become a healthier organization with increased participation among parties and chambers. NCOIL will continue to work on timely issues and act on them quickly. Health care insurance will continue to be a huge issue, along with technology and flood insurance. “Working with our partners, in this room, NAIC, NCSL and in this world we live in.”

Rep. Lehman noted that the experiment at this meeting to run consecutively with the NAIC was useful but maybe in a different format in the future. NCOIL needs to move meetings back to November from December. December is too late in that process for states that have pre-file deadlines. He also thanked the NCOIL staff for their help in transitioning him to this role as President, including a trip to the NCOIL office New Jersey that he took with no photo ID, which, he noted, is a story for another day.

Lastly, he stated to Sen. Morrish that it has truly been an honor to know and serve with him. He noted that all legislatures have “Blade Morrish’s” in their chambers that participate for the right reasons. Rep. Lehman noted that out of respect for Blade he was not wearing a tie and offered a symbol of their gratitude with a personalized NCOIL seal (not a lapel pin).

Sen. Morrish thanked the staff by name who worked tirelessly to make his role as president easy on him. He stated that the organization is in much better hands with their expertise. He stated to the legislators who have been attending to please continue. This organization is valuable. He stated that he has been honored to serve and “will miss you all tremendously”.

Rep. Lehman acknowledged the incoming officers in their new roles and said there is a great team coming. Noted that there was no other business, he asked for a motion to adjourn.

ADJOURNMENT

There being no further business, Sen. Morrish made a motion to adjourn that was seconded by Rep. Jordan. The committee adjourned at 12:39 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
AUSTIN, TEXAS
DECEMBER 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the JW Marriott Hotel in Austin, Texas on Wednesday, December 11, 2019 at 5:30 p.m.

Representative Bart Rowland of Kentucky, Vice Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Shawn Vadaa (ND)
Sen. Travis Holdman (IN)	Asm. Andrew Garbarino (NY)
Rep. Matt Lehman (IN)	Asw. Pam Hunter (NY)
Rep. Joe Fischer (KY)	Asw. Ellen Spiegel (NV)
Rep. Edmond Jordan (LA)	Rep. Tom Oliverson, M.D. (TX)
Rep. George Keiser (ND)	Del. Steve Westfall (WV)
Sen. Jerry Klein (ND)	

Other legislators present were:

Sen. Matt Lesser (CT)	Sen. Paul Utke (MN)
Rep. Chris Judy (IN)	Rep. Donna Pfautsch (MO)
Rep. Peggy Mayfield (IN)	Rep. Bruce Grubbs (MT)
Sen. Gary Dahms (MN)	Sen. Cale Case (WY)

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Rep. Matt Lehman (IN), NCOIL Vice President, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Jerry Klein (ND) and seconded by Rep. Keiser, the Committee approved the minutes of its July 12, 2019 meeting in Newport Beach, CA without objection by way of a voice vote.

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL INSURANCE
MODERNIZATION LEGISLATION

Rep. Bart Rowland (KY), Vice Chair of the Committee, first noted that the consideration of the NCOIL E-Commerce Model Act, sponsored by Rep. Edmond Jordan (LA), will be removed from the agenda and will be discussed and considered at the NCOIL Spring Meeting in March.

a.) Discussion on NCOIL E-Titling Model Act

Del. Steve Westfall (WV), sponsor of the NCOIL E-Titling Model Act (Model), stated that the Model is simple in that it requires the Department of Motor Vehicles (DMV), or appropriate state agency, to develop or utilize an existing electronic vehicle titling system to process motor vehicle title transactions, including, without exception, salvage, junk and/or non-repairable titles. The system shall allow for the use of electronic signature and provide for the submission of all required and/or associated documents by electronic means.

Jim Taylor, VP of Auto Data Direct, Inc. (ADD), stated that it is amazing that for 20 years the automobile industry across the country, particularly in 18 jurisdictions, has had the opportunity to do electronic transactions of their titles. By that, they sell the car to the dealership, get on the computer, upload the information to the DMV electronically, make images of the documents and submit them to the DMV electronically, and the titles are issued with no paper and no problems. Unfortunately, the insurance industry has not had that opportunity and therefore the purpose of the Model is to bring the insurance industry and total-loss salvage title processing into the modern day world such that documents can be signed electronically, transmitted to the DMV electronically, titles can be issued and the cars can be sold at auction. The process is not new and has been used by multiple industries across the country and it is time for the insurance industry to get the same opportunity.

Mr. Taylor stated that what makes the process so unique is that it is very fast. Normally, if you are transmitting paper to a DMV via Fed-ex that can take several days and then the DMV has to open the package up, grade the paperwork, make copies, manually input the data into their own system, generate a title and send it back. That can take anywhere from 15 to 20 days depending on the speed of the DMV. With electronic processing, it can occur same day as it is that quick and efficient. The system is also accurate in the sense that the DMV personnel are not receiving paper forms and then reentering that data into their database. Traditionally, the insurer or the dealer processing this creates an electronic file themselves, so they are doing the data input and providing the forms electronically either by true electronic forms or scanning the paper in and sending those scans. So, there is less data entry and error, so the titles get issued faster and more accurately.

Mr. Taylor stated that the entire process becomes more efficient. If you can imagine the millions of paper documents that are sent via Fed-ex between insurance carriers and DMVs every month to process salvage titles it is mind boggling. And when those papers get to the DMV, they ultimately have to get scanned into an electronic format anyway, so the process is essentially being entirely electronically based. Mr. Taylor stated that Florida took advantage of this process this year as it has had an electronic platform called Electronic Filing System that has been in place for 20 years. However, it was solely for the use of the automobile dealer industry. FL HB 1057 allowed that platform to be used by the insurance industry. Florida is somewhat unique in that it has third party vendors that actually work with the carriers and are the in-between for the carrier and

DMV. The FL Dep't of Highway and Motor Vehicles is current programming the system and it is looking like it will be implemented in June of 2020. Mr. Taylor stated that ADD is excited that the Model is something that can be considered by other jurisdictions, and thanked Del. Westfall for sponsoring the Model.

Frank O'Brien, VP of State Gov't Relations for the American Property Casualty Insurance Association (APCIA), stated that this issue is a win-win. Many DMVs across the country are in the process of updating their existing computer systems in order to comply with the federal government's real-ID Act requirements. That provides the industry and states with the opportunity to move the titling process into the 21st century and do what everyone is familiar with which is electronically transferring documents. There are a couple of technical issues in the Model that will probably need to be addressed in terms of referencing federal standards. This is a highly technical area, but it is also an area in which efficiencies would mean additional efficiencies for state governments, insurers which would ultimately benefit consumers.

b.) Discussion on NCOIL Rebate Reform Model Act

Rep. Lehman, sponsor of the NCOIL Rebate Reform Model Act (Model), stated that the Model was drafted after the discussion this Committee had in July at the NCOIL Summer Meeting. The discussion included The Honorable Eric Cioppa, Superintendent of the Maine Bureau of Insurance and NAIC President, discussing the work he did in Maine to pass rebate reform legislation. The goal of the Model is to bring some uniformity to the world of state rebating laws. Rep. Lehman noted that he does not believe consumers complain about rebating, but it is rather something legislators, regulators, carriers, and agents discuss to make sure there is fair competition.

Rep. Lehman noted that Section 3 of the Model is focused on the agent community. Section 4 deals with value-added services and whether certain products offered by insurers would be considered an impermissible rebate. Rep. Lehman stated that the Model tries to make sure that the service is geared towards actual risk prevention/education/assessment/monitoring or control which is why the word "exclusively" is used. Section 5 of the Model deals with services provided that are either free or less than market value and whether they would be deemed an impermissible rebate such as back support of filing forms or loss control services that may have a dollar amount but are just included in the product. Rep. Lehman stated that no vote will be taken on the Model today and hopefully after hearing from the panel today, the Model will be ready for a vote at the Spring Meeting in March. Rep. Lehman noted that the NAIC is also working on this issue and he looks forward to working together.

The Honorable Dean Cameron, Director of the Idaho Department of Insurance and NAIC Secretary-Treasurer, stated that the NAIC appreciates Rep. Lehman bringing this issue forward and would love to work with NCOIL on the Model. Dir. Cameron stated that the majority of Insurance Commissioners are not really enforcing the existing rebating laws which is a sad commentary, but it is the reality. If there is not a consumer complaining about rebates or some other type of situation, Insurance Commissioners are not going out trying to enforce rebating laws. If there is something seen regarding taking rebates and paying for premiums or someone who has taken a more systemic approach where they are offering services for zero cost if the individual will by an insurance product then that becomes an issue of an illegal inducement under the Unfair Trade Practices Act (UTPA).

Dir. Cameron stated that most rebating laws have been around for 100 years. Many states have adopted the UTPA. Rebating laws were established because there was a situation in the country where agents were figuring out ways to sign people up for the product without them paying any premium and after one year they would drop off. There were some pretty horrific cases in Idaho where people went to prison after doing that. Dir. Cameron stated that it is clear to the NAIC that something needs to be done and its Innovation and Technology Task Force (Task Force) has begun to look at ways that current insurance laws are barriers to technology and rebating laws have been a focal point of that discussion.

There are a number of items where it makes sense to allow insurance companies to offer certain items such as wearables and pipe/flood monitors in homes. Those items should be allowable regardless of whether they meet a dollar threshold. However, it is important to be careful so as to not open the barn door so wide that people can go back to the days of creating an unlevel playing field by using commission dollars to pay for premiums and then if they sell a certain amount of business they demand a higher commission thereby creating solvency issues. In the long run, such a process is harmful to consumers as it causes the price of the product to increase. Dir. Cameron stated that the NAIC looks forward to working with Rep. Lehman and noted that some states have issued bulletins on rebates such as North Dakota. This is also a situation of being careful of what is asked for because currently, with the exception of wearables and other devices, rebates have not been a huge issue.

John Fielding, General Counsel for The Council of Insurance Agents & Brokers (CIAB), stated that CIAB appreciates NCOIL working on this issue and looks forward to submitting specific comments on the Model. CIAB's members are the largest brokers in the country and in the world and place over 90% of the commercial P&C in the country. Out of about the 170 million lives that are in employer-sponsored plans, CIAB's members sell or consult about 70% of those policies. Accordingly, CIAB comes from the commercial broker perspective – not the personal line or carrier perspective – as rebating laws affect CIAB's members differently. Mr. Fielding stated that from CIAB's perspective we are talking about business to business relationships – sophisticated entities working with each other and wanting to provide the best services at the best price. In the commercial space, the rebating laws are not protecting the consumer or solvency and are really all about turf protection. The laws protect CIAB's members from having to compete and in doing so they harm commercial consumers on price and by inhibiting innovation and service.

Mr. Fielding stated that CIAB believes the government should not pick winners and losers in this marketplace or tell consumers that they cannot get a deal. For those reasons, commercial brokers should be carved out from rebating prohibitions. More specifically, it is important to keep in mind going forward that the rebating laws apply directly to brokers and not by or through insurers with whom they might be working with. Brokers have independent obligations to comply with the law and brokers also have their own independent relationships with their clients, distinct and separate from the insurer-policyholder relationship and that has to be reflected in whatever Models are enacted. Those ongoing relationships began before placement and they can continue long after a policy is placed. The relationships are generally related to insurance coverage but they are not necessarily related to an individual or a specific policy, nor are they limited to the specific list of areas that are listed in the draft Model such as loss prevention - the relationships can be broader.

An example is that the Affordable Care Act (ACA) was enacted ten years ago and it obviously brought about huge changes to the employer-sponsored marketplace and in dealing with that, CIAB's members had to do a number of things. Such members had to educate their clients, figure out what problems or opportunities the ACA created, and then help their clients make changes. The employer didn't know what to do so they looked to their insurance professionals to help them. Fast forward a few years and CIAB members are helping their clients comply with ongoing changes such as reporting requirements and COBRA administration and enrollment. CIAB has seen continued changes such as health reimbursement arrangement (HRA) and health savings account (HSA) rules where employers are looking to brokers to figure things out. Commercial brokers are looking to be flexible and they want the freedom to work with their clients just like all other parts of the markets do. That is why CIAB believes there should be a carve out for commercial brokers. Mr. Fielding stated that CIAB believes that this is a great opportunity to make the rebate laws that are over 100 years old reflect how the marketplace looks today.

Mr. O'Brien stated that NCOIL should be commended for taking action with respect to rebating laws and stated that this is a reflection of the NCOIL process. Ever since the 2017 NCOIL Summer Meeting, NCOIL has been taking a look at innovation and changes in the marketplace. Over the course of many sessions it became clear that there were going to need to be, or should be, a number of changes in state law in order to enable the provision of additional services and products that APCIA's customers are looking for. Rebating laws are a prime example of that.

One of the reasons why APCIA is involved in this discussion is that its customers, whether producers or insurers, are looking to APCIA to provide a certain level of expertise because they are the experts in the insurance business. As the marketplace evolves, people are beginning to say to APCIA "why can't you help me?" whether it be the provisions of information regarding the ACA or loss control services. APCIA has since offered some modest changes to the rebating laws so that APCIA's members could have the opportunity to buy loss control related devices and provide them to consumers in an effort to assist them. Mr. O'Brien stated that as APCIA went out into the states, it discovered that a lot of the rebating laws have been on the books for 100 years and have been weighed down with esoteric and somewhat ridiculous interpretations and have therefore lost all contact with their historic underpinnings. The laws did begin to prevent the practice of agents rebating premiums back to consumers, but they have now morphed into an area of where you come out with some goofy interpretations.

For example, in Massachusetts – which has one of the most restrictive rebating laws - the Insurance Commissioner at one point in time was required to opine that if you had a stress ball it was ok for the consumer to take the stress ball off the counter at the agency, but it was not ok for the producer to hand the stress ball to the consumer. That does not make sense. Mr. O'Brien stated that the Model consists of some language that APCIA offered for consideration, as well as the current Maine rebating statute. Mr. O'Brien stated that he worked with Maine Superintendent Eric Cioppa to enact said statute and although it is a good statute, both he and Supt. Cioppa would have liked to see it go further. The Model is a somewhat modest proposal that in APCIA's view tries to deal with the issues surrounding the traditional marketing practices while at the same time attempting to put in place some certainty relative to loss control services and devices.

Mr. O'Brien stated that the Model is needed despite states developing bulletins on this issue because often times you can look at a statute which says one thing and the bulletin says another. Accordingly, the Model is an opportunity to provide certainty and clarity. One of the fundamental things that APCIA likes to do, which it hears from its members, is to know what the rules of the road are – this is a chance to define what some of those rules of the road are. Mr. O'Brien stated that APCIA does have some concerns with the use of the word "exclusive" and believes that the word "reasonable" may be better. The devil will be in the details with this issue. Mr. O'Brien stated again that NCOIL has been a leader on this issue and it has been noticed across the country that NCOIL is somewhere where insurance innovation is taken seriously.

Wes Bissett, Senior Counsel of Gov't Affairs for the Independent Insurance Agents & Brokers of America (IIABA), stated that at the outset, the agent and broker community is very diverse and IIABA has hundreds of thousands of members nationwide. Accordingly, IIABA does not have a unanimous perspective on this issue but there are some areas where there is general agreement. About five months ago, the IIABA submitted detailed comments to the NAIC on this issue and Mr. Bissett stated he would be happy to submit those to NCOIL as well. As a starting point, anti-rebating laws have and continue to serve a number of purposes one of which is, as cited by the insurance treatise, to protect the solvency of the insurance company as well as preventing unfair discrimination among insureds of the same class, protect the quality of service, avoid concentration of the market among a few insurance companies and avoid unethical sales. So, while there may not be a solvency benefit to the anti-rebating laws, there are still some other purposes that remain relevant today and meaningful. If the laws did not exist there would be the possibility for insurance players to perhaps absorb short term losses and offer products that arguably would provide a short-term benefit to consumers, but the long-term effects would be anticompetitive in nature.

Mr. Bissett stated that there has been a lot of productive activity at the state level over the past ten years or so regarding rebating and most of it has taken the form of regulations and bulletins. More recently, there has been some statutory action that focuses on some of the areas that the Model targets such as establishing monetary thresholds and/or allowing the types of meaningful risk mitigation products and services everyone has heard about. The statutes are somewhat narrow but states such as Arizona, New Hampshire, Pennsylvania and New Mexico have acted within the past couple of years. In PA, the recently adopted law enables agents and companies to provide offerings that relate to loss control of the risk covered by the policy. Arizona did something similar as well.

Mr. Bissett stated that he believes that Rep. Lehman has done a great job of not taking a chainsaw to anti-rebating laws but rather looking only at the areas that are in need of meaningful reform. Focusing on things like risk mitigation and things that are actually tied to the insurance transaction makes sense whereas offering things that really have no nexus to the insurance transaction may not be as warranted. Mr. Bissett stated that despite general consensus that something should be done to reform anti-rebating laws, the process of doing so may not be that easy. There are some complex, public policy issues involved here that will involve line-drawing in ways that might not be that easy.

Mr. Bissett stated that IIABA has the most concerns with Section 5 of the Model and the offering of things that are tangentially related to an insurance contract or the administration thereof. One thing to think about with that language is to make sure that

the product offered in that instance cannot be conditioned upon some subsequent event happening such as buying insurance or appointing the person as an agent. IIABA has seen some things in the marketplace recently where people were playing games with those scenarios so there may need to be further focus and drafting in that area.

Birny Birnbaum, Director of the Center for Economic Justice (CEJ), stated that going by the comments from the panelists thus far one might think that insurers are unable to provide loss prevention services. However, insurers have been engaged in loss prevention with their policyholders for well over a century. Therefore, it is a bit of a misnomer to state that insurers are not able to provide loss prevention services. There are telematics services in the auto insurance industry and there are wearable devices that companies are using, and they are tied into the premiums that people pay. Mr. Birnbaum stated that what APCIA has proposed is a really a massive re-regulation of insurance rating under the guise of helping innovation. CEJ believes that the issues that need to be addressed can be addressed much more narrowly.

With regard to the Model, Mr. Birnbaum stated that CEJ recommends NCOIL working closely with the NAIC as they are working on this issue as well. The things that the regulators bring to the table on this issue are what tools they need to monitor these issues, and what kind of regulatory authority and resources are needed to make sure that the things everyone does not want to happen do not occur. Mr. Birnbaum stated that the term “value added service” should be removed from the Model – what is being talked about under that term are loss prevention services so they should in fact be called that. The term value added service is vague and could mean anything to anybody. It is also very important to distinguish between products and services that have a rate impact and those that don't. For those not familiar with it, there is something called the filed rate doctrine which protects insurers from challenges to their rates or their policy forms from consumers if those rates and forms have been filed with the insurance department. Once an insurance company files a rate with the department, even if a consumer thinks that they are being gouged, they cannot challenge it because the legislature has vested with the regulator the authority to review those rates, which makes sense. If the Model opens up the ability to basically change what people pay for premiums by calling it a rebate, what's happening is that insurance companies are being opened up to rate challenges. CEJ does not want to see that as CEJ believes the regulatory structure makes sense and should not be disturbed.

Mr. Birnbaum stated that CEJ believes that the language in Section 5 regarding the service being “tangentially related” should be changed to “directly related.” Also, with regard to the language “...the services are offered on the same terms to all potential insurance customers” Mr. Birnbaum noted that if he is offering private flood insurance, and the loss prevention service being offered is a flood prevention device, is it sufficient to say that he is offering a flood prevention device to all potential customers when a customer with a low value home might get something worth \$150 and a customer who lives in a mansion might get something worth \$5,000?

Mr. Birnbaum further stated that the issue of unfair discrimination is real. As we enter into an era of big data, insurance companies have greater ability to identify not just the current value of a customer but also the lifetime value. Opening the door to all sorts of rebates and incentives to people who the insurer views as high value customers as compared to low value customers requires ensuring that the products are in fact offered equally to everyone. Lastly, Mr. Birnbaum stated that the large-scale brokerage industry

is incredibly concentrated. Four brokers hold a tremendous market share and market power. The idea of unleashing those people to use their vast amount of resources to compete for business has already been realized – we have seen what happens. Fourteen years ago, the New York Attorney General entered into a \$100 million dollar settlement with one of the largest brokers for bid rigging which is not unrelated to the types of things that the rebate reform efforts could unleash. CEJ thanks NCOIL for its work in this area and again urged NCOIL to work with the NAIC to ensure that the complicated issues are addressed, and unfair discrimination is prevented.

Erin Collins, Asst. VP of State Affairs for the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC looks forward to working with NCOIL on this issue and believes that there are a couple of opportunities for some language changes that could offer some clarity and ease of use in terms of getting the mitigation services, especially value added services, to policyholders. NAMIC believes that there is enough specificity in Section 4 so that should a value-added service meet that definition then it should not go through another regulatory process contained with the filing. If it meets the standard within the statute, that should be sufficient. Ms. Collins complimented Rep. Lehman on making this issue a standalone bill rather than opening up different portions of the insurance code.

With regard to the intent and impact of the Model, it is important to note that there is nothing Machiavellian here – this is about trying to provide a value-added service and answering a call from consumers to have their insurers help them. The end game here is to reduce the risk of loss. Ms. Collins also noted that the lens within which we should look at this issue and other issues going forward when talking about the offering of any product to consumers, is that it is a misnomer that there is a protection gap. The insurance system has a series of products such that each consumer has the ability to choose a product that they want and the level of coverage they want.

Karen Melchert, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked NCOIL for working on this issue thus far and noted that the life insurance industry comes at this issue with a different perspective because life insurers don't do a lot of risk mitigation or loss control services. Accordingly, ACLI has offered some proposed amendments to the Model. Regarding permissible gifts and prizes, ACLI's board policy has its threshold limit at \$100 on both raffles and gifts. While that may be too low for the P&C industry, there are certain products in the life insurance industry that do not even pay \$250 for the premium so if you can rebate them more or give them a gift that is worth more than the premium being paid that is not a wise decision.

The majority of ACLI's comments focus on Section 4 and while ACLI has no problem with the language put forth by APCIA, it does not go far enough to bring in certain types of value-added services. ACLI has proposed language "or that have a nexus to or enhance the value of the insurance benefits." Ms. Melchert noted that an example of value-added services that ACLI's members provide to its customers are will preparation services, grief counseling services, repatriation of a body that passed away overseas, and financial wellness issues. All of those services are primarily assisting the beneficiary so anything that is not included in the contract but goes to enhance the experience of that policy is considered to be a value added benefit and ACLI's members would like to continue to be able to provide them.

Ms. Melchert stated that the issue of implementation credits should also be in the Model as ACLI believes that they should be distinguished and written in the contract. ACLI does not want the Model to be a method to do implementation credits without disclosing in the contract. ACLI has provided suggested language reflecting such. In Section 5 of the Model, Ms. Melchert stated that ACLI proposed language to clarify that the services contemplated by said Section do not otherwise qualify as permissible value added services in Section 4 because if you are offering something to everyone regardless of whether or not they purchase a product, that is not really a rebate. Ms. Melchert stated that ACLI appreciates NCOIL getting involved with this issue and looks forward to working with the Committee on this issue going forward.

Rep. Lehman thanked the panel for all of the comments made. With regard to Mr. Birnbaum's statement about how insurers have been engaged in loss prevention with their policyholders for well over a century, Rep. Lehman stated that the Model is trying to investigate the things that are common in today's marketplace. It is not so much to say what insurers can and cannot do but to stop some investigations that are going nowhere and to provide some common sense. With regard to Mr. Birnbaum's comment of how the term value added service should be called loss prevention services, Rep. Lehman stated that he believes there are many things added that are not loss prevention focused. For example, providing motor vehicle records (MVRs) for trucking risks for free is not really a loss prevention but rather a hiring practice. Insurance educational materials are also sometimes provided to clients. Accordingly, while the focus of that Section of the Model may be on loss prevention services, Rep. Lehman stated that he would not change the verbiage. Rep. Lehman stated that judging from the remarks made today it seems like the main issues to be resolved center around terminology. The Model is still a work in progress, and he looks forward to working on it to get it ready for final adoption.

Rep. Keiser stated that he supports Rep. Lehman on this issue and noted that North Dakota has enacted legislation on this issue in addition to recently issuing a bulletin. Rep. Keiser replied to Mr. Bissett's earlier remark and stated that there is no way every possible contingency would be put into statute – that is why we have insurance commissioners and that is why in legislation they are given authority to regulate and write administrative rules as things develop. Rep. Keiser stated that recently he was looking at a fairly old building for purchase and one of his concerns was how much insurance would cost. Rep. Keiser asked his agent to look at the building and see if there would be any problems with insuring it. That could be viewed as loss mitigation, but Rep. Keiser noted that he did not even own the building. Rep. Keiser stated that we cannot anticipate every possible contingency. In response to the comment made earlier by Dir. Cameron, Rep. Keiser stated that if the law is not being obeyed now then it needs to be changed.

Sen. Gary Dahms (MN) stated that he does not agree with Mr. Birnbaum's comment regarding how the term value added service should be changed to loss prevention service and noted that it is unfortunate that the Committee and panel is discussing the issue as it is a case of splitting hairs. There are always bad actors in every industry but the majority in this industry are good actors and they are not conducting themselves in a manner referenced by the Model so as to pad their wallet – they are acting in that manner to help their insureds and keep costs down. If you do some loss prevention or value-added work and you prevent a claim, then that not only helps that specific insured but it also helps a lot of other people in that same classification/pool. Accordingly, it is

frustrating to hear arguments over the terms value added and loss prevention as more important issues deserve consideration.

Dir. Cameron stated that the NAIC welcomes NCOIL's participation throughout the NAIC's work on this issue and noted that Mr. Birnbaum did make some good points, particularly in the big data conversation. Dir. Cameron stated that he does not believe that any Insurance Commissioner has enforced a law that prevents insurers from being able to provide services to their clients – that is not happening. Dir. Cameron also stated that the comment regarding the Massachusetts Insurance Commissioner and the stress ball shocked him. Through a text message exchange, the Massachusetts Insurance Commissioner stated that the stress ball situation is not factual and noted that Massachusetts was one of the first to allow for wearable risk monitoring devices. Dir. Cameron stated that Insurance Commissioners are trying to find solutions where they are helping the consumer and allowing the consumer to be protected and progress. Insurance Commissioners want to make sure there is no unfair discrimination and avoid going back to the era of rebating one's premium. Dir. Cameron noted that the NAIC is working on amendments to the UTPA and the plan is to have that done by the end of 2020. The NAIC looks forward to collaborating with NCOIL on this issue. Rep. Lehman noted that during the meeting of the NAIC's Innovation & Technology Task Force earlier this week, Rep. Lehman stated that NCOIL would be more than willing to participate in the drafting group put together by the Task Force.

Mr. Birnbaum stated that from CEJ's perspective, words have meaning and when you go to a consumer and say "we have this great product with value added services" that does not tell a consumer very much. On the other hand, if you tell a consumer "we have an insurance product and I can provide a lot of loss prevention and risk mitigation services to you" – those words have meaning to a consumer. That is why CEJ brings this issue to the Committee's attention. CEJ does not mean to quibble about the issue but rather wants to ensure the consumer knows what he or she is getting.

ADJOURNMENT

There being no further business, the Committee adjourned at 6:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
AUSTIN, TEXAS
DECEMBER 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the JW Marriott Hotel in Austin, Texas on Wednesday, December 11, 2019 at 2:30 p.m.

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

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Sen. Vickie Sawyer (NC)
Sen. Jason Rapert (AR)	Rep. Tracy Boe (ND)
Asm. Ken Cooley (CA)	Rep. George Keiser (ND)
Sen. Jack Tate (CO)	Sen. Jerry Klein (ND)
Rep. Richard Smith (GA)	Sen. Shawn Vedaa (ND)
Rep. Martin Carbaugh (IN)	Asw. Maggie Carlton (NV)
Rep. Peggy Mayfield (IN)	Asw. Ellen Spiegel (NV)
Rep. Joe Fischer (KY)	Sen. Neil Breslin (NY)
Rep. Dean Schamore (KY)	Asm. Andrew Garbarino (NY)
Sen. Dan "Blade" Morrish (LA)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Utke (MN)	Del. Steve Westfall (WV)
Sen. Paul Wieland (MO)	

Other legislators present were:

Sen. Matt Lesser (CT)	Rep. Donna Pfautsch (MO)
Rep. Doug Gutwein (IN)	Rep. Bruce Grubbs (MT)
Rep. Chris Judy (IN)	Sen. Jim Perry (NC)
Sen. Andy Zay (IN)	Sen. Roger Picard (RI)
Rep. Edmond Jordan (LA)	Rep. Julie Johnson (TX)
Del. Mike Rogers (MD)	Rep. Eddie Lucio III (TX)
Sen. Gary Dahms (MN)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Sen. Jerry Klein (ND) and seconded by Rep. Martin Carbaugh (IN), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Jack Tate (CO) and seconded by Rep. Carbaugh, the Committee approved the minutes of its July 13, 2019 meeting in Newport Beach, CA without objection by way of a voice vote.

CONSIDERATION OF NCOIL DRUG PRICING TRANSPARENCY MODEL ACT

Rep. Tom Oliverson, M.D. (TX), Vice Chair of the Committee and sponsor of the NCOIL Drug Pricing Transparency Model Act (Model), stated that it is hard to believe that this Committee has actually been discussing the issue of drug pricing transparency since March of last year; and has been discussing the Model since December of last year. Rep. Oliverson thanked everyone involved for their input. The Model has come a long way since it was first introduced and although it does not give everyone everything they want, it is something that everyone can live with and that is usually a good place to be.

Rep. Oliverson then noted the changes that have been made to the Model since it was last discussed, including sponsor's amendments that have been proposed since the 30-day materials for the meeting were issued. Regarding the sponsor's amendments: first, at the end of Section 4 – which deals with drug manufacturer requirements – Rep. Oliverson proposed adding a Drafting Note that states: States may wish to raise or lower the percentages and dollar amount set forth in Section 4(b)(1) depending upon each state's economic environment as it relates to prescription drug prices. Rep. Oliverson stated that the thresholds that trigger the reporting requirements are a tricky issue because there is a fine line between making them too high so as to be essentially meaningless, and too low so as to make the amount of data being reported very burdensome for state agencies to handle. Accordingly, Rep. Oliverson stated that he wants to make clear that, while the thresholds in the Model are strong, he does not consider them to be perfect and the drafting note is a good compromise that provides states flexibility when considering the thresholds.

Next, in Section 6(a)(2), Rep. Oliverson stated that he would like to remove the language at the beginning of the second sentence: "For any health [carrier/insurer] with an affiliated pharmacy benefit manager with fewer than five (5) clients." Rep. Oliverson stated that was more of a drafting error than anything and that language did not belong in that section. Before closing, Rep. Oliverson noted that each industry that the Model covers is present today and he thanked them for all of their input. As is always the case with NCOIL Models, states are free to change any provisions as they deem appropriate.

Saiza Elayda, Senior Director of State Policy at Pharmaceutical Research and Manufacturers of America (PhRMA), stated that PhRMA opposes the Model and feels that the Model does not provide anything meaningful to patients when shopping for insurance. The Model slightly misses the mark on helping patients understand certain things. PhRMA was hoping that the Committee would consider other reforms such as capping copays or limiting out of pocket maximums.

Brendan Peppard, Regional Director of State Affairs for America's Health Insurance Plans (AHIP), thanked Rep. Oliverson and the Committee for the dialogue surrounding the Model and noted that there are some changes to the Model that AHIP would still like to see but the Model is much improved. AHIP believes that this is an important issue because of the rising drug prices that are hitting consumers every day. Mr. Peppard noted that it is the pharmaceutical manufacturers alone who set the price of drugs and it

is important to remember that. Mr. Peppard noted that AHIP does believe that the reporting threshold numbers should be lowered to 10% which is a level that many pharmaceutical manufactures have already agreed to in principle. AHIP appreciates the drafting note but Mr. Peppard stated that if the Committee really wants to tackle drug price increases, perhaps something such as a medical consumer price index (CPI) should be examined.

Mr. Peppard stated that AHIP believes that language should be included in the Model regarding launch price information and suggested using language that was enacted in Oregon. AHIP believes that language would be very useful. Regarding Rep. Oliverson's recent amendment to Section 6, pending review of the language, AHIP believes the amendment is proper and thanked Rep. Oliverson for making that change. However, regarding the aggregation language in Section 5 relating to pharmacy benefit managers (PBMs), AHIP believes that there needs to be broad-based aggregation language added. AHIP believes that without that language, there is the possibility that publicly released information for any individual company could be used to back into specific proprietary confidential business-sensitive information. Mr. Peppard noted that as Section 5 is currently drafted regarding the "less than 5 client" issue, in many markets that language would only apply to one PBM which means that the language would be nullified and there would be no aggregation. AHIP would appreciate further discussion regarding that language as it does not believe the Model is ready to move forward without that issue being addressed.

Melodie Shrader, Senior Director of State Affairs at the Pharmaceutical Care Management Association (PCMA), thanked Rep. Oliverson and the Committee for the time dedicated to the Model. Ms. Shrader noted that rebates are paid on brand name drugs that generally do not have generic equivalents. PBMs negotiate those rebates with manufacturers in order to reduce the price that the client ultimately pays for the drugs. The average cost of a brand name drug, excluding specialty drugs, is about \$350. According to a recent study on PBMs, on average PBMs reduce that cost by approximately 25% so the price of the drug is decreased to about \$268. Of that, PBMs keep about 4% and the manufacturer keeps about 88% of that dollar and pharmacies keep about 7%. It is important to understand the value of rebates in keeping down the cost. That is the system which we work within today. 90-95% of all of those rebates go back to the client and it is the PBM's goal to keep it to the lowest net price.

Ms. Shrader noted that the Model is very similar to what was enacted in Texas this past legislative session, but there are some significant differences. Ms. Shrader stated that the drafting note amendment sponsored by Rep. Oliverson is important because in Texas the number is 40% and in the Model it is 60% before triggering a reporting requirement. That is a fairly significant difference so the drafting note is important. Ms. Shrader noted that the rebates are negotiated in private contracts between savvy and sophisticated parties. The reason PCMA is concerned that the data for a PBM with more than five clients is not aggregated before being published is that said data is proprietary information. PCMA is concerned that if that proprietary information is put out into the marketplace, it could be a disruptor. PhRMA already knows what rebates they pay to each PBM; they know what their market share is and they know what their competitor's market shares are. With another piece of information, such as the rebates paid to one PBM versus another, it will be a piece of information that is only going to be useful to PhRMA. PCMA is very concerned about that. PCMA agrees with the Committee that the rising cost of drugs is alarming and with providing rebate information

to regulators. However, PCMA must oppose any publication of proprietary information. PCMA supported the final version of the Texas legislation but must oppose the Model in its current form and requests that an amendment be considered before adopting the Model. PCMA requests that the same amendment referenced by Rep. Oliverson in Section 6 be made to Section 5.

Rep. George Keiser (ND) asked if there has been any discussion on the rebating side on the rebates from pharmaceutical manufacturers to pharmacists. Rep. Oliverson stated that issue was not included in the Model and that was because as he and others looked for policies that were already out there in certain states, it was found that there was an emphasis on three main segments of the marketplace: drug manufacturers, PBMs, and health insurers.

Asw. Maggie Carlton (NV) asked who the Model actually applies to because there are numerous insurance schemes in each state including self-insured groups, health and welfare trusts, the Blues and standard health insurers. It is known that what is put in statute does not affect every insurance scheme in the state. Rep. Oliverson stated that as implemented in Texas, and as proposed in the Model, the goal was to cast as broad of a net that could be cast while not applying to things that states would not have the ability to regulate such as federally preempted health plans. Asw. Carlton stated that the Model would apply to a very small group in Nevada because the other groups have most of the coverage in the state. Rep. Oliverson stated that is correct but noted that if Nevada is like Texas, which he suspects is, the state's largest health plan in terms of numbers of covered lives is probably teachers or employees and those definitely would fall under the Model so you would get a fair amount of data from that group. Asw. Carlton stated that Nevada is actually the opposite of Texas in that regard.

Upon a Motion made by Rep. Oliverson and seconded by Sen. Dan "Blade" Morrish (LA), NCOIL President and co-sponsor of the Model, the Committee voted without opposition to adopt the Model, as amended, by way of a voice vote.

CONTINUED DISCUSSION ON NCOIL SHORT TERM LIMITED DURATION INSURANCE MODEL ACT

Rep. Martin Carbaugh (IN), sponsor of the NCOIL Short Term Limited Duration Insurance (STLDI) Model Act (Model), stated that the Committee had a good discussion on the Model at its last meeting in Newport Beach and noted that some changes have been made to the Model since then. First, the title of Section 3 has been changed from "Preferred Provider Plan Requirements" to "Network Based Plan Requirements" as there are multiple types of network-based plans, such as ones that use exclusive provider networks. Relatedly, the term "preferred provider plan organization" was added to the definitions section of the model. Second, Section 4(b)(2) was revised to clarify that when an individual exceeds the duration limit in subdivision (1), a new policy must be issued as it is not a renewal, but rather a new enrollment. Lastly, in Section 7 - which deals with disclosure requirements - language was added to require the insurer to specify the essential health benefits where no coverage is offered.

Rep. Carbaugh noted that at the July meeting in Newport Beach, there was a lot of discussion regarding the Model's requirement to have the short term insurance plan have an annual limit of at least \$2 million dollars. Rep. Carbaugh acknowledged that said limit is arguably a departure from current practice but it is important that if the plans

are being bought for a longer period of time that there be a substantial limit as we see healthcare costs continuing to rise. Also, as stated in July, the difference in premium between a plan that has a \$250,000 limit versus a \$2,000,000 limit is really negligible. Rep. Carbaugh noted that he is still open to further changes to the Model and hopes that the Committee can vote on it at the Spring Meeting in March.

Brian Blase, President & CEO of Blase Policy Strategies, stated that he served as Special Assistant to President Trump at the National Economic Council for 2.5 years. One of the main focuses of the Administration was expanding affordable coverage for Americans. President Trump signed an Executive Order (EO) titled "Promoting Healthcare Choice and Competition Across the United States" which contained an expansion of association health plans (AHPs), short terms plans, and things called health reimbursement arrangements (HRAs). The actions were meant to benefit two main groups: middle class families, including the self-employed who didn't have an offer of employee coverage, and small businesses and their workers as small businesses were frequently not offering coverage. The fact is that the Affordable Care Act (ACA) exchanges are not working as intended. Although enrollment has been stable since 2015 at about 10 million people, 70% of enrollees have an income below 200% of the poverty line which is about \$50,000 for a family of four. Enrollment is 60% below expectations as the plans are not attractive unless the people receive large subsidies or have significant medical needs.

Mr. Blase stated that unfortunately, individual market enrollment outside the exchanges is deteriorating. Between 2016 and 2018, 2.5 million fewer unsubsidized enrollees had coverage in the individual market, a decline of 40%. Despite the strong economy, the number of people without insurance between 2017 and 2018 increased by 1.6 million for individuals 300% above the poverty line which is about \$75,000 for a family of four. Small employers are also finding it increasingly difficult to continue offering coverage. Between 2010 and 2018, the proportion of workers at firms with 3 to 49 workers covered by an employer plan fell by more than 25%. The Administration took three actions to help those individuals. First, the Administration opened a second pathway for employers to form AHPs and gain the regulatory advantages and economies of scale that large employers receive when offering coverage. The new pathway allowed any employers within a state to join together and form an association and also to open up the association to sole proprietors. Unfortunately, a federal judge in March ruled the new pathway to be an invalid interpretation of ERISA. The Department of Labor (DOL) appealed and that appeal was heard by an appeals court a few weeks ago.

Second, the Administration issued a rule to expand STLD insurance. Such coverage is exempt from federal mandates and premiums can accurately reflect risk. Such plans can be tailored to what people need and are generally much less expensive than ACA plans. In a late 2016 rule, the Obama Administration severely restricted these plans as people were increasingly choosing them rather than ACA plans. The Obama Administration limited coverage to 90 days and prevented renewals. Such actions harmed people who got sick by leaving them without coverage after the three month period ended as people can only buy ACA plans during a six week period each year. For those reasons, the National Association of Insurance Commissioners (NAIC) opposed the Obama Administration rule. The Trump Administration rule largely reversed those restrictions. Said rule restored the 364 day contract period, permitted renewal of plans for up to three years, and clarified that people could combine short term plans with separate insurance products dubbed "renewal guarantees" that people could

purchase to protect them from undergoing medical underwriting in the future. The rule also required short term plans to include a disclosure requirement urging consumers to carefully review benefit designs and indicating that such plans do not meet ACA requirements. Such plans will likely resemble a typical non-group plan offered before 2014.

Mr. Blase noted that Chris Pope of The Manhattan Institute conducted an extensive study comparing ACA plans to short term plans. According to his findings, for equivalent insurance protection, the premiums for short term plans are much lower, in some cases about half the cost. Moreover, Mr. Pope found that narrow network health maintenance organizations (HMOs) are often the only type of ACA plans available and that short term plans generally cover a much broader set of providers. An initial legal challenge to the Trump Administration's short term plan rule failed. In total, the AHP and short term plan rules, combined with the elimination of the individual mandate penalty, significantly improved people's ability to purchase coverage that works best for them. The White House Council of Economic Advisors estimated that the net economic benefit of the AHP and short term plan rules, combined with the elimination of the individual mandate penalty, is about half a trillion dollars over the next decade.

Mr. Blase stated that there is a role for state action on both AHPs and short term plans. States should permit their residents to fully benefit from such plans and where it makes sense, implement common sense regulation such as solvency requirements for AHPs and appropriate disclosures for short term plans. Several states took action last year to expand their resident's ability to benefit from AHPs and short term plans. However, Mr. Blase strongly cautioned against consumer protection type legislation that mostly restricts consumer choice. People should be able to purchase plans that work best for them and we should be careful in substituting government's judgment for what people need for the judgment of consumers who have different needs and preferences.

Mr. Blase stated that the third regulation may be the most profound – the expansion of HRAs. In part because of the tax exclusion for employer-sponsored insurance, employers have a lot of control over a worker's health insurance. Choices are often restricted and 80% of firms that offer plans only offer a single option. In June, the Administration released a final rule that provides employers another method of offering coverage in a way that promotes choice and portability for workers. The benefit is through HRAs which are tax advantaged mechanisms for employers to reimburse employee healthcare expenses. As a result of the HRA rule, starting next month employers can provide workers with tax free contributions for the workers to buy coverage in the individual market. A defined contribution for health insurance is similar to 401K plans and 403B plans for retirement savings where employers provide a set amount of funds with workers having control over the investment. The Administration estimates that in about five years, 800,000 employers, nearly 90% of them with fewer than 20 workers will offer an HRA and more than 11 million people will be enrolled in the individual market. Mr. Blase stated that the HRA rule, which permits integration only with ACA compliant plans, should show that the Administration was focused on expanding available coverage through all means. With common sense reform to the individual market, the HRA rule holds the promise to revolutionize health coverage with families in greater control with more portable options.

Mr. Blase then discussed the 1332 waivers which the Administration has been approving. The Administration approved several of them for state reinsurance programs

to help subsidize the cost of people with high claims. Such waivers have generally resulted in premium decline in states that have had them of 10-15%. Last year, the Administration released new guidance making it easier for states to modify aspects of the ACA and improve their markets through 1332 waivers. States should take a close look at such guidance and Georgia should be commended for developing the first waiver consistent with the new guidance. Mr. Blase stated that no issue troubles American families more than rising healthcare costs. One year ago, the Administration released a 120 page report "Reforming America's Healthcare System Through Choice and Competition." It is a bold and thoughtful report that contains more than 50 recommendations to improve the healthcare system. As state legislators embark on their important work, it is worth remembering that there are two ways in which policy can lower healthcare costs: one is to align incentives and provide information so employers and consumers can be the best possible shoppers of care; and the other is to inject competitive forces in the provision of care. Anything that advances those two aims is likely a step forward.

Steve Kline, Director of Gov't Relations at the National Association of Insurance and Financial Advisors (NAIFA), stated that NAIFA supports the Model and feels that its duration and disclosure provisions largely mirror the federal short term rule which NAIFA supports. The Model expands upon that federal framework in some other ways particularly with the provider network and benefit requirements. NAIFA supports the availability of short term plans in the market as there is an important role for such plans in a number of circumstances. For example, individuals may be in the middle of a job transition and discover that COBRA payments may be too costly; folks that are new retirees seeking new health insurance coverage while they wait to enroll in a Medicare plan; or clients going through a life transition such as early retirement or divorce.

Mr. Kline stated that some of NAIFA's members have stated that short term plans can also provide some important supplemental coverage. For example, self-employed persons who want additional coverage to complement their major medical plans, as well as individuals maybe looking for supplemental coverage to defray the high cost of prescription drugs. Mr. Kline stated that short term plans can provide an affordable option to some policies in the individual market. Many consumers do reside in areas where there are very few options for health insurance and what is available can be very costly. In that circumstance, a short term plan may be the only affordable option, especially those consumers who may not qualify for an ACA premium tax credit. For example, one of NAIFA's members had a client who was a 49 year old male in need of health insurance. The client discovered that the least expensive plan on the individual market would have cost him over \$700 but he was able to get a short term plan for about \$400 which included all of the client's preferred doctors. Mr. Kline closed by stating that short term plans ensure that consumers can maintain some critical but temporary health insurance coverage, provide some supplemental benefits, and in certain markets perhaps serve as an alternative to some individual market plans. The Model helps ensure that short term plans stay on the market and for those reasons, NAIFA supports the Model.

Asw. Pam Hunter (NY), Chair of the Committee, stated that during the Committee's July meeting, Michelle Lilienfeld of the National Health Law Program (NHLP) stated that the majority of the short term premiums collected goes towards administrative costs. Asw. Hunter asked Mr. Blase's thoughts on that and for comments as to whether an amendment should be made to the Model relating to medical loss ratio (MLR)

requirements. Mr. Blase stated that there is not great data surrounding short term plans. The NAIC is actually engaged right now in a data call surrounding such plans. Mr. Blase stated that he does not believe therefore right now that there is a really good understanding of what the MLR really is for short term plans. Mr. Blase stated that he is not a huge proponent of minimum loss ratios as they contain pretty bad incentives for insurers to increase spending. Essentially, they cap profits at a percent of spending which does not create an incentive on the insurer's side to have the lowest possible spending.

Sen. Matt Lesser (CT) stated that he is glad to hear that the Committee will not move forward with voting on the Model today given the legal and regulatory uncertainty that is hanging over the proposed expansion of short term plans. Sen. Lesser stated that he hopes moving forward that the Committee can be mindful of the name of the product – short term limited duration plans. Connecticut has adopted laws that prevent renewal of such plans and also requires that they be consistent with essential health benefits (EHBs) required elsewhere in the marketplace. That is important as it still allows for preexisting condition exclusions and other changes that will lower the cost relative to other plans in the marketplace but it captures the original intent of the legislation establishing such plans which is to provide a limited duration option for people in between other options.

Rep. Deborah Ferguson (AR) stated that she is concerned that a lot of short term plans have \$1,000 daily maximums which won't even touch what a daily hospital visit costs. Rep. Ferguson stated that she would like to see something in the Model protecting the daily limit in addition to the annual limit.

Rep. Oliverson stated that he agreed with Rep. Ferguson and noted that a \$2 million dollar limit could also be easily thwarted if there are not protections put in place for caps on individual spending. For example, you could have a \$2 million dollar policy but if there is a \$50,000 cap per individual then essentially the \$2 million number is meaningless if someone is diagnosed with a serious illness.

DISCUSSION ON NCOIL HEALTH CARE SHARING MINISTRY MODEL ACT

Rep. Carbaugh, sponsor of the NCOIL Health Care Sharing Ministry (HCSM) Model Act (Model), stated that the Committee had a great introductory discussion on the topic in July. Rep. Carbaugh noted that he brought this topic forward for discussion at NCOIL mainly because of a scenario he became aware of regarding a friend of a friend who was involved with a HCSM – essentially, all of the medical bills that he and his wife thought were eligible to be shared with the HCSM were not. Rep. Carbaugh noted that as an agent, he is contracted with a HCSM, and has only sold the product to one person although he has presented it as an option to several people as there is a lot of interest in more affordable healthcare options. Rep. Carbaugh stated that he thought NCOIL would be a good forum to have this discussion as there is not a lot of regulation surrounding HCSMs. Rep. Carbaugh stated that he is not proposing a ton of regulation but believes there needs to be registration and minimum reporting requirements. Rep. Carbaugh noted that he looks forward to hearing from the panel and further discussing the Model.

Asw. Hunter asked Rep. Carbaugh to provide a brief explanation on what HCSMs are as there are several legislators present today who were not present at the Committee's July meeting. Rep. Carbaugh stated that HCSMs are essentially a medical bill sharing

arrangement where people of similar faith agree to pay (you cannot call them premiums) monthly allotments to an organization or sometimes directly to other members when they have bills that are eligible to be shared. You cannot call it an insurance claim because it is not insurance and it is not a contract. Consumers need to be aware of the complexities of HCSMs. Most HCSMs are good actors and go above and beyond to tell the consumer that they are not buying an insurance contract – it is a promise that people of similar faith will make to help pay medical bills that arise providing there are no preexisting bills and that you meet the requirements of the plan, such as no smoking.

Keith Hopkinson, Of Counsel at Winstead PC, stated that he has represented Christian HCSMs (Christian) for the last 18 years and has been well informed about how HCSMs operate. Christian is the oldest, the original, and the largest sharing ministry in the country but most people have probably never heard of it and there are several reasons for that. The way that they develop their membership is through word of mouth and they do a lot of reach out at various Christian conferences and the like, and they also have a good network with a lot of the Christian churches across the country. Christian does not advertise in national media whereas other HCSMs do which is a big distinguishing characteristic. Christian also does not use insurance agents – it does everything by word of mouth and everything is essentially between the ministry and the members. Mr. Hopkinson stated that Christian's goal has always been to stay in their lane and on their side of the fence as they are not insurance and that is emphasized repeatedly with its members. Their website also makes that clear and they go to great lengths to avoid the potential for any confusion in any aspect of a prospective member's consideration of sharing as a possible opportunity for them to exercise their faith as well as to meet their health needs.

Mr. Hopkinson stated that Christian has reviewed the Model and at the outset they applaud it as a very strong effort. The reality is that we are in a very difficult time for sharing and there is a lot of unsavory behavior that has crept into the world of sharing that has given the concept of legitimate sharing a black eye. Mr. Hopkinson stated that it is probably inevitable at this point in time that as sharing became more known by the consumer that there were going to be elements that crept into it that have different agendas other than faith. Clearly there is a problem with bad actors. Christian believes that the Model makes a substantial effort to address many of the concerns heard from both legislators and regulators across the country as to the sharing ministry problem. Christian believes that the Model does a key thing which Christian has embraced and advocated for – embracing transparency and sunshine. Sunshine is a great antiseptic for rooting out some of the behavior that has crept into the world of sharing in the last couple of years.

Mr. Hopkinson then discussed a few highlights of the Model. Mr. Hopkinson first noted that somewhere in the Model there is a zero missing from a citation to the federal code as it should be 5000 and not 500. The meat of the Model is that it requires certain information from HCSMs for purposes of registration. The Model asks that the HCSM prove that it is a certified sharing ministry at the federal level under the definition that is currently law in the country under the ACA. That is important because there needs to be some type of standardized definition as to what a HCSM is. The Model does a good job of defining what a HCSM is conceptually but around the country there is sort of a patchwork of definitions in addition to the federal definition and there should be just one.

Mr. Hopkinson stated that the Model also asks for disclosure of third-party vendors which is very interesting and is in the context of enrolling members or negotiating with medical providers or the aspect of the financial sharing of a member's medical needs. Christian believes that is a good place for sunshine because vendors are typically a profit third party entity outside of the ministry which is not to say that it might not be beneficial to a ministry's membership if the ministry had some type of outside vendor providing services in one or more of those arenas. Christian notes with some concern that is one of the areas where there is a possibility for abuse and taking advantage of the ministry. There may be conflicts of interest with respect to officers or directors that are on the board of the ministry but also involved with the vendor. Christian believes that there is no reason to not make that disclosure so that the consumer can make an evaluation as to whether they are comfortable with a ministry that has a third-party vendor setup.

Mr. Hopkinson stated that it is Christian's view that all ministries are supposed to be nonprofits which means that you are maximizing the benefit that the member receives for their dues. When you start having expense items that are outside of the ministry, that means you are starting to load up expenses of a pure non-profit model whereby money that might be available for needs is going somewhere else. Christian believes that a legitimate ministry would have no problem explaining how each aspect of the ministry helps members. Mr. Hopkinson stated that Christian really likes that the Model parallels the concept that already exists at insurance departments with the risk purchasing group and risk retention group act. There is a federal authorization that allows for all of that and the states then have a registration requirement for those risk purchasing groups or risk retention groups. Accordingly, this is something that insurance departments are already comfortable with and insurance departments are the ones getting complaints regarding HCSMs.

Mr. Hopkinson stated that Christian found the Model's anti-fraud provision to be very interesting. There might be some sort of boogeyman reaction to that from some folks in the ministry arena but from Christian's perspective, it is not a problem and it is a beneficial two way street because it allows the ministry to report fraud that they encounter.

Asw. Hunter asked Mr. Hopkinson to explain why Christian does not use insurance agents. Mr. Hopkinson stated that Christian is very focused on avoiding any possibility of consumer confusion on the part of prospective members regarding the fact that sharing is not insurance. Christian has a very difficult time of understanding how anyone sitting in an insurance agent's office is going to understand that the product is not insurance although they purchase their auto insurance and other insurance from the agent. The mere appearance of the potential for confusion or impropriety is reason to not use insurance agents. Another reason is that agents are an expense item and Christian is a non-profit. There should be no need for a ministry to pay commissions – and Christian has heard of some egregious numbers from some of the bad actors – which is money that is basically taken away from the consumer and not eligible for sharing. That leads to a non-profit entity built on generating incentive and profit for third parties outside of the ministry.

Joann Volk, Research Professor at the Georgetown University Center on Health Insurance Reforms (CHIR) stated that CHIR began researching HCSMs last year and talked to some regulators about them as well. Ms. Volk first noted the research CHIR

did last year in which they researched five HCSMs, one of which was Christian, and talked to state regulators in 13 states about what their views of HCSMs were. Ms. Volk then noted research CHIR did last year in which they spoke to brokers in six states, and an online broker, about how they view the changing individual market, particularly after the zeroing out of the individual mandate. In those discussions, CHIR heard that for those looking for more affordable options than the ACA, brokers will often refer them to either short term plans or HCSMs as a legitimate alternative to insurance.

Ms. Volk stated that HCSMs typically limit membership to those who share a set of religious beliefs and you may have to sign a pledge saying such. Most HCSMs serve individuals but there are some out there marketing to small employer groups. You do have to pay a monthly payment or “share” to cover the expenses of others and they are prescribed based on age, level of coverage and in some cases health indicators. There are un-sharable or member responsibility amounts that are akin to deductibles which you must cover on your own before you can submit bills for sharing. Ms. Volk noted that the administration of HCSMs varies as sometimes you are referring your share directly to another member in need and in other cases you are sending it to the ministry to distribute to put into an account that can be accessed and shared with others.

Ms. Volk stated that the ministry determines what is sharable as it has a defined set of benefits that will often eliminate pre-existing conditions and might also have other limits on services and conditions that might not comport with religious beliefs. Some ministries condition reimbursement on factors other than a defined benefit so even if it fits the description they might say that before a claim can be submitted for sharing, even after you have hit your un-sharable amount, you must show that you tried to access the charity program at the hospital for help paying the bills and you also might authorize the ministry to negotiate on your behalf with providers to obtain a discount first. Some ministries also ask that you first pursue a legal case if there is a possibility that someone else could pay before it can be shared. Ms. Volk noted that the first research she referenced earlier has details as to how HCSMs operate with respect to pre-existing conditions, benefit exclusions, and dollar and visit limits.

Ms. Volk stated that HCSMs are not insurance because there is no promise to pay or cover claims and HCSMs are careful to avoid using insurance terms so that people do not believe they are subject to a deductible and have to pay a premium. But even so, CHIR found from research and by speaking to regulators that there are many aspects of HCSMs that are similar to insurance and therefore could lead to consumer confusion. Some HCSMs will refer to provider networks; borrow language from common insurance language terminology like suggesting the product is available in gold, silver and bronze levels; a defined set of benefits and cost-sharing as the guidelines lay out what exclusions are and what is covered up to certain amounts and what is covered after a waiting period. Some HCSMs may also require the consumer to get prior authorization to determine medical necessity before he or she can consider it sharable, and there is a claims processing feature when submitting claims for some HCSMs.

Ms. Volk stated that one of the big gaps that the Model could address is that there is no independent data as to how many people are enrolled in HCSMs. Ms. Volk stated that the only number she has seen and used frequently is that the Alliance for HCSMs (Alliance) has said that membership grew from fewer than 200,000 prior to the ACA to more than 1 million today. Many HCSMs use brokers, have sophisticated websites and will run advertisements during open enrollment specifically when people are shopping for

insurance to suggest that they might consider a HCSM. A recent uptick has been seen in HCSM marketing from both CHIR and state regulators. Ms. Volk stated that the regulators CHIR spoke to stated that the cost of the ACA plans was the primary driver of HCSM membership. Ms. Volk stated that based solely on price, if you are looking for something more affordable and you don't qualify for premium tax credits, HCSMs certainly seem to be a much more affordable option.

Ms. Volk stated that regulators do not have a systematic way to collect data on enrollment and they are concerned that a lot of the marketing of insurance-like features contribute to consumer confusion that they don't understand what they are getting when a consumer buys into a HCSM. There was not a concern that there was going to be risk segmentation against the ACA marketplace but without knowing how many people are enrolled it is hard to assess that. CHIR found that states can perform oversight regardless of HCSM safe harbor status.

With regard to features that may lead to consumer confusion, there is a defined benefit package and the different benefit packages may be sold at different rates much like health insurance. The benefits are contingent upon paying a monthly share and they come with what is akin to deductibles, copays and coinsurance. Ms. Volk then provided an example of a Christian offering which used gold, silver and bronze levels with different membership fees just as you would with health insurance for gold, silver and bronze plans. Ms. Volk then noted Christian Care Ministry's disclosure that there is no deductible but there is an amount that must be paid before medical bills may be shared; and that there is no premium but an amount that must be paid monthly to be a member.

Ms. Volk also noted that some HCSMs suggest that there is a defined provider network and if you go to a preferred provider, much like with insurance, you will pay less out of pocket than you would for an out of network provider. Ms. Volk then provided an example of Medishare material which refers to a preferred provider organization (PPO) and outlines the consequences if you choose a PPO versus a non-PPO. Ms. Volk noted that it looks a lot like an insurance plan that has a network.

Ms. Volk stated that HCSMs may be sold by insurance brokers and the commissions can be substantial. Covered California recently did a survey of their certified brokers and found that where brokers are paid a 2.6% commission for ACA plans, the HCSMs are in the 15-20% range. Ms. Volk also noted that HCSMs are also sometimes referred to as a replacement for insurance that might provide similar financial protections. Ms. Volk then referenced the website of a HCSM, Sedera Health, which states that it is a "proven alternative to health insurance" and suggests other features that are a lot like insurance.

Regarding the regulatory framework surrounding HCSMs, there is an exemption under the ACA's individual mandate section for those that are in a HCSM that meet a certain definition. However, that was exclusively for the purposes of the individual mandate and does not at all affect state's ability to regulate or legislate in this area. CHIR found that there was some confusion about that – that there should be a hands off approach to HCSMs because the ACA sort of sanctioned them. No state currently regulates HCSMs as insurers and in 30 states there are "safe harbor" laws which specifically exempt HCSMs that meet a certain definition from insurance regulation. Some states borrow from the ACA's definition but others go beyond that. For example, Pennsylvania has a much more robust safe harbor and the exemption only includes those ministries that do

not use any financial incentives for enrollment and do not use member funds towards administration and do not directly or indirectly suggest that claims will be paid or that there is a history of covering people's bills.

Ms. Volk stated that state safe harbor laws do define which HCSMs are exempt from insurance regulation but not all HCSMs meet that definition. Most safe harbor laws require each HCSM to provide a written disclosure that the entity is not an insurance company and most require participants to be provided with a monthly statement identifying total qualified claims and some require publishing the share of qualified claims that are assigned to other members to pay. A minority of the safe harbor laws require an annual audit prepared by an independent CPA that must be available upon request.

Ms. Volk stated that CHIR has been talking to state regulators and has a publication arriving soon focused on how states can get a closer handle on monitoring the market and understanding who is enrolled and how HCSMs operate. CHIR has also seen some state activity surrounding HCSMs which will be in the publication. To give a preview, CHIR suggests that at the very least, states should be: actively evaluating whether HCSMs meet their safe harbor definitions; requiring transparency about the operations that goes beyond the reporting of enrollment to also include not just the qualified expenses and those assigned but how many claims have been submitted and paid; and requiring submission of marketing materials to see if they are confusing to consumers. Ms. Volk noted that the claims information is not only for regulators but also for prospective enrollees so that they can better assess the likelihood that their bills will be covered by other members. Ms. Volk noted that states should also consider what role, if any, producers should have in facilitating HCSMs.

Covered California is now telling its certified brokers that they have to do a full disclosure and screen participants first for ACA subsidies because in the case of one HCSM, more than half of its members had an income that would qualify them for a subsidy for a comprehensive ACA plan. Massachusetts, which still has an individual mandate, is tightening up the exemption from the definition for HCSMs from said mandate to state that the ministry cannot use brokers and cannot use money on administrative costs. Texas and Alaska recently reissued bulletins reminding brokers of their liability if they sell unlicensed or unauthorized insurance and their liability for covering unpaid claims.

Bradley Hahn, CEO of Solidarity Healthshare (Solidarity), stated that his background is as an attorney for 21 years dealing with a lot of religious law and conscience protection issues. Solidarity exists to meet the demand of Catholics, many of whom have moral and religious concerns about traditional health benefits. Solidarity partnered with a Christian Mennonite HCSM to form a true partnership with the Mennonite and catholic church. To this day, people are still joining and Solidarity appreciates all of the support it has received along the way. Mr. Hahn stated that the core elements of Solidarity are focused on protecting the conscience rights of Christians concerned about many issues that various insurance offerings may have. Solidarity also aims to provide members with meaningful support to cover their healthcare costs and to build an authentic and vibrant Catholic community. Building a community is a bedrock of Solidarity which means it resists approaches for more rapid growth that may come at the expense of forming a true community. Solidarity believes that focusing on conscience and helping address the cost for members help achieve the goal of community.

Mr. Hahn stated that as of today there are roughly 9,000 families and almost 24,000 total members in all 50 states. Solidarity's members must sign a Christian statement of faith and comport to a lifestyle that is informed by Catholic teachings. There are three sharing programs to meet different budgets. Solidarity deals with pre-existing conditions in a different way: if the pre-existing condition can be improved by a lifestyle change there is a Solidarity well/coaching program to try and coach members into wellness and be a full member of the community. There are also other expanded offerings as well such as a telemedicine program to try and limit the cost for members. Solidarity's main focus on the process is on reducing costs so there is a lot of energy applied there. Solidarity negotiates amounts with healthcare providers to try and achieve the greatest possible level of savings for members. Solidarity also uses reference based pricing models and other cash pay models to try and determine what fair and just pricing is for a procedure or service. Solidarity is also trying to build awareness among providers and members on how the billing process works and to advocate for transparency in medical billing.

Mr. Hahn stated that so far in 2019 Solidarity has had roughly \$39.8 million dollars worth of medical bills submitted and \$16.7 of that has been shared which means that it received a 58% reduction in medical bills on behalf of its members. Going forward, Solidarity wants to maintain that level of affordability for its member and also look at other issues as well such as how to control drug prices for its members. From the beginning, Solidarity has been very careful to avoid engaging in any activities that could be construed as the business of health insurance. Mr. Hahn stated that he has thoroughly studied the federal and state HCSM exemptions and noted that for example, Solidarity does not use brokers and does not pay commissions to people that are members. Solidarity is careful to make sure that any marketing materials are not misinterpreted and do not contain any promises of insurance or promises to pay. Solidarity's efforts are mostly targeted at the Catholic community such as Catholic radio, Catholic events and Mr. Hahn speaking about healthcare reform and conscience protection in healthcare reform. Solidarity is excited about its future and members who want to join because of the overwhelming interest in protecting religious and moral convictions while building a vibrant ministry.

Mr. Hahn stated that looking ahead, Solidarity is very optimistic about the continued success of Solidarity as it tries to fill a gap in the larger healthcare system. Solidarity is focused on policy reforms at the federal and state levels to foster a robust marketplace while at the same time providing for protections for the ministries and the individual members. The overarching goal is to make sure there is no confusion in the marketplace regarding what health sharing is about. Mr. Hahn thanked Rep. Carbaugh for his leadership in this area with the Model and noted that Solidarity supports guardrails and protections for ministries and ministry members. Solidarity wants to work with the Committee to ensure that legitimate HCSMs continue to operate with clear parameters to avoid the blurring of HCSMs with insurance activities as well as ensuring consumers clearly understand the difference between insurance and HCSMs.

Mr. Hahn stated that ideally, he desires a system in which HCSMs are free to operate without threat, including the threat of coverage mandates or other actions to coerce sharing of morally objectionable services. In exchange for operating under clear guardrails such as those set forth in the Model, HCSMs want to make sure they do not blur the line with insurance activities. Mr. Hahn stated that he is eager to continue these discussions and is confident that HCSMs can continue to co-exist with traditional

insurance. Mr. Hahn believes that Solidarity is fulfilling an important need and its focus on conscience, cost and community coupled with its commitment to negotiating member's bills will result in future stability. Mr. Hahn thanked the Committee for inviting him to speak about Solidarity and how it fits within the HCSM landscape.

Kevin McBride, Attorney for Sharable LLC which is a technology provider for health care sharing, stated that Sharable supports some of the HCSMs present today and have also been contacted by non-Christian entities who are interested in doing health sharing. Sharable supports stronger consumer protections than those that are currently in the Model and also requests that the Committee focus on the federal definition of what a health care sharing entity is. The federal definition allows health sharing among "members who have a common set of ethical or religious beliefs" yet there is also a provision in the federal statute that limits health care sharing to only entities that have been in existence since 1999. The only entities in existence since 1999 are the Mennonite group that Mr. Hahn referenced and traditional Christian groups that Mr. Hopkinson represents. Sharable has been contacted by a Jewish group in New York who have not been in existence since 1999 but would like to do healthcare sharing. Sharable would like to support them in doing that and Sharable strongly supports consumer protections, fraud protections, and transparency in every respect. Accordingly, Sharable supports the Model and asks that the Committee consider making the abovementioned change regarding the definition of a HCSM.

Shanee Tracey, Director of Gov't Affairs at Christian Care Ministry (CCM), stated that CCM operates a HCSM called Medishare which has over 400,000 members across the United States. As a Christian faith community, Medishare has been facilitating the voluntary sharing of its medical expenses among its members since 1993 as an exercise and expression of its beliefs. Since its inception, Medishare members have shared over \$3 billion dollars in medical expenses incurred by its members and during that time, Medishare members have fully shared every incurred medical expense eligible for sharing in accordance to the guidelines adopted by the members which CCM believes reflects God's faithfulness to its ministry. Ms. Tracey stated that CCM fully supports the objectives of the Model to promote transparency and to disseminate clear and relevant information regarding the HCSMs operating within in each state. To that end, a number of the provisions set forth in the Model largely mirror provisions that CCM is currently promoting in other states. CCM thinks that the Model can be improved by incorporating, among other things, specific federal tax requirements for exempt organizations, state consumer protection laws, and more clearly defined and targeted enforcement authority. Ms. Tracey stated that CCM welcomes the opportunity to contribute to the development of the Model and thanked the Committee for the opportunity to speak.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that he believes the bottom line with this issue is that there is a lot of money getting involved so a lot of people are getting concerned much more than they used to be. Sen. Rapert stated that in some ways this issue reminds him of the long held divisions in the fight between banks and credit unions. Banks do not like the credit union non-profit status along with a host of other issues. Sen. Rapert asked how is it that we should go down the road of states requiring non-profits things that the federal government and the IRS do not require, especially when it comes to dealing with faith. Sen. Rapert noted that Ms. Volk emphasized that there is nothing that prevents states from regulating HCSMs and stated that it is almost as if Ms. Volk is inviting and urging states to cross lines that the federal government does not cross as it relates to non-profits.

Ms. Volk stated that she believes the important distinction is that the states regulate insurance and part of the recent attention to this issue is that there is one HCSM, Alieria, that has been shut down by about five states and other states have issued warnings about it. In that case, the regulators said that what Alieria was doing was insurance and therefore was illegally operating and selling insurance. Accordingly, that is an important distinction – it is not just a non-profit, it is a non-profit that is providing people something that is held out to be an alternative to insurance and will provide financial protection. Ms. Volk stated that she is skeptical of states relying on just disclosures and noted that many states have issued consumer alerts about Alieria and HCSMs in general. Colorado conducted focus groups with people who had various forms of coverage, some of which had Medishare, and their statements included “I know it’s not insurance but it is essentially the same”; “I have hoops I have to jump through with my insurance company so this is the same.” Accordingly, Ms. Volk stated that if someone is just looking for a more affordable alternative to insurance as opposed to the original intent of HCSMs, you can see how one could fall victim to some of the terminology.

Sen. Rapert stated that with regard to Alieria and the comments made regarding how states can take action if necessary against HCSMs, it seems that the current regulatory process works as a bad actor was held accountable. In Arkansas, there are fraud laws which would come into play that are enforced by the Attorney General so anyone that is conducting an unfair trade practice or anything amounting to fraud can be held accountable. Accordingly, Sen. Rapert asked why should a new body of regulation be promulgated for these entities when they are specifically exempted, and why should the veil of the IRS non-profit status be pierced. This is seen all the time with arguments to tax churches when you try and pierce through that veil. If “bad” HCSMs have been dealt with through Attorney Generals, why is a new avenue of regulation being sought?

Ms. Volk stated that she believes what is going on is that there is a regulatory vacuum which has invited bad actors and much more aggressive marketing. Alieria, which has been shut down, is now an FBI investigation and Ms. Volk stated that she is suggesting that states should pay closer attention to HCSMs before any of them become an FBI investigation that leaves people with huge unpaid bills and serious medical conditions. Relying purely on complaints about bad actors is not an effective approach to regulation. Sen. Jack Tate (CO) stated that today is the first time he has heard about any consumer confusion or bad actors relating to HCSMs and noted that he is curious if there is any information that would lead to any statistically significant amount of confusion and bad acting in the HCSM space before there is a rush to regulate over anecdotal stories.

Mr. Hopkinson stated that the Alieria situation is important because the conduct was clearly fraud but the way the state’s were able to have authority over the situation was because Alieria was also selling insurance and was using unlicensed insurance agents and using unauthorized unfiled and unapproved insurance products. That was the hook that allowed states to go after them. The reason that CHM believes that the Model is important is because the Model allows the state to get the picture of who is operating in the state as well as giving the state some sort of regulatory authority to say “if you are not registered here and you meet this criteria then we have the ability to automatically go into unauthorized insurance issues” and that opens up the ability of the Attorney General. CHM believes that the Model is necessary because at this point the concept of HCSMs is being polluted by bad actors. CHM doesn’t have the ability to go out and stop someone it believes is acting improperly so there needs to be somebody out there that has the authority to go out there and do something. CHM believes the Model walks the

fine line of not having the states regulate too much and allowing the states to step in if there is a HCSM that does not report properly.

BRIEFING ON UPCOMING HEALTH COMMITTEE TOPICS

a.) Introduction of Patient Dental Care Bill of Rights Model Act

Rep. George Keiser (ND), sponsor of the NCOIL Patient Dental Care Bill of Rights Model Act (Model), stated that if this issue has not arrived in other states yet he believes it will soon – it has arrived in North Dakota. The issue deals with creating transparency and addressing contract rights relative to dental benefit plans. The current version of the Model is solely for introductory purposes and there has already been a lot of input from interested parties. Rep. Keiser urged the Committee members to review the Model as it is relatively self-explanatory. Rep. Keiser then noted a few of the issues that the Model addresses. The dentists in North Dakota are concerned when they contract into a network and subsequently find that the network has now contracted with additional networks and they feel that the additional network customers are not qualified to be served by that dentist and the dentist had no authority or input into agreeing to that. There are many other areas where the dental health networks are taking some very aggressive steps that benefit them at the expense of the dentist. The Model seeks to address that and create transparency and address the legitimate contract rights of all the parties.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA) stated that it is no secret that patients around America are confused by their coverage. The ADA feels that the issues set forth in the Model provide a step forward in terms of transparency and helping patients and their doctors properly use the coverage that they have. The Model deals with five reforms: network leasing; medical loss ratio; retroactive denial; virtual credit cards; and prior authorization. Regarding retroactive denial, insurance carriers audit their claims payment and adjudication activities to ensure accuracy and efficiency both before and after payments. That is something that dentists can agree to but what is unfair is coming back years later asking for repayment and then that occurring and then a surprise bill having to go to the patient. That is the kind of issue that is addressed in the Model and the ADA believes it warrants the Committee's consideration.

Mr. Peppard stated that AHIP is still reviewing the Model and noted that AHIP is generally in favor of transparency but has significant concerns about the way the Model has been drafted. AHIP looks forward to working with the Committee to make changes and hopefully get the Model to a place where everyone can support it.

Eme Augustini, Executive Director of the National Association of Dental Plans (NADP), stated that she is here today on behalf of NADP as well as its partners at AHIP, ACLI, NAVCP and AAPAN. NADP opposes the Model and has concerns with it because it would not improve dental patient welfare and wouldn't lower the cost of or access to dental care. The Model contains five disparate topics and the thread running through them is regulating the relationships between dentists and carriers rather than patient rights. If the idea is to improve the welfare of dental patients and consumers there are some other policy options that the Committee could explore. An example could be allowing hygienists or the concept of midlevel providers like dental therapists to perform basic dental procedures which could increase access to care especially in more rural

areas. NADP is always of course sensitive to concerns expressed by providers and NADP routinely works with dental associations to address the issues as they are raised. NADP looks forward to working with Rep. Keiser, the Committee, and interested parties on the Model going forward.

Karen Melchert, Regional VP of State Relations at ACLI stated that while ACLI disagrees that the Model is a patient's bill of rights, ACLI agrees that there are ways to work together on the Model to achieve greater transparency and disclosure associated with dental network leasing and on other aspects of the Model that will ensure that customers have access to the coverage they want and care by their chosen dental providers. Ms. Melchert noted two issues in the Model that ACLI would like to address: leasing provider networks – many insurers do not have extensive networks in all states and can only meet adequacy by leasing provider networks and while the industry is eager to work to improve the transparency of the network leasing process, ACLI believes it is important to do so in a way that enables leasing to occur to meet consumer needs. Also, with regard to the application of the medical loss ratios to dental plans, ACLI finds that problematic. The ACA sets very high medical loss ratios for qualifying major medical coverage, however, there are significant differences between medical and dental coverage that render medical loss ratios inappropriate for dental coverage and ACLI would like to address that going forward. ACLI looks forward to working on the Model to ensure something is created that is helpful to dentists and consumers and those that provide the coverage.

b.) Prior Authorization Reforms

Mark Pratt, SVP of Public Affairs at CAQH, stated that CAQH is not an advocacy organization but was rather asked to come speak today about the meaningful progress that stakeholders are making working collaboratively to improve the prior authorization process. CAQH commends NCOIL in examining this important issue. Prior authorization is obviously an important issue to policymakers and it is also an issue that legislators deal with from a constituent service standpoint and it is important to make sure the process works as effective as possible. CAQH is a non-profit and develops shared initiatives to standardize, streamline, and automate healthcare business practices with the objective of reducing administrative costs and burden and complexity in the healthcare system. CAQH partners with about 800 health plans, hospitals, health systems and other provider organizations and routinely engage more than 1.6 million providers who CAQH offers its services to at no charge.

CAQH Core is led by its own distinct board and is a multi stakeholder board consisting of an equal number of health plan and healthcare provider representatives. It is supported by well over 100 organizations that participate in work groups, pilot projects and the like. Its mission is to develop operating rules that support standards, accelerate interoperability and align administrative and clinical activities to benefit patients, providers, and health plans alike. CAQH Core has been designated by the Secretary of HHS as the authoring entity for operating rules for HIPAA administrative transactions. Mr. Pratt stated that you can think of operating rules as analogous to something that the banking industry did many decades ago to facilitate the ability for folks to use their ATM card in any financial institution across the country. CAQH Core developed the rules of the road so to speak around various transactions in healthcare. Some of its earlier work relates to eligibility and benefit verification, claims status, claims payment and the like.

One example of an eligibility rule that was developed with stakeholders was that when it comes to patients at the point of care having to work with their providers and determine what the copay and deductible would pay, the rules allow that to happen in real time at the point of care.

With respect to prior authorization, it is important to note that CAQH Core does not get into questions that are confronted during the legislative process such as “should there be prior authorization or not” or “what services should be subject to prior authorization.” Rather, the rules that CAQH Core works with stakeholders on are designed to specify how information regarding these transactions is exchanged on an electronic basis. That is important because there is a lot of room for progress with respect to automating the prior authorization process. CAQH Core conducts an annual survey each year that aims to benchmark the progress that is being made to move to electronic transactions. While a lot of progress has been made on other transactions, we are not where we want to be with respect to prior authorization. Only about 12% of prior authorizations are fully automated according to last year’s survey and just over half of all prior authorizations are still done manually, i.e. phone, fax, e-mail.

CAQH stated that the work it is doing with stakeholders is designed to move the ball forward to make progress to enable a more optimized process and drive industry wide adoption so as to make the system work better for everybody involved. That involves providing information within standard transactions to enable automation, developing timeframes and consistent experiences for turnaround time for prior authorization and to support the exchange of clinical documentation. Mr. Pratt stated that the work CAQH Core is doing is currently before its board and hopefully CAQH Core can present the final work product at the Committee’s meeting in March. After the board acts and CAQH starts socializing the work with stakeholders there will be a lot of interest in the work that stakeholders have done to move the process forward. Mr. Pratt noted that state governments can become involved with CAQH’s in two ways: participate in its work groups at no cost to state agencies, and achieve certification that they have achieved conformance with the operating rules that have already been developed which is sort of a good housekeeping seal of approval. Over 360 organizations have achieved certification and the Texas Medicaid agency was the first state agency to date to achieve certification across all phases of rules that CAQH has adopted. Mr. Pratt thanked the Committee for the opportunity to speak and noted that he looks forward to being a resource moving forward as the Committee considers these issues.

c.) Update on Biosimilar Landscape

Daren Sink, Senior Director of Gov’t Affairs at Pfizer, stated that he would like to provide a brief update on the biosimilar landscape as a follow-up to the general session that took place at the Summer Meeting in July. One of the things to be aware of heading into legislative sessions is to consider biosimilars when looking at pricing issues and looking at cost savings and whether or not it is being maximized in states. Right now, biologics account for about 1/3 of the spending of all medications to the tune of about \$320 billion dollars worldwide. Biosimilars only account for about 1% of that and right now the biosimilar market worldwide is about \$10 billion dollars. The familiarity with these medicines and where they are going has become significant. Additionally, a number of biosimilars have been approved globally in the last two years. In 2017 there were 19 approved; 23 approved in 2018; and another 10 in 2019. So, familiarity with them has become significant and the use of them has picked up greatly.

Mr. Sink stated that the big five countries in Europe account for the majority of that use and the uptake in the U.S. has been limited particularly at the state level largely because of educational/familiarity reasons, becoming comfortable with the medicines, and the market system that can make them available. Mr. Sink stated that as state legislators consider these issues it is important to make sure nothing is left on the table. Right now, the savings being generated by the use of biosimilars in the states is about \$243 million dollars. If it is fully vetted out it is believed that about \$71 billion dollars worth of savings could be achieved over time that would be repetitive – that is data from the Pacific research Institute. Mr. Sink offered Pfizer as a resource for any states considering these issues and noted that it is very important that this uptake occur because the market needs to turn. Like we have seen with the generic market before, the importance of turning that market to allow for affordability with innovative therapies for new medicines coming out is vital.

d.) Introduction of Vision Care Services Model Law Concept

Asw. Hunter noted that Sen. Bob Hackett (OH) is sponsor of the proposed Vision Care Services Model Law (Model) and as he is unable to be here today so this topic will be briefly introduced for further discussion in 2020.

Robert Holden, State Gov't Affairs Director for the National Association of Vision Care Plans (NAVCP), stated that NAVCP represents the 16 largest vision care plans operating nationally. NAVCP supports the Model as it is important to address the vision care services industry specifically. NCOIL has previously addressed non-covered services for purposes of the dental industry and NAVCP is interested in NCOIL considering that for the vision care industry as well. The vision care market is unique because it combines a healthcare service which is typically an annual eye examination along with the purchase of eyewear at retail so it stands apart from most other forms of healthcare in that way. Consumers have an increasing number of options to purchase eyewear and they are increasingly looking at online options of the purchase of eyewear through large retailers. The industry and NAVCP's member plans support consumers having strong options of getting their eyewear through their independent optometric practice. NAVCP believes that the Model strengthens that and allows plans to work together with optometrists to do that. NAVCP looks forward to working on the Model with the Committee in 2020.

Mr. Peppard stated that AHIP supports the Model and looks forward to working on it with the Committee in 2020.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES
COMMITTEE
AUSTIN, TEXAS
DECEMBER 12, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations and International Insurance Issues Committee met at the JW Marriott Hotel in Austin, Texas on Thursday, December 12, 2019 at 9:00 a.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Rep. George Keiser (ND)
Rep. Richard Smith (GA)	Sen. Neil Breslin (NY)
Rep. Peggy Mayfield (IN)	Asm. Andrew Garbarino (NY)
Rep. Joe Fischer (KY)	Sen. Roger Picard (RI)
Sen. Dan "Blade" Morrish (LA)	Rep. Tom Oliverson, M.D. (TX)
Rep. Tracy Boe (ND)	

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Paul Utke (MN)
Sen. Dan McConchie (IL)	Rep. Donna Pfautsch (MO)
Rep. Edmond Jordan (LA)	Rep. Bruce Grubbs (MT)
Del. Mike Rogers (MD)	Asw. Maggie Carlton (NV)
Sen. Gary Dahms (MN)	Asm. Kevin Cahill (NY)

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Rep. Tracy Boe (ND), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Keiser and seconded by Sen. Neil Breslin (NY), the Committee approved the minutes of its July 11, 2019 meeting in Newport Beach, CA without objection by way of a voice vote.

CONTINUED DISCUSSION ON NCOIL INSURANCE BUSINESS TRANSFER MODEL
LAW

Asm. Andrew Garbarino (NY), sponsor of the NCOIL Insurance Business Transfer (IBT) Model Law (Model), stated that he believes the Model is close to being ready for a vote but some work still needs to be done. Since the last meeting of the Committee in March some changes have been made to the Model including: expanding the “purpose” section to more accurately explain the purpose of the Model and IBTs in general; a drafting note was added in Section 3L. to point out that states may wish to remove certain lines of insurance from the scope of an IBT; more information was added to Section 6 which governs what the IBT plan must contain when submitting it to the Insurance Commissioner for his or her review. Asm. Garbarino stated that he appreciates everyone’s work on the Model thus far and he looks forward to continuing to work on it.

Karen Melchert, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked Asm. Garbarino for continuing to work on the Model to get it to a point that perhaps ACLI could support it. There are varying opinions within ACLI’s membership regarding IBTs. ACLI looks forward to continuing to work with Asm. Garbarino. ACLI would like to see its IBT principles in the Model but ACLI understands the need for the Model to be flexible for states to consider it. If ACLI’s principles are not included in the Model then ACLI would ask that there be a requirement that regulations are promulgated. The ACLI has been told by a few states that they are not considering promulgating regulations regarding IBTs and ACLI believes there needs to be more of a map or guidelines for the regulators as IBTs come before them. The ACLI is developing language to that effect and will share it with NCOIL well in advance of NCOIL’s Spring Meeting.

On behalf of the National Conference of Insurance Guaranty Funds (NCIGF), Barbara Cox stated that NCIGF is the coordinating body for the property/casualty guaranty funds. NCIGF has looked at IBT, restructuring, and corporate division statutes and has some concerns that as the current guaranty association laws are written there might not be coverage for the transferred business in many states. Since all types of insurance such as personal lines and workers compensation insurance could be involved – the types of business that the P&C guaranty funds would normally protect – NCIGF decided that needed to be fixed. Accordingly, NCIGF’s position is as follows. If there was guaranty fund coverage before the transaction, there should be guaranty fund coverage after the transaction. Conversely, if it was non-admitted business such as surplus lines or a risk retention group, then there should be no guaranty coverage as a result of the transaction if there was no coverage before the transaction.

Ms. Cox stated that NCIGF is undertaking a multistate effort to revise the guaranty association acts to include transferred business which was guaranty-fund covered before the transaction. The template language is almost ready. There is some variation among state guaranty fund laws. A lot of them do adhere to the NCIGF and NAIC model, and the NCOIL Model Guaranty Association Act, but the template will need to be adjusted for those variations which NCIGF is quite willing to do. This effort has been vetted with the NCIGF board which includes 8 fund managers and 12 industry persons. NCIGF also has a public policy committee with essentially the same makeup. NCIGF believes its legislative effort will have wide support. There may be some guaranty fund members who take a different position as NCIGF is a voluntary organization and cannot compel anyone to go along with anything. Nevertheless, NCIGF believes it has wide support for the effort and does not believe that the “fix” for this will come through the NCOIL Model. NCIGF would probably at some point request that the NCOIL Model Guaranty Association Act be amended to deal with this issue. Ms. Cox stated that she

hopes that the NCIGF legislative effort will be supported in states as it is very positive for covered claimants.

Bob Ridgeway, Senior Gov't Relations Counsel at America's Health Insurance Plans (AHIP), stated that AHIP's members are reasonably comfortable with ACLI's IBT principles and believe that the principles should be in some way incorporated into the statutory language if at all possible. That is not to say necessarily that those things must happen but perhaps a listing of the principles with language saying that the Commissioner, and probably the independent expert, must take consideration of these issues in reaching their decision. With regard to guaranty fund coverage, Mr. Ridgeway stated that he would like to look at some language that was offered as an amendment to the Illinois restructuring law. Some language that has been offered for consideration regarding the guaranty fund coverage issue is awkward and could be improved to address the issue as it is very important to not create guaranty fund coverage where it didn't exist, nor take it away where it did exist.

Asm. Garbarino stated that he spoke with ACLI regarding his concerns that the ACLI's principles were vague and ACLI has taken steps to work on that so that the principles could be included in the Model. Asm. Garbarino stated that he thinks it could be a good idea to require the Insurance Commissioner to adopt regulations rather than simply authorizing he or she to do so. Asm. Garbarino further stated that he is certainly open to new language that would better address the guaranty fund coverage issues discussed today.

Sen. Klein asked Ms. Melchert if the ACLI is getting close to the point where it believes that the Model sufficiently addresses ACLI's concerns. Ms. Melchert replied yes and noted that it is still a work in progress.

The Honorable Glen Mulready, Commissioner of the Oklahoma Insurance Department, stated that as the author of the Oklahoma IBT legislation and now the regulator overseeing it, he does not disagree with anything said today but cautioned changing the Model. Cmsr. Mulready stated that the IBT process is still new and that if you have seen one IBT, you have seen one IBT. The very first IBT that the OK Insurance Department has will have its first hearing at the court level next week and it is all runoff business – typical longtail business that has not sold a policy since 1972. The second IBT that is in the Department is all reinsurance and discussions are ongoing with other potential transactions. The ACLI's principles are well thought out and great principles and they should absolutely be considered by the independent expert, regulator and court.

Regarding the guaranty fund issues, Cmsr. Mulready stated that the whole process is set up so that policyholders are not materially adversely impacted and that is why the three step process exists involving the independent expert, regulator, and court. If a lot of policyholders did have guaranty fund coverage and then did not, they would be materially adversely impacted. Cmsr. Mulready stated that if such a transaction came to his office, it would be disapproved. It is important to trust the process – a process that has worked for almost 20 years in the UK involving almost 300 transactions without a failure.

CONTINUED DISCUSSION OF PROPOSED AMENDMENTS TO NCOIL MARKET
CONDUCT SURVEILLANCE MODEL LAW

The Honorable Dean Cameron, Director of the Idaho Department of Insurance and NAIC Secretary-Treasurer, stated that market conduct surveillance is very important to the NAIC and is important to make sure that consumers are protected and that there are not actors out there acting inappropriately. The NAIC wants to make sure that whatever Model is brought forth does not throw the baby out with the bathwater and make it more difficult for regulators to do their job or make it more difficult to protect consumers. At the same time, the NAIC recognizes that there are changes and improvements that can be made and there are opportunities to collaborate with NCOIL and the industry.

Dir. Cameron stated that there are a couple of issues that the NAIC sees in the current draft of the Model that gives the NAIC some heartburn and concern. There is a provision in the draft Model relating to cybersecurity which states “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.” The intent of that language may be reasonable, but the language gives the NAIC heartburn. The NAIC does not want a situation where a Commissioner cannot examine a company on a cybersecurity breach. If you think about some of the cyber breaches that have occurred, such as the Anthem breach, Anthem did not handle that situation well and regulators need to be able to go in and see when the carrier knew that it had a cyber breach, what steps it took to mitigate the breach, and what steps it took to inform customers and regulators.

Dir. Cameron stated that another proposed amendment to the Model talks about material violations to the law and reliable and credible sources; and another proposed amendment requires that before notifying the company, that there be an examination. Dir. Cameron stated that is an awkward chicken-and-the-egg type of approach as the only way regulators can appropriately do an examination is to have a discussion with the carrier so as to indicate what the problem is. Dir. Cameron stated that he realizes there are times when that has not happened appropriately but for most regulators, the first step when there is a situation that the regulator thinks needs examining is to sit down with the carrier and lay out the issue and state how the regulator would like to look at records to make sure it has been handled appropriately. Dir. Cameron noted that the NAIC does not believe that market conduct examinations ought to be fishing expeditions nor should they last forever.

Another provision in the draft Model that gives the NAIC some heartburn is the provision in Section 7 regarding the change in estimated budgets. Dir. Cameron stated that he does not believe an arbitrary cap is needed as that would tie the hands of the regulator who is conducting an examination if one is needed. Obviously there can be discussions about how to determine if an examination is needed and why it is needed, but a threshold on budget is not the threshold that should be there.

Rep. George Keiser (ND) stated that, with regard to the budgetary cap, it seems there are two forces at play. One is to limit the currently unlimited exposure to the company because they ultimately are paying the bill. But as the amendment is currently written, if you hit that cap then the examination must be closed down despite what is discovered in the examination. Therefore, Rep. Keiser questioned whether the language should state that anything over 10% should be discussed and presented back for justification. Rep. Keiser noted that the current situation is an open checkbook and companies are not happy with that fact that you can come in and hire outside people that charge

significantly different rates. Those issues should be addressed but the current language regarding the budgetary cap may not be appropriate due to the ability to essentially shut down the examination regardless of what is discovered.

Dir. Cameron agreed with Rep. Keiser's interpretation of the language but noted that not every state conducts examinations as described by Rep. Keiser. Idaho does not charge for market conduct examinations – they are on the department's dime. Idaho charges a fee for being licensed and that covers their financial examination and/or a market conduct examination. Also, depending on the size of the insurance department, it does become difficult for the regulator because oftentimes a market conduct examination is needed but the department does not have adequate staff to do it so they end up hiring an outside contractor which sometimes can be a little unwieldy for the department to control and for the carrier to pay the bill. There needs to be an accommodation.

Dir. Cameron stated that he is not sure if every state does this but in Idaho, he makes staff come to him and discuss why they want to conduct a market conduct examination. Obviously if there is a carrier that is violating mental health parity and mental health issues, that is a stronger market conduct examination than one initiated for carriers not appointing agents appropriately just because of signature and dating issues. With regard to the latter, that is not a priority for an examination although it may be an issue that the department would point out to the carrier. Also, if the examination is going to last a long time, Dir. Cameron stated that he makes staff come back to him after a certain length of time to justify its continuation. Dir. Cameron stated that he believes those are reasonable issues to consider but an arbitrary 10% budgetary cap would be harmful to consumers.

Erin Collins, Asst. VP of State Affairs for the National Association of Mutual Insurance Companies (NAMIC), thanked Sen. Travis Holdman (IN), NCOIL Immediate Past President and sponsor of the proposed amendments to the Model, and the Committee for having this discussion. NAMIC believes that this conversation is important, and many aspects of the Model address some important issues in the insurance market, some of which were outlined by Dir. Cameron. NAMIC has shared goals with Dir. Cameron and the NAIC in terms of looking at the market conduct examination process. Ms. Collins stated that one of the problems that the industry has faced over the last decade or so as conversations have begun about the need for risk based regulation is that there needs to be an according conversation about changing the old way of regulating the insurance industry so that we are not just building new frameworks on top of old frameworks and ending up with redundant regulatory mechanisms. That does not help the industry, the market or the regulators.

Ms. Collins stated that Dir. Cameron made some excellent points and NAMIC looks forward to working on improving the proposed amendments to the point where they are adopted. Regarding the cybersecurity issue previously discussed, the intent of the proposed language is to make sure that by virtue of examining cybersecurity among multiple facets across the regulatory structure, a cybersecurity risk is not created in and of itself in the companies as all of that information goes back and forth through different portals. Regarding the budgetary cap issue, the intent there is to put some belt and suspenders on so that it does not teeter into ongoing, unending concepts. NAMIC looks forward to working on the amendments with Dir. Cameron and the Committee.

Birny Birnbaum, Director of the Center for Economic Justice (CEJ), stated that today,

everyone's collecting more and more data about the consumer, from the consumer and about the natural and built environment. Insurers collect more and more data to be able to perform analytics and take action in real time – whether for underwriting, claims settlement, anti-fraud or loss prevention. Financial regulators collect vast quantities of data and routinely expand their data collection. For example, insurers report every bond, every equity, every reinsurance agreement, every investment – why? So regulators can assess immediately what impact a financial market event will have on individual insurers and industry. The exception to more data, better analytics and greater efficiency is insurance market regulation. Market regulation is still based on an audit methodology and not an analytics methodology. It makes no sense to require a market conduct examination to gather data for analysis. And industry complaints about market regulation costs and inefficiencies are tied to the audit type approach. Proposals that place more hurdles in front of regulators to perform market analysis and take action to protect consumers not only harms consumers, but raises the costs of market regulation for insurers.

Mr. Birnbaum stated that unfortunately, the proposed amendments don't move market regulation towards a more data-based approach but create even more bureaucracy while delegating legislative authority to administrative agencies. Throughout the proposed amendments there are references to "material violations of law and consumer harm" before anything can be done. For example, in the definition of "market analysis" – which is the process by which information is gathered to assess whether there are issues that need to be investigated further or taken action on – it says that the patterns or practices of insurers licensed to do business in this state that deviate materially from state law or significantly from the norm or regulations and that may pose a demonstrated material potential risk to the insurance consumer. This proposal directs the commissioner to take on the role of the Legislature and decide which laws to enforce and which to not. It introduces vague terms that encourage lack of uniformity across the states – deviating materially from law and pose a material potential risk. Mr. Birnbaum stated that he guarantees there will be 51 different interpretations of those terms if the Model was enacted across the states.

Instead of making market regulation more efficient, the proposal will make it less efficient by giving insurers yet another tool to object to regulatory action – insurers will object to regulatory actions claiming the regulator did not prove the violations are material and did not prove the material risk to consumers. These changes will make an already cumbersome process even more cumbersome and will hamstring the people in charge of consumer protection. Another problem in the proposal is in the section regarding complaints. It is important to understand how insurance regulators deal with complaints and what the difference is between a confirmed complaint and an unconfirmed complaint. A confirmed complaint is one in which the insurer is determined to be at fault. But regulators get many more complaints that provide useful information – for example, if there are a number of complaints from consumers regarding coverage they thought they had, that's useful information to prompt a review of how an insurer explains its coverage even if it is not the fault of the insurer. However, the proposal limits market analysis to confirmed complaints and is therefore telling regulators to ignore useful data - that does not make sense.

With regard to the cybersecurity issue, Mr. Birnbaum stated that the proposal conflicts with both the NAIC Cybersecurity Model and the recently adopted chapters and checklists in the Market Regulation Handbook which provides market regulators with

post-breach checklists for market regulation activities. If the intent is cooperation between market regulators and financial regulators, then that is what should be required – but market regulators should not be barred from doing the job they should do in the event of a breach.

Another issue in the proposal deals with domestic deference and a state's acceptance of another state's market conduct examination. In financial regulation, the accreditation program of the NAIC requires one state to accept the financial examination of the insurers' domiciliary state. But the accreditation program is designed to ensure that every state has the resources and expertise to perform a competent financial examination. Accordingly, there are not states saying that they don't have enough money to hire a financial examiner so the job won't be done – the accreditation program says that states must do so, so it ensures that states have the resources and skills to do a competent financial examination.

Mr. Birnbaum stated that the market conduct model proposal seems to import that procedure for market conduct examinations – acceptance by regulators in one state of a market conduct examination by another state. There is no rationale for such a provision for at least three reasons. First, unlike the financial condition of an insurer which doesn't vary from state to state, market conduct can and will vary state by state due to differences in legal requirements and insurer practices. Second, unlike financial examinations, there are no standards – accreditation or otherwise – for market conduct resources for a state. Third, for market conduct issues which do cross state lines, state insurance regulators already have a tool called multi-state examinations. Mr. Birnbaum questioned whether the Committee would want the Commissioner in Indiana to rely upon the New Mexico Commissioner to tell him or her whether insurers were paying the proper premium tax in Indiana? Or whether an agent licensed in NM was also properly licensed in Indiana? Or whether disclosures required by the Indiana legislature were being provided to Indiana consumers? Or whether insurers in Indiana were complying with prompt pay laws? Mr. Birnbaum stated that he does not believe Committee members would do that or want that.

On the issue of examination costs, Mr. Birnbaum stated that if you fund your departments sufficiently, you can eliminate the need for most contract examiners. There are many departments that have no market conduct examiners on staff, so they have no choice but to use contract examiners. If you want to eliminate the majority of contract examiners, states should follow what Idaho does. Also, it doesn't make sense to cap regulatory expenses, when insurers can drive up the cost by lack of cooperation. Mr. Birnbaum stated that he has worked on market regulation issues since 1991 and that he interacts with market conduct examiners and market regulators all the time. There are stories about what drives up their time and costs and it is because when they make a request for information, they don't get what they asked for and have to ask for it again. That drives up the cost and therefore it does not make sense for regulators to be limited in their ability to carry out their responsibilities through no fault of their own.

While CEJ has concerns with the current draft, CEJ would like to work with the Committee to modernize insurance market regulation and bring market regulation into the age of data analytics. CEJ would suggest that the Committee's efforts should be focused on empowering regulators to collect more data and provide them with the tools to analyze the data in real time. For example, instead of finding out a year after the fact that there is a rogue agent engaged in unsuitable sales, it would be better to collect data

in real time about sales in the marketplace so that it can be highlighted and focused on and narrowly targeted instead of having to do a market conduct examination of the company to identify one rogue agent.

Sen. Klein asked Mr. Birnbaum for comments on how the Committee should proceed with the amendments to the Model. Mr. Birnbaum stated that he does not believe any of the amendments move the industry towards modernization. The Model as-developed already is a strong foundation and the changes that are needed are those that better empower regulators to collect and analyze data because it is the ability to do so that will move market regulation towards greater efficiency. The market conduct examination is a blunt tool and in an era of data analytics, regulators should be given sharper tools.

Dir. Cameron stated that upon returning home, Committee members should talk to their regulators about the needs of their state when it comes to market conduct. Dir. Cameron agrees that certain changes can be made to the market conduct process in order to make the approach more efficient and there are some circumstances where examinations have taken longer than needed and they have not been as focused as they should have been. The NAIC welcomes working with NCOIL and the industry to work on improving the process but the first step will be to really define what the issues are and what they are within individual states. Dir. Cameron noted that there is a difference regarding cybersecurity exams. When a financial examination is occurring, the goal is to see if a carrier has cybersecurity plans and methodologies and approaches in place. When a market conduct exam is occurring, there already has in many cases been a cyber breach and the goal is to find out if the carrier handled it according to their own plan or according to state/federal law. Just because the carrier is examined for cyber under the financial examination does not mean that should be the end of it.

Sen. Gary Dahms (MN) stated that the proposal is well thought out, but it is important to not lose sight of the fact that different states handle these examinations different. Sen. Dahms stated that he understood where Mr. Birnbaum is coming from but noted that sometimes the insurance departments treat the insurance companies the way Mr. Birnbaum believes that insurance companies sometimes treat their clients. Accordingly, it is important to be cautious as to how the Committee proceeds with this proposal and make sure that there are some rights built in for the insurance companies. Sometimes the companies are not even told why the regulators are coming in to examine and when the exam will end or how much it will cost. Regulating those areas is important in order to keep costs down because if you have an insurance company with a market conduct exam that goes on for years with accompanying bills, rates will increase because the costs must be borne somehow.

DISCUSSION ON THE REAUTHORIZATION OF THE TERRORISM RISK INSURANCE ACT

Jim Lynch, Chief Actuary and VP of Research and Education at the Insurance Information Institute (III), stated that the terrorism risk insurance act (TRIA) was triggered by the 9/11 attacks which inflicted about \$47 billion dollars of damage that went across different lines of insurance. Immediately after those attacks, the insurance markets froze up. The III put together a white paper that documented the way that the insurance markets have behaved since 9/11 when there was no TRIA. Insurance market froze after 9/11 because insurance companies are very good at managing risks when they understand the risks but if they don't understand the risks things can go haywire. From

an insurance standpoint, terrorism is hard to underwrite because there is not a lot of historical data; acts of terrorism are not random; there are many “attack modes”; and the attacks are often geographically concentrated. For example, before 9/11, insurance companies anticipated that the worst thing that could happen at the World Trade Center was if a commercial airliner crashed into it but they did not contemplate that someone would concentrate that risk by directing two planes towards the twin towers.

Mr. Lynch stated that quickly after 9/11, Congress passed TRIA. TRIA has been renewed and changed over the years and it has a lot of moving parts to it. Generally, TRIA functions such that most commercial lines of insurance must offer terrorism coverage. In exchange, for events causing over \$200 million dollars in damage (in 2020), each insurer can recover 80% of their losses after they have satisfied their own internal deductible. Then, the government – except for the very large events – must recover 100% of its outlay from policyholders. How that plays out is complicated because the program has been renewed and changed.

The III worked with the Reinsurance Association of America (RAA) which has a very highly regarded model that can say, given a certain type of event in a certain city, how much losses are going to be, how much of those losses are going to be insured, and how those losses are going to be split between what the federal government ends up paying net, what insurers end up paying net, and then what the policyholder surcharge is that the government recoups post-event. Accordingly, III and RAA ran a scenario asking what if 9/11 happened again under the original terms of TRIA, under the 2020 terms, and under the 2030 terms. In the first scenario, the net amount that the federal government pays falls to zero – there will still be initial funds going out upfront but the government will recover all of it. The amount that the insurers must pay will rise consistently through 2030. The amount that policyholders must pay via the surcharge will continue to increase.

Mr. Lynch noted that TRIA was supposed to do two things: make terrorism insurance available (which it did) and make terrorism insurance more affordable. Since 2003, the cost of risk is down about 80% as estimated by some of the brokerage firms that are involved heavily in the market. Regarding the take up rate of the insurance, Mr. Lynch noted that it varies state to state but there is pretty good concentration in the geographic areas that are most exposed to terrorism risk.

Mr. Lynch noted that the second time there was no terrorism insurance program was for about three weeks in 2015 when the enabling legislation expired. There was some concern because many thought that if TRIA was not renewed, insurers were likely to invoke exclusions in existing policies that disallow claims for terrorism, and banks were likely to deny credit for the projects that require such insurance as part of a loan agreement. However, TRIA-renewal legislation was ultimately passed very quickly in early 2015.

Mr. Lynch stated that TRIA is scheduled to expire at the end of 2020 and there is legislation already introduced to renew the program. The reason why the effort to renew has started so early is because reinsurance treaties cover risks that span several years. Also, for insurance policies that are renewed next year in 2020 – anything that is renewed after January 1st will at least be trivially exposed to terrorism risk without TRIA. That is especially true in workers’ compensation because it is statutory coverage and does not make an exception for terrorism so that terrorism risk continues on and that

could create a complicated situation for insurers. There also could be possible rate pressures. If the insurance market starts to freeze up and coverage does not become available, one way that the market will clear, is by seeking rate increases where it is legally available to do so. Currently, insurers are also introducing conditional endorsements and other conditional items – all conditioned upon the expiration of TRIA. Those are all reasons why there is a drive to renew TRIA in a timely manner.

Mr. Lynch noted that there are two bills currently pending in Congress regarding TRIA reauthorization. One bill overwhelmingly passed the House on November 19th. On November 20th, virtually identical legislation passed the Senate Banking Committee. TRIA reauthorization is a major initiative for the insurance and reinsurance companies and their lobbying groups. To this point there is no significant substantive opposition inside or outside of Congress. The Consumer Federation of America did release a statement that TRIA should not be renewed because it believes that the market can already support terrorism insurance, but Mr. Lynch stated that when he speaks with insurance trade organizations, they are being told differently by their members.

Asw. Maggie Carlton (NV) asked if throughout the evolution of TRIA the definition of terror has changed, particularly given the occurrence of events such as what occurred in Las Vegas recently. Mr. Lynch stated that the definition of terror in TRIA is defined by the Secretary of Treasury. The legislation also requires Congress to consult with the Attorney General and other branches of the federal government. Being declared a terrorist event within TRIA, therefore, comes from the federal government. In terms of insurance policies, however, that is an issue for the individual policies. Mr. Lynch noted that no events since 9/11 have met the federal definition of a terrorist event, including the Las Vegas incident referenced by Asw. Carlton. The Boston Marathon tragedy was thought by many to be an act of terrorism but for purposes of TRIA, it was not. The Boston Marathon bombing also had trouble meeting the \$5 million dollar damage threshold set forth in TRIA. Mr. Lynch stated that he believes the bombing might have reached the threshold but just barely.

Rep. Keiser stated that he owns a small company and he purchased cyber insurance and terrorism insurance. The threshold to get to the federal terrorism backstop is so high that if there were a cyber terrorist event in his community, it is doubtful that it would meet that threshold. The exclusions and deductibles in the policies are also very high and therefore Rep. Keiser asked if small businesses that have purchased this type of insurance really have insurance and how difficult is it for such businesses to prove that a cyber event is a terrorist attack.

Mr. Lynch stated that if you have cyber, the TRIA legislation was written before cyberattacks were really thought about as insured events. Since then there has been regulatory guidance from the Federal Insurance Office (FIO) that states that for the cyber coverage that has been written in the lines of businesses that are covered by TRIA, if a cyber-attack meets the federal definition of a terrorist event the attack could be covered by TRIA. If there is an event that is considered to be terrorism, but the federal government does not define it as such, there may be coverage under specific policies.

The way that the policies are written is such that terrorism is excluded from the policy but then you can buy back terrorism coverage. So that means that if there is a loss that's terrorism and you did not buy back the coverage then you are in a tough spot. But if that event was not labeled a terrorism loss, as in Boston, then that means there is no way for

the insurance company to invoke a terrorism exclusion. So, the way the legislation is written is such that it creates a bit of clarity there.

If the event is defined as a terrorism event, insurance will still respond even if it is not large enough to meet the TRIA threshold. Rep. Keiser stated that if you read the policy it has out of pocket limits and the maximum coverage is extremely limited which is how they can underwrite it. Therefore, your exposure may be up to \$200,000 but the event may be \$250,000, \$500,000 or \$1 million and people have no coverage and they don't realize that. Mr. Lynch stated that is sounds like what is being borne by the small business in Rep. Keiser's statement are deductibles and limits that fall short of being able to protect the business adequately. Rep. Keiser stated that having the policy helps one sleep at night but reading the provisions does not. Mr. Lynch stated that is something that should be discussed with a risk manager.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
AUSTIN, TEXAS
DECEMBER 12, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the JW Marriott Hotel in Austin, Texas on Thursday, December 12, 2019 at 3:30 p.m.

Representative Joe Fischer of Kentucky, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Rep. Tracy Boe (ND)
Sen. Mark Johnson (AR)	Rep. George Keiser (ND)
Asm. Ken Cooley (CA)	Sen. Jerry Klein (ND)
Sen. Jack Tate (CO)	Sen. Shawn Vedaa (ND)
Rep. Edmond Jordan (LA)	Asw. Ellen Spiegel (NV)
Sen. Gary Dahms (MN)	Del. Steve Westfall (WV)

Other legislators present were:

Sen. Dan McConchie (IL)	Rep. Donna Pfautsch (MO)
Rep. Chris Judy (IN)	Rep. Bruce Grubbs (MT)
Rep. Peggy Mayfield (IN)	Sen. Roger Picard (RI)
Del. Mike Rogers (MD)	Sen. Cale Case (WY)
Sen. Paul Utke (MN)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Sen. Gary Dahms (MN), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Martin Carbaugh (IN), Vice Chair of the Committee, and seconded by Sen. Jerry Klein (ND), the Committee approved the minutes of its July 13, 2019 meeting in Newport Beach without objection by way of a voice vote.

DISCUSSION ON THE USE OF GENETIC TESTING INFORMATION IN LIFE INSURANCE UNDERWRITING

Mark Rothstein, JD – Director of the University of Louisville’s Institute for Bioethics, Health Policy and Law – stated that some may think that this issue is not ripe for consideration, but he believes it is. Between 1990 and the present time, there have been a number of laws enacted on health insurance discrimination and genetic discrimination in employment at the state level but very few meaningful laws have been enacted in terms of genetics and life insurance at the state level. At the federal level, the Genetic Information Nondiscrimination Act (GINA) enacted in 2008 deals with health insurance and employment but none of the other forms of insurance. Mr. Rothstein stated that there are three types of state laws in this area and they all have limitations. An example of the first is that the laws only apply to discrimination against carriers of recessive disorders – these laws date back to the early 1970s and were designed to prevent discrimination against individuals who had sickle cell trait but not sickle cell disease. For recessive disorders you need two copies, one from each parent in order to be effective. California and Maryland still have those provisions.

The second kind of limitation is the fact that many of the laws say that genetic discrimination is unlawful unless there is actuarial justification. Massachusetts and Montana have those types of laws. That issue was debated earlier this year in Florida where a bill to prohibit genetic discrimination not only in life insurance but also disability and long-term care insurance was introduced. It was very controversial and eventually it was not enacted but it also contained an actuarial justification provision. You might wonder why you would want to enact such laws because such laws are already on the books via unfair trade practice law which make it unlawful to discriminate on the basis of anything that is not actuarially justified. Mr. Rothstein stated that perhaps the most stringent state to pass a law in this area is Vermont which prohibits life insurers from acquiring genetic testing of an applicant or using the results of a family member’s genetic test but it does not prohibit the use of genetics tests that were run in the clinical setting and are in the individual’s medical records that you can lawfully request as a condition of considering someone for life insurance.

Mr. Rothstein stated that he believes it is a critical stage now to consider these issues because at the present time between 25 and 30 million people in the U.S. have had direct to consumer genetic testing such as 23 and Me. Most of those are in the ancestry realm where you are not going to deal with health information of a predictive nature but there are at least 2 million of these tests that do generate predictive health risk assessments and they are off-record because if you have had these tests they send you the results and what you do with them is up to you and if you don’t want to tell anybody no one will know. Mr. Rothstein questioned that if you don’t think 25 million is enough, what would 50 or 75 or 100 million mean? From the industry perspective, the more people who have information that the industry doesn’t have, the more uncomfortable the industry is about the risk of adverse selection. Mr. Rothstein stated that there are also other technologies besides simple genetic testing that are increasingly being used which he believes will put pressure on insurance companies to do something. The first type of technology is polygenic risk score which combines dozens or hundreds of factors and algorithms to project what the risk is. These are already marketed to individuals so you can get your risk of heart disease or cancer. Some insurance companies have already started using epigenetic age estimators to try and figure out life expectancy.

Mr. Rothstein stated that genetic testing in underwriting is not nearly as valuable as many people think it is. Mr. Rothstein then discussed what type of genetic information might be valuable in underwriting. In order to be valuable, the information must be an

adult-onset disorder. If you have someone that applies for life insurance and they already have a condition that is not the case here because then you treat that as any other medical condition. Predictive genetic testing has to be for adult onset disorders. A disorder which has a high penetrance would be valuable information, which means that there is a high likelihood that a gene will be expressed if you inherit it. There must be a high absolute risk in terms of what it means regarding the likelihood that the person is going to get sick and how does that compare to the average person in the population – you might have three times the risk of someone in the population but that could mean three in a million instead of one in a million. There must be a high mortality rate for the condition which gets into the issue of how treatable it is – that is a moving target and very complicated. There must be a lack of family history. If your father died of Huntington's disease, you don't need a genetic test because it is what called an autosomal dominant disorder – 50% of that person's children are at risk and you would be at risk of Huntington's disease without a genetic test. So, if you have family history you don't need a genetic test but a genetic test would be valuable where there is no family history and that could arise during de novo mutations (something that is not inherited and just happens in the process of reproduction); a young adult applicant for life insurance whose parent is not quite at the age of onset of the condition concerned about; and where there is no family health information such as an orphan, adoptee or misattributed paternity.

Mr. Rothstein stated that he is suggesting that there are very few cases which meet all those criteria – some are early-onset Alzheimer's disease, some neurodegenerative diseases like Huntington's disease or Lou Gehrig's disease, some hereditary cancers, and some syndromic conditions such as Li-Fraumeni and Lynch where if you inherit a certain mutation you are at risk for a variety of cancers. Mr. Rothstein stated that just because a condition meets those criteria does not mean that someone cannot be medically underwritten and given life insurance – breast cancer is an example where increasingly life insurers are finding that they can write life insurance for.

With regard to other countries that have dealt with these issues, Mr. Rothstein stated that the U.S. is an outlier in the sense that it has not regulated life insurance and the use of genetic information. The argument is not that the U.S. is compelled to do what's done in the UK or Canada, rather, now we have evidence of the effect of these laws on the life insurance companies as well as the people applying for life insurance so the laws can be used as case studies. The UK has had a moratorium on this practice since 2001 so there is very good evidence on the effect of banning the use of genetic information in life insurance underwriting for policies below 500,000 pounds. In 2015, Canada implemented an industry-developed ban on predictive genetic testing in life insurance for 250,000 Canadian dollars which was done to forestall legislation but it did not work because in 2017 Canadian Federal Bill S-201, the Genetic Nondiscrimination Act, was passed which prohibits imposing genetic testing for any "good or service." Mr. Rothstein stated that similar to how the U.S. has the McCarran-Ferguson Act which gives jurisdiction over insurance regulation to the states, the Canadian constitution gives jurisdiction over insurance regulation to the provinces. Accordingly, for the Canadian federal government to enact that law it couldn't use the word insurance and instead used the phrase "good or service." Quebec has challenged that law – it won in the lower courts and it is now pending in the Canadian Supreme Court.

Mr. Rothstein stated that Australia had a voluntary moratorium that went into effect in July and other countries that regulate genetic information in life insurance underwriting

include: Argentina, Belgium, Bulgaria, Denmark, Estonia, France, Germany, Iceland, Ireland, Israel, Lithuania, Luxembourg, the Netherlands, Portugal, Sweden, and Switzerland. It is interesting to note that the regulations have not resulted in substantial increases in costs for life insurance companies and have not resulted in decreased accessibility for individuals to get life insurance through higher prices. One of the most cited studies in the UK stated that the laws resulted in a 0.1% increase in cost.

Mr. Rothstein stated that he believes that genetic testing saves lives and he does not want to see anything that discourages people from undergoing genetic testing. Early detection of certain gene-mediated illnesses, especially cancers, is essential. There are about 130,000 hereditary nonpolyposis colon cancer cases per year and about 21,500 cases of hereditary diffuse gastric cancer per year. Those are largely preventable cancers if you do genetic testing although what you have to do to survive is not pleasant - you have to remove the person's stomach prophylactically. The other option is even less pleasant because it is largely non-treatable because by the time it is diagnosed it has spread throughout the abdomen. Mr. Rothstein stated that people are not being tested for this because they are afraid of losing access to life insurance, disability and long-term care insurance and it is tragic. Mr. Rothstein has met with many genetic counselors and many clinical geneticists and if you ask them the question "have any of your patients declined to get tested even though they are at risk because of their concerns about social implications" – they all reply "yes."

Mr. Rothstein stated that it must be U.S. public policy to encourage those people to be tested and especially in the context of that it is not going to ruin the insurance industry and make it unprofitable and raise the cost to the level of unaffordability. Life insurance has to be the next form of insurance that is going to be subject to the rules discussed. It has been done with health insurance and employment and the sheer size of the life insurance industry warrants these regulations. Mr. Rothstein stated that he is not advocating for a fundamental change in the way life insurance is underwritten. It should not be guaranteed issue, community rated or a welfare plan or anything like that. Mr. Rothstein stated that he is not opposed to life insurance companies getting other health information, environmental factors, or family history in medical underwriting. Rather, genetic test results of the individual applicant should not be used in life insurance underwriting. There are other issues that will have to be dealt with such as whether applicants can voluntarily submit a good genetic test – but those are better left for legislative hearings. Mr. Rothstein urged the legislators present to take this issue on in their respective states.

Dr. David Rengachary, Sr. VP & Chief Medical Director for US Mortality Markets at RGA Reinsurance Co., stated that this is the first industry advocacy issue he has become involved with because he has heard a lot of misconceptions about what life insurers do and do not do with this type of information. The first misconception that is heard a lot is that life insurers want this information so that they can decline more people for insurance. Dr. Rengachary stated that his boss has never told him that they have to find ways to decline more people for insurance. That is simply not the way the competitive industry works, and it ignores a basic fact that very often, the test results are negative and they offer the consumer a path to a more favorable rate. In Dr. Rengachary's opinion, taking away that information would be anti-consumer because it takes away the ability from the consumer to do what they want with their genetic information and data.

The second area of misconception deals with fairness. It is often heard that it is not fair

to use this information because there is no control over it. The problem with that is that life insurers must be fair to all applicants. So, when there is an applicant with genetic information on their application, it is not seen in a vacuum. On top of that application of a person with Huntington's disease is an application of a mother of four with colon cancer and below that, an application of a teenager with multiple sclerosis. Accordingly, Dr. Rengachary stated that in his mind he must be fair not only to those people who have decided to take a genetic test, but to those people who decided not to, those who have decided to disclose that information and those for which no genetic testing is available such as a police officer with a spinal cord injury, or those who are current policyholders.

Dr. Rengachary stated that if there are two people with the exact same disease and the exact same mortality and one of those individuals received their diagnosis through a genetic test while the other received the diagnosis through a set of pictures, it is patently unfair to charge them different premiums. The third area of misconception is that life insurers don't need the information as they can just increase the premium a few dollars and it will be fine. Some of the challenges with that is that the information has become increasingly pervasive throughout the medical record. We used to think of genetic testing as something rare and only affecting Huntington's disease or breast cancer but now we see the information for things as basic as newborn screening and the staging of cancer. So, the idea that insurers can separate things out in a medical record and a genetic record is antiquated. The other problem is that removing genetic information would not only change whether or not someone would apply for a policy but would change the amount that they would apply for by a significant degree. A basic example is for someone who makes \$100,000, they may qualify for \$3 million of insurance but people usually only apply for a fraction of that because there are a wide range of financial vehicles and it doesn't make sense to invest in only one. But now you have somebody with a markedly lower life expectancy and therefore it makes a lot of sense for that person to maximize their insurance at the \$3 million level for themselves and their family. You can imagine if there are just a handful of those types of scenarios, viability of those policies and companies can be a significant issue.

Also, imagine if there are a few states that decide to remove the ability of life insurers to use genetic information. Policyholders are not restricted to buy life insurance from their state – they can cross borders and buy life insurance. Accordingly, the policyholders in the states that decide to remove this ability from life insurers would have to bear the burden of a nation's worth of policies which is unsustainable. Dr. Rengachary stated that such a scenario may sound like an exaggeration, but it is not if you ask yourself the question of whether you would purchase a \$300 flight for \$3 million. Another misconception often heard is that genetic information is used in life insurance but not in health insurance, so if it is good for health why doesn't it work for life? One reason is because life insurance is not only voluntary but is also voluntary in the amount the person wishes to apply for. You can apply for \$5,000 or easily apply for \$5 million – that is a key difference in life and health insurance since for health insurance you are just reimbursed for your medical costs. The only way that we are able to arm the consumer with such a powerful level is the free and open exchange of information. That level playing field is the entire basis for life medical underwriting. The other key difference between life and health insurance is that health insurance has the ability to re-price on a yearly basis but for life insurance there is one single opportunity to make a prediction that must last sometimes 50 years into the future and if the insurer is off by a small amount the viability of the policy vanishes and if that occurs on a large number of

policies, the viability of the company can be an issue.

Dr. Rengachary stated that the final misconception to address is that life insurers want *carte blanche* when it comes to genetic information. There are many reasonable types of things which can be done and insurers understand that there is a heightened sensitivity among consumers about this information so if there needs to be greater rigor and discussion about informed consent then that is a conversation which many insurance companies are certainly open to having. But that conversation makes sense to occur not only around genetic information but around all medical information. There is another misconception that life insurers are hungry to buy data from 23 & Me.

Dr. Rengachary stated that he has never heard about a life insurance company requiring an individual to undergo genetic testing as a precondition for insurance and although he cannot speak for an entire industry, he believes that many would like to discuss that issue. In return, he believes that there are three basic elements that would need to be the cornerstone of sustainable and successful genetic legislation. The first of which would be to maintain the level playing field – the equal sharing of information related to mortality is the cornerstone of a life insurance market that has been successful for consumers and companies alike for over 100 years. The second element is some element of practicality – at the end of the day life insurers are not as resourceful as the CIA and do not have 300 genetic counselors in the back room to redact millions and millions of medical records to try and remove the genetic information. Lastly, the legislation must be actuarially sound – at the end of the day life insurers make billions of dollars' worth of promises and those promises may not come to be paid until well after the promisor retires or passes away. It is very important the decisions are made now that supports the ability to make those promises decades into the future.

Rep. Joe Fischer (KY), Chair of the Committee, asked with respect to family history questions on the application, do any life insurers ask whether someone has had a genetic test. Dr. Rengachary stated that he cannot speak for every company, but the standard industry practice is to simply ask whether the applicant has had any recent diagnostic test or medical visit. The problem of relying on family history is that it can be an inaccurate recollection as not many can say exactly what your parents had and that was the year they had it and that was the specific type of cancer – it doesn't work like that. Also, there is no means of verification – you are relying entirely on self-reporting and there is no database and underwriting requirements that have relied entirely upon self-reporting that have fared well. Further, it casts entirely too wide of a net – for every person with a family history of breast cancer there may be 20 people with a family history but only one person that has the actual breast cancer. So, if that information was removed we would be setting up scenarios where insurers couldn't look at the genetic test result and instead of rating that one individual the insurer would have to rate the 20 individuals that had the family history of breast cancer which does not make sense.

Sen. Gary Dahms (MN) asked if genetic testing was part of the life insurance purchasing process would there be any changes realized. In some applications there will be a question asking if there are family members that have had cancer. If that question was removed but you now have genetic testing, would that change the balance in the pools?

Dr. Rengachary stated that he does not believe that there would be a change in the balance of the pools in that scenario. It may be perfectly reasonable to consider that question along with any other medical test or procedure just to provide some clarity. The

challenge is that when you rely on the medical record, more and more times the information may not be there as it may be in the results from companies like 23 & Me. Dr. Rengachary stated that he does not believe the pools would be changed for two reasons, the first of which deals with research and the notion that insurers are essentially killing people by using this information. That argument completely falls away when you compare it to every other medical test that insurers have used for decades in the life insurance process. EKGs are used to assess a lifelong cardiac risk; and colonoscopies are used to assess a gastrointestinal risk. Dr. Rengachary stated that he has never received a call from a cardiologist or a gerontologist saying that the life insurer is keeping the person from doing those types of screenings by using it in the life insurance process. The same is true for genetic testing. Sen. Dahm's question is a very important one to question to consider as Dr. Rengachary believes that everyone agrees that the price would ultimately increase, so what happens next? All of a sudden you have a healthy individual and when they look at financial vehicles, the more costly life insurance policy may not make sense for them but still may make sense for the person who is sick or who has a serious genetic condition. So, that person will buy the policy and the pool becomes sicker, their prices increase further and you have a classic death spiral scenario.

Mr. Rothstein stated that he has been working on this issue for 30 years in advising insurance companies, legislators, and other countries, and the traditional arguments that have been raised need to be rethought. Actuarial precision cannot dominate what the thinking is. Policy has always been an important element of what legislators have done and what organizations nationally have done. Before World War II, the life insurance industry had separate mortality tables based on race. Unfortunately, you could still today make an actuarial case that we should rate people differently because of their different life expectancies because of their race. From a policy standpoint, we said no as that is wrong and life insurance companies have not gone out of business because of that. Mr. Rothstein stated that some of the concerns that have been raised about people asking for \$5 million of coverage is not in accord with reality and the companies he has worked with. If someone who is of a modest income suddenly applies for a \$5 million life insurance policy, that raises all sorts of red flags and the underwriters are not going to take kindly to that. At the very least, the reinsurer is not going to take kindly to reinsuring the coverage of that.

All of the countries previously mentioned have put caps on the amounts so if it is more than a certain amount, life insurers can use genetic information but there is a limited amount that people can get without submitting genetic information. Mr. Rothstein stated that it is correct that the life insurance industry would just hope that genetic information and testing from the actuarial process would just go away, but it is not going to because people are getting their own tests. The question is how we are going to respond to that as a matter of policy. Mr. Rothstein stated that this is not the same thing as someone who is getting a colonoscopy or an EKG – tests received in the clinical setting to diagnose and treat a current condition is not the same thing as predictive genetic testing for what may come down the road 20 years in the future. Every study that Mr. Rothstein has seen clearly indicates that there is a substantial percentage of people who are not getting tested. If policy can be implemented without disrupting the industry or access to insurance, it should be done as other countries have done it and there are no problems there in terms of profitability or access. If there is concern that there might be problems with profitability or access, then an option to consider is what was done in the UK in that it implemented a moratorium for a certain period of time to see what would happen and

then make a decision about continuing it. Mr. Rothstein stated that it is important for state legislators to be proactive with this issue to protect their constituents.

Dr. Rengachary stated that with regard to the notion that the use of genetic information should be equated with the use of race, that is an issue that needs to be taken head-on. Historically, what Dr. Rothstein stated was correct but there is a key difference in trying to equate actuarially genetic information with race. There is no race which has a life expectancy of three years or 30 years but there are genetic diseases which do. Dr. Rengachary stated that he is not suggesting that if a race did have a life expectancy which was that short that insurers should be able to use that information, rather, he is suggesting that if you were to equate that then you would have to come up with an entirely different system. The other problem with equating genetic information with race is that you are including all genetic information in that category. Certainly, a good reason why race is excluded is that historically, protected classes have been subjugated for decades but now you are including all genetic information within that protected class and that includes things like the ability to roll your tongue and the color of your ear wax. Any protected class would find it downright offensive if you were to give all that type of genetic testing the same degree of protection as a protected class.

With regard to the notion that genetic information bans have been successful in other countries, Dr. Rengachary stated that a reasonable question to ask is if we want the U.S. life insurance system to look like it does in other countries. Part of the reason that other countries are able to do this is that they have a very different underwriting process. Some countries allow a lot of information upfront but then at claims time the policy is aggressively re-underwritten – the so-called practice of underwriting at claims time. That results in a much higher tendency to rescind the policy if they find information was not disclosed. Dr. Rengachary stated that he does not believe consumers here would go for that. Other countries that have enacted these bans also have equally restrictive bans on direct to consumer genetic testing which clearly differs greatly from the U.S.'s policy on those tests. At the end of the day, the U.S. has produced a life insurance system which is robustly competitive, more innovative, one with better prices and thus a system which has higher uptake than many other countries. Dr. Rengachary stated that he believes U.S. consumers would like to keep that current system.

Rep. Deborah Ferguson (AR) stated that the U.S. has domestic life insurance companies that write policies overseas and asked if those companies have left the countries that have enacted bans on using genetic testing information in underwriting. Mr. Rothstein stated that he has seen no evidence of that. Dr. Rengachary stated that he does not want some of the legislation in other countries to be seen as successful. Two pieces of the legislation referenced are one and two years old. So, for a life insurance system that requires a long lens of decades of analysis, how much do we really know after one or two years? There have been some companies, especially in the living benefits area since genetic testing is more relevant to living benefits in some ways, pull back on the types of products that they were willing to offer because of the types of genetic testing bans referenced.

DISCUSSION ON LIFE INSURANCE UNDERWRITING TRENDS AND DEVELOPMENTS

Colin Devine, Principal of C. Devine and Associates, stated that he is currently involved with a venture fund called Health Catalyst Capital that works with InsurTechs and one of

the portfolio companies is Clareto. Mr. Devine stated that he believes the technology used by Clareto has the potential to be the most dramatic change ever seen in life insurance underwriting, not because it introduced some sort of new testing but basically because it takes the process which is based on mail and faxes into this century by speeding it up. Mr. Devine stated that the life insurance industry is not growing despite the demographics still being favorable. Some problems include legacy liabilities and low interest rates make it difficult to price products today. Also, recruiting has become a concern in this industry as it is difficult to find people to come into the industry and wait a year to get paid in getting their first commission check. Technology can help alleviate those problems. Mr. Devine stated that if you look at life insurance sales, the industry is somewhat stuck in the mud. The number of policies being sold is actually going down. Even though people need the product, on an inflation-adjusted basis the industry is losing ground.

Mr. Devine stated that when discussing how life insurers make money, it is all about underwriting and there are four basic pricing assumptions. One is mortality – how long is someone going to live. Another is long-term interest rates – what can be earned on the premiums; another is lapses – how long will the product be in-force; and the last is operating expenses. InsurTech can come into play in this area in several ways, one of which is risk selection. Certainly, over the past few years the use of rx data has become standard and has made a big difference. Big data and genetics also make a big difference. Behavior engagement also plays a big role. Mr. Devine stated that with interest rates remaining stagnant, lapses not being able to be controlled, risk selection being able to be improved a little, operating expenses becomes the biggest opportunity to have meaningful change.

Mr. Devine stated that InsurTech can be viewed as both an enabler and disruptor. About a decade ago, the health and life industries went their separate ways and now they are coming back together because what underpins underwriting is health data – it is all about the medical records. Mr. Devine also noted that people typically don't like buying life insurance because it takes too long to get a policy. For every legislator present at the meeting today, Mr. Devine stated that no one would get a policy issued for more than \$100,000 in under three months. We are in an Amazon-prime world and people want products instantly. Additionally, the actual underwriting for that three-month policy is ten hours at most. The rest of the time is spent chasing down medical records and doing the paramed exam which in many cases the applicant did not even need. Accordingly, changing the speed of accessing medical records can greatly improve the speed of the overall underwriting process and make for a better experience.

Mr. Devine stated that the use of big data analytics is real and being used. Currently, on a very granular basis everyone present at this meeting could be underwritten against everybody who has been in the Medicare-Medicaid database on a non-differentiated basis, living and dead. That is interesting because the answer of whether or not someone who has had a heart attack is a better or worse risk is that it depends. Men typically clean up their diets for about 12 months and then go back to the way they were. However, women often change their diets and lifestyles and become a much better risk. That is how you can use big data to better assess and offer coverage to people who may have not been able to receive it.

Mr. Devine stated that John Hancock probably has the most advanced case of utilizing technology in their platform. They launched a program called Vitality that uses the Apple

Watch to monitor certain things. Principal Financial has a similar engagement type platform. Transamerica/Aegon also just launched their platform that utilizes the Apple Watch. With John Hancock, the Apple Watch can help reduce premiums and provides rewards to policyholders – so it engages people to live healthy lives. Life insurers want everyone to live until 110. Apple Watches are therefore arguably medical devices and whether or not companies get comfortable enough to underwrite based on that data is a different discussion, but it does improve risk-selection in terms of what somebody does post-issue.

Mr. Devine stated that one of the companies he is involved with is Cardiogram which is an app underpinned by artificial intelligence and developed by former google engineers. Over 2 million people use the app every day and they mirror the U.S. population – they are not all triathletes. The app essentially works as a check engine light as it will alert the user to a few types of health conditions. 40% of people with atrial fibrillation do not know they have it. Hypertension is 20% undiagnosed. Sleep apnea is 80% diagnosed. 36% of people with diabetes do not know they have it and the app can actually pick-up pre-diabetes based on a heart rate. That is why companies are starting to look at this type of technology. Mr. Devine stated that John Hancock also released a new program called Aspire which is aimed at diabetics to help them live a healthier lifestyle so that they can be offered coverage.

Dave Dorans, CEO of Clareto, stated that Clareto launched a product about two years ago which is referred to internally as Patient Authorized Data (PAD) solutions that Clareto believes can revolutionize the life underwriting process. Mr. Dorans stated that consumers are put into a tough choice of deciding to get a fully underwritten product which takes weeks upon weeks and it is an extremely painful process whereby the paramedical comes to your house and you probably have to take time off work. Or a consumer can get a simplified issue product and pay a dramatically higher premium. The situation is unfair to consumers because they are typically not knowledgeable about the products available so very often, they are being railroaded down a certain path. Accelerated underwriting has really hit the industry the past several years where insurers are trying to essentially give a fully underwritten rate without having to through all the tests. There was even a scenario where the time from signing the application to the time of passing away was 29 minutes – a stage four cancer patient. As an industry, a way was needed to fix that because the underwriting models used today have high costs, long cycle times, and it is very inconvenient for the consumer.

Mr. Dorans stated that he believes that electronic health data can be a significant savior to radically change not just the underwriting process but also the issues of new agents not entering the business. Agents don't want to enter the life insurance business and P&C agents don't want to sell life insurance because its too much trouble and too much paperwork. Some of the tools that are being made available now in the electronic health data space can fundamentally change those problems. Clareto was formed about three years ago with a healthcare foundation so it understands healthcare and a lot of the interoperability issues and therefore progress is being made on the healthcare side to bring those tools to the life space.

There are opportunities to bridge the life and health industries to radically change the underwriting process and make it fairer and simpler for everybody. By making the process simpler, the protection gap can also be lessened. If you look at the agents that are left in the business, they are no longer serving the middle market and have moved

upstream to sell \$5-10 million policies to wealthy people and that contributes to the protection gap. Mr. Dorans stated that the real breakthrough in the way health data is being received is using the concept of health information exchanges (HIEs). HIEs have been around since the 1990s but there was a big boost to the HIE concept after the Affordable Care Act (ACA) and the Health Information Technology for Economic and Clinical Health (HITECH) Act were enacted which put about \$500 million in federal funding into building up HIEs to be the backbone of interoperability. About another \$500 million in state funding has also been added to that.

Mr. Dorans stated that some of the HIEs did a fantastic job and signed up all of the hospitals and doctors in their area. Some did a mediocre job, and some did a poor job. But for the HIEs that are in existence and the ones that are starting to come back into existence, Clareto believes that the life insurance use case not only helps the life insurance industry and helps the consumer but also is a potential source of funding for HIEs because life insurers are willing to provide funding to the data that HIEs have access to. Most HIEs operate on a statewide or regional basis and some are still governmental entities and non-profits. About a handful are profitable organizations but that is not the ethnical model. Most often the HIE is a statewide designated entity but there are some states that have several, such as California which has about seven or eight HIEs that operate in regions across the state. Texas has a number of HIEs as well. Clareto believes that HIEs are an ideal methodology in order to get the best data that you can get and radically transform the system.

Mr. Dorans stated that the case study that Clareto is following and is what Clareto uses when discussing with HIEs why the life insurance model makes sense is one in which the Social Security Administration (SSA) has been doing since 2009. The SSA underwrites about three million disability claims per year and they started using HIEs and other sources of electronic health records to great success. That is the example being followed by Clareto to try and deliver this method to life insurance companies. Clareto operates a HIE in central Virginia and the beauty of that is that there are different medical systems. If a patient shows up in the emergency room at VCU at midnight on Saturday night, the doctors at that hospital can tap into the HIE and download the medical records of that patient from any hospital or physician that participates in the HIE. In addition to saving lives, that can save money in healthcare costs because it can remove the situation of ordering an MRI for someone on Thursday who just had one on Monday at a different physician. If everyone participates and everyone puts their data into the HIE, then everyone can use the data in appropriate ways on the backside. Clareto was one of the pioneers in setting up the e-health exchange which is the predominate way of sharing this information back and forth.

Mr. Dorans stated that Clareto is going to be that single point of access to be able to go out and put together HIEs around the country. Clareto is working with HIEs across the country to convince them of the value of this use case and the opportunity to help doctors and patients. Under the typical model for a doctor's office, when a request comes in someone has to stop treating patients, dig through files and then deliver records via a fax machine. That entire process takes about three weeks and there is an opportunity to do it in just minutes. Mr. Dorans stated that there are a couple of other methods that are available to get medical information for life insurance and there are companies out there doing all of them. One of them is to access the patient portals that doctors give access to now with a username and password. From the life insurance perspective there are a couple of problems with that, one of which is anti-selection as it

really does put the patient in the position of saying “I will give you the credentials of my podiatrist but I might forget to give you the credentials of my oncologist.” The other problem is that doctors don’t always put a very true and rich record into it because they don’t want to transmit that much bad information directly to patients. Mr. Dorans stated that another option is to work with the big EMR vendors which provide the software to the doctors but the big problem with that is that it puts the insurance company or even the patient in the place of needing to know what software their doctor uses and nobody really knows that.

Clareto loves the HIE model because it is EMR-system agnostic and Mr. Dorans noted that it would be great if legislation was passed that encouraged people to utilize in HIEs. In North Carolina, legislation was passed last year imposing a penalty on anyone in the statewide Medicaid reimbursement if the doctor doesn’t participate in the state designated HIE. The vast majority of benefits that it provides is for patient care and interoperability in healthcare, but it has ripple effects that go down the line. It is in everyone’s interest for everyone’s information to be held within an HIE as they are stewards of the data and are only going to use it in appropriate situations.

Mr. Dorans noted that Colorado has given Clareto access to 88% of its citizens and Clareto has all of the appropriate data security information in place. Clareto also did a deal with Missouri, NYC/Long Island, Utah, Delaware, Utah, and New Mexico. Clareto is now in a position to deliver within a matter of minutes, high-quality medical data to the life insurance company that they can use to make decisions to deliver the Amazon-type experience to the consumer and remove the scenario of getting blood tests and other lengthy tests completed. As a benefit, the life insurers are willing to pay for the data. It is of course illegal to sell health data, but they can be reimbursed for their efforts. The HIEs, which are struggling because of the disappearance of federal and other funding, benefit from the life insurer funds so that they can increase their sustainability over the coming years. This is an opportunity for a win-win-win.

Mr. Dorans stated that there are a lot of other opportunities to use HIEs across multiple underwriting scenarios, the first of which is the replacement of the traditional attending physician statement (APS), a document which takes weeks to get. One carrier that Clareto has been working with ordered four records and they were able to be delivered in about 45 seconds and the carrier stated that the records were all they needed to issue the policy and they were able to cancel any additional requirements that were needed and instantly send the policy off to issue in one day as opposed to the traditional process. Mr. Dorans also stated that HIEs are an opportunity to beat down some of the anti-selection that is out there. There is a possibility to start ordering records on everybody and not just people who are going to have APS’s and have a better risk selection across the board and improve the quality of the pools. More information at the point of sale seems to be the fairest thing for everybody. HIEs can also really start to move us into the accelerated underwriting world where we start to move all of the policies very quickly and make decisions within minutes or hours as opposed to having to wait weeks.

Rep. Ferguson asked if Clareto’s HIE is interoperable with EMRs for insurance purposes. Mr. Dorans stated that Clareto does two things – it runs a standard HIE in Virginia and that is for all purposes; but it also has harnessed the knowledge about how to run an HIE and how to get data and interchange data between different systems so Clareto is now traveling around the country within the same company but in a different

division – PAD – and signing up other HIEs with Clarteo being the middle-man. So, if any of the 800 life insurance companies wants to get data, they can come to Clarteo which will sign up all the HIEs around the country and connect the two so that they don't have to make point to point connections.

Rep. Ferguson stated that she has become pessimistic about the interoperability of EMRs particularly when you look at the big two – Epic and Cerner – that because of proprietary reasons don't have any incentive to do interoperability in hospital systems. Rep. Ferguson stated that in her city in Arkansas, one hospital is with Epic and because they want to protect their managed care organization (MCO), there is no incentive to be interoperable. Unfortunately, when the ACA was enacted there was no requirement for interoperability but rather a suggestion. Mr. Dorans stated that he agreed with Rep. Ferguson and noted that when he was introduced to this idea, he was in the life insurance industry and did not even know what an HIE was. There is a bias baked into the cake that EMR vendors want to compete against each other and if a \$300 million dollar Epic system is going to talk just as well as the \$200,000 system bought from Practice Fusion, you are not going to want to make them talk to each other because no one is going to want to buy the top-rated brand. Because HIEs are non-profit and because some are run by the states, they are agnostic to that and really just about patient care and exchanging data back and forth between systems. The e-health exchange was formed and has come up with a standardized format that can take data from entities such as Epic, Cerner, or Practice Fusion and exchange that data with physicians and insurance companies.

Rep. Ferguson stated that she believes it becomes pretty cost prohibitive for the health exchanges to do that in some cases because they are constantly updating their systems and to keep writing that integration is cost prohibitive. Mr. Dorans stated that it is not cost prohibitive and the opportunity for HIEs is to embrace alternative use cases that have the opportunity to actually be revenue generating to them as opposed to costing money and using that to underwrite the activities they want to provide to the community on the treatment side.

Sen. Mark Johnson (AR) asked if the industry is looking towards something that might be analogous to a FICO score such that if your "health score" is a certain number then you have some faster track to medical underwriting; and if you had a bad score that would not mean you couldn't get life insurance but just that you would go on the slow trail so to speak. Mr. Dorans stated that step one would be putting together the network and making all of the data available before deciding who the scorekeeper would be. It is a fantastic idea, but the problem is first getting all of the data and progress is being made on that front. Mr. Devine noted that the issue is getting that data in a standard format and then once you have it and insurers are comfortable with it, underwriting is very slow to embrace change because underwriters realize that they have to live with any mistakes made. Just getting underwriters to go from the fax machine to an electronic record has been a journey.

ADJOURNMENT

There being no further business, the Committee adjourned at 4:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
AUSTIN, TEXAS
DECEMBER 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the JW Marriott Hotel in Austin, Texas on Wednesday, December 11, 2019 at 11:00 a.m.

Representative Matt Lehman of Indiana, NCOIL Vice President and 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. Martin Carbaugh (IN)	Sen. Shawn Vedaa (ND)
Rep. Joe Fischer (KY)	Asw. Ellen Spiegel (NV)
Sen. Dan “Blade” Morrish (LA)	Sen. Neil Breslin (NY)
Sen. Paul Utke (MN)	Sen. Roger Picard (RI)
Rep. Tracy Boe (ND)	Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Paul Wieland (MO)
Rep. Doug Gutwein (IN)	Rep. Bruce Grubbs (MT)
Rep. Peggy Mayfield (IN)	Asw. Maggie Carlton (NV)
Rep. Edmond Jordan (LA)	Asm. Kevin Cahill (NY)
Del. Mike Rogers (MD)	Del. Steve Westfall (WV)
Sen. Gary Dhams (MN)	
Rep. Donna Pfautsch (MO)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Asw. Ellen Spiegel (NV) and seconded by Sen. Jerry Klein (ND) the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. George Keiser (ND) and seconded by Rep. Martin Carbaugh (IN), the Committee approved the minutes of its July 12, 2019 meeting in Newport Beach, CA without objection by way of a voice vote.

UPDATE ON STATE ADOPTION/INTRODUCTION OF AMENDED NAIC CREDIT FOR REINSURANCE MODELS

Rep. Matt Lehman (IN), NCOIL Vice President and Chair of the Committee, stated that at the Committee's last meeting in July, the Committee discussed what the amendments to the NAIC's Credit for Reinsurance Model Law and Regulation (Models) aim to do and what legislators should expect in sessions when bills seeking to implement the amendments are introduced. Rep. Lehman stated that to NCOIL's knowledge, no state legislation has officially been introduced or pre-filed for 2020 sessions, but states are actively working on such legislation. Rep. Lehman asked for an update on the Models and how the NAIC is working with state legislatures to introduce this legislation.

The Honorable Glen Mulready, Commissioner of the Oklahoma Insurance Department, stated that U.S. states must adopt the revisions to the Models prior to October 1, 2022 or face potential federal preemption by the Federal Insurance Office (FIO). Cmsr. Mulready stated that it is very important for NCOIL and NAIC to work together on this to make sure there is no federal preemption. In December of last year, a second Covered Agreement was signed between the U.S. and UK which mirrors the language from the U.S.-EU Covered Agreement.

In June of 2019, the NAIC adopted revisions to its Reinsurance Models which are intended to implement the reinsurance provisions of the Covered Agreements. The revisions eliminate the reinsurance collateral requirements for reinsurers that have their head office or are domiciled in any reciprocal jurisdictions. For reinsurers that are domiciled in those qualified jurisdictions to obtain similar treatment as those jurisdictions subject to the Covered Agreements, they must provide to the states the same treatment and recognition afforded by the EU countries pursuant to the Covered Agreement. Therefore, the revisions to the Models include the requirement that the qualified jurisdiction must agree to recognize the state's approach to group supervision including group capital. The NAIC greatly appreciated NCOIL's support of the amended Models and strongly believes that continued state action on the Models is the best defense against federal preemption. It appears that there are about 15 states, including Oklahoma, that currently plan to introduce the Models during the next legislative session.

The Honorable Dean Cameron, Director of the Idaho Department of Insurance and NAIC Secretary-Treasurer, noted that the Covered Agreements were not something instituted by the NAIC. The NAIC had some concerns with the Covered Agreements but the reality is that they were signed and now states must take action to avoid federal preemption. At the end of the day, protecting consumers is vital and that is inherent in the state-based system of insurance regulation. Consumers would be harmed if there was to be federal preemption in this area. Rep. Lehman agreed and stated that since he began coming to NCOIL meetings several years ago, there always seems to be common ground between NCOIL and NAIC in preserving the state-based system of insurance regulation.

UPDATE ON NAIC ANNUITY SUITABILITY WORKING GROUP

Rep. Lehman asked for an update on the status of the proposed amendments to the NAIC's Suitability in Annuity Transactions Model Regulation (Model) and noted that some NCOIL member legislators have raised concerns about the "rearview mirror" issue where producers are held liable by a standard other than the circumstances that existed

at the time of the recommendation. Dir. Cameron first thanked NCOIL for its input throughout this process and noted that the process is almost complete. The process of amending the Model started with the U.S. Department of Labor (DOL) issuing regulations that were later found to be overreaching and egregious that would have required a fiduciary standard of anybody selling an annuity product. In addition to that being an overreach of authority, that would have had a chilling effect on average citizens being able to access annuity products and being able to plan for their retirement.

The NAIC pushed back on those regulations and the end result was that it was decided it would be best to update the Model. Dir. Cameron stated that he chaired that NAIC Working Group initially but was not able to push the amendments across the finish line. The term "best interest" was avoided because it was highly politicized and was ill-defined and it would make it difficult for regulators to be able to regulate and determine whether someone acted in another's best interest. Since that time, the Securities and Exchange Commission (SEC) came out with their Regulation Best Interest so the landscape changed. The Insurance Commissioners then felt that they did not want an inferior standard so the amendments to the Model needed to be a best interest standard; but the NAIC needed to do a better job of defining what that meant and providing safe harbor provisions.

Dir. Cameron stated that under the current version of the Model, which will likely be finalized on December 19th and then handed back to the A Committee to be finalized again, there is a standard of care required of every producer. The NAIC believes that most agents already act in the best interest of the consumer as that is how they stay in business. The Model has certain disclosure requirements as well as conflict of interest and documentation provisions. Dir. Cameron noted that many of the provisions are what we would term as best practices, such as the agent documenting the recommendation they made and why they made it and why the consumer chose the recommendation they did. The NAIC has listened to industry and interested parties intently and by and large a lot of the comments submitted found their way into the Model, including the rearview mirror issue. Dir. Cameron stated that there is also an increased obligation by the carrier to monitor what their agents are doing. The ultimate goal is to protect the consumer.

Rep. Lehman asked Dir. Cameron to touch upon the intended use of the product section; the documentation section; and whether the changes to the Model have risen to the level of a change in public policy that legislative action is required as opposed to regulatory action. Dir. Cameron stated that he believes there will be some need to change statutory language and not just changes in regulations. The agent community is going to want the safe harbor in statute. Dir. Cameron stated that provisions in the Model were included whereby the consumer can check certain boxes stating that they do not wish to disclose certain things or they can state what their plan is for the product which happens more often than one might think, particularly in rural communities. Dir. Cameron also stressed that the Model is not finished yet and any further input on it is welcomed. Dir. Cameron stated that notes are great, but it is in the agent's best interest to use the forms contemplated by the Model. Dir. Cameron stated that he believes the forms may be adopted by rule and not put into code so that is something that legislators may want to work with their Insurance Commissioners on.

Sen. Jason Rapert (AR), NCOIL Immediate President, stated that a couple of years ago NCOIL formally opposed the DOL fiduciary rule by means of adopting a Resolution. At

that time, it was not certain whether NCOIL would be successful in taking that position, but success was in fact reached. Sen. Rapert asked for the NAIC's thoughts on how its process relating to the Suitability Model might be affected by the news that the DOL will release new fiduciary regulations. Dir. Cameron stated that the NAIC has been working very diligently to try and have collaboration between the SEC and DOL. The DOL has made it clear of its plans to release new regulations and Dir. Cameron stated that was an impetus for the NAIC to stay out in front of them. The NAIC believes that consumers are best protected if you have a more homogenous or reasonably homogenous rule so that agents know what the rules are, and they don't have to play by different sets of rules. The NAIC has been told that the DOL is waiting patiently to see what the NAIC's work product will look like.

Dir. Cameron noted that the SEC's rule is labeled "best interest" but that term is not defined. The NAIC is hopeful that how it has defined "best interest" makes the most sense and will lead to more regulatory unity. Sen. Rapert stated that he hopes that NCOIL continues to stay active on this issue going forward and that he has spent his entire professional career serving clients. Sen. Rapert has been fully Series 7 licensed and he sees many giving that license up due to the onerous regulations and they move strictly to the investment advisor role. It is important to consider going forward whether regulations may serve to put such a stranglehold on advisors, and they are held responsible so as to guarantee that every investment will realize a gain – that is not reality. There are not a lot of young people coming into the Series 7 arena for that reason and that may affect the annuity side of the insurance arena as well.

Dir. Cameron stated that he too was Series 7 licensed and understands Sen. Rapert's comments. If the DOL fiduciary rule were to have gone into effect, Idaho would have experienced a traumatic increase in the number of agents leaving the market. Most of those agents would have been independent agents whose bread and butter is not selling annuities or retirement products, but rather selling P&C products and they do not need the hassle if a client comes in with a little bit of money to set aside for retirement or put aside in an annuity. Dir. Cameron stated that unfortunately these issues have become politicized so that is a factor as well.

Rep. George Keiser (ND) stated that at a recent meeting an annuity expert stated that over 80% of the annuities sold in the U.S. are sold to households with incomes less than \$200,000. Rep. Keiser stated that surprised him and asked Dir. Cameron if the NAIC has had discussions as to why that market is suitable to annuities and higher markets are not. Dir. Cameron stated that suitability goes to a broader sense than just income but that is a major component. Those with higher incomes may have a higher tendency to invest in other products rather than annuities so they may also have access to other advisors and choices and may be willing to take more risk where those purchasing annuities are typically risk-averse and wanting to be secure in their investment in wanting something close to guaranteed return. Dir. Cameron stated that he is not sure at what income levels you start to see those differences.

UPDATE ON INTERNATIONAL INSURANCE DEVELOPMENTS

Rep. Lehman asked for an update in international insurance developments, specifically the recent developments surrounding international capital standards (ICS) negotiations with the International Association of Insurance Supervisors (IIAIS) and the split among Team USA members regarding the new version of the ICS. Dir. Cameron stated that the

story surrounding this was tremendous and that the state legislators present should be very proud of the Insurance Commissioners involved. There was a significant threat to the state-based system of insurance regulation and a significant threat as to how consumers are protected and how carriers are able to operate in today's marketplace. For years the international community has promoted an ICS standard that was egregious and harmful to carriers. There are many carriers active in both the U.S. and EU markets. The standard was so egregious that it would have forced the elimination of long-term products such as annuities and long-term life insurance products.

Dir. Cameron stated that the standard came from a different philosophical stance as much of Europe has a greater government safety net. U.S. carriers were very concerned as to what the standard would look like and how it would apply and impact the U.S. insurance industry. Dir. Cameron stated that he believes Insurance Commissioners did a great job of collaborating with the Federal Reserve and Treasury and all of Team USA. The issue was finally brought to a vote at a recent international meeting. The NAIC and others fully expected to vote "no" at the meeting as there was a great deal of animosity towards Team USA members. However, at the end of the day the international community gave Team USA members everything it wanted including changes to the ICS method that will make it easier for U.S. carriers and allow the U.S. to use its own standard and have it be equivalent to the international standard.

Dir. Cameron stated that when it came to a final vote, unbeknownst to the NAIC, FIO voted "no." It is still unclear as to why FIO voted "no" and some have suggested that because of all of the political pressure that had been placed on them through Congress they felt like they had no choice. Despite there being not a lot of media attention on this issue, the NAIC has received a lot of accolades for standing up for the state-based system of insurance regulation. Dir. Cameron stated that compliments should also be given to Congress who had signed a letter to support Team USA.

DISCUSSION ON REGULATORY ISSUES SURROUNDING MARIJUANA LEGALIZATION

Rep. Lehman stated that due to its proximity, Indiana employs a lot of Ohio citizens, and Ohio has legalized both medical and recreational marijuana. If someone is under a medical prescription of marijuana in Ohio and is working in Indiana and is injured on the job, no benefits would be provided under workers' compensation in Indiana. As much as this is an issue for legislators, Rep. Lehman asked how the NAIC is dealing with certain cross-border issues relating to marijuana. The Honorable Lori Wing-Heier, Director of the Alaska Division of Insurance, stated that it is a complicated issue because an employer often requires rigorous safety procedures, including drug testing, but the question that becomes an issue is if an employee has used a recreational drug on his or her own time and is injured on the job, should work comp benefits apply? Dir. WingHeier stated that she believes the issue will be played out in the courts over the next few years but noted that work comp has traditionally held that if you are impaired on the job, benefits will not apply to the injury.

The question then becomes where that fine line is of when someone is using the drug for recreational purposes on their own time, but the drug does not entirely leave their system when arriving on the job. Alaska has held that the employers still have the right to drug test and the right to enforce the no alcohol and no drugs policy. If someone were to be caught in a random drug test, then they would go through counselling and

disciplinary actions and possibly be terminated for that offense even though marijuana is legal in Alaska. One of the primary concerns in Alaska is the safety of employees and in some cases that means protecting them from their own use of the drug.

From an insurance industry standpoint, Rep. Lehman noted that another interesting factor is that Ohio is a monopolistic state, so the carriers are not really part of the debate. In Indiana, a Resolution was sent to Washington DC that said marijuana needed to be removed from the Schedule I drug list so that states have more regulatory ability within that realm. Rep. Lehman asked if the NAIC is supportive of more regulation being given to the states in this area because if states have the ability to legalize it then they should have the ability to regulate it as a product. Dir. Wing-Heier replied yes and stated that earlier this year there were two bills in DC relating to marijuana safe harbors for banks and insurers. If you have a cannabis industry and it buys insurance, in theory the insurer cannot sell the product because it is an illegal industry so most of the coverage now is in surplus lines. While those are not bad companies to be with, they are outside of guaranty fund protection and expensive for startups. Accordingly, the NAIC is working to see what it can do to have everyone in the chain in the cannabis industry from the person who owns the building that they rent to the medical professionals who sees patients using marijuana, to others you may not necessarily think of including bankers, be within a safe harbor.

Dir. Wing-Heier stated that there is a lot of risk involved in the cannabis industry. Since it is a cash industry, it is amazing the amount of cash that is being held by the industry and they are unable to bank it as others may be able to. Such businesses cannot take credit cards and if you go into one of the businesses you will see that there is an ATM in case the customer does not have cash. Accordingly, a small business owner may be sitting there with \$40,000 in cash and buying their products in cash. That presents a huge risk not just for the cash itself but for the employers behind the counter holding the cash.

Rep. Lehman noted that during NCOIL's DC Educational Fly-in a few months ago, NCOIL was supportive of the Clarifying the Law Around Insurance of Marijuana (CLAIM) Act which provided those dealing with marijuana in the insurance industry the benefit of a safe harbor. Rep. Lehman stated that it sounds like NCOIL and NAIC are on the same page with this issue. Dir. Wing-Heier agreed and noted that this issue is new. There are 33 states that have legalized marijuana for medical use and 11 states that allow for medical and recreational use. Dir. Wing-Heier stated that this issue is only going to become more prevalent and noted that as states begin to get involved with it, it is like nothing the industry has dealt with because of the way it has been perceived as a schedule I drug and the fact that it cannot be transported across state lines and cannot be on trains, planes or ferries.

Sen. Rapert stated that an article was recently published that noted the Secure and Fair Enforcement (SAFE) Banking Act of 2019 is dead. Sen. Rapert noted that he does not buy the public relations campaign that has been waged to try and normalize drug use in the country. It is a disruption to the nation and a sideshow to the states and is waste of time. In the future you will probably see a federal challenge in federal court to the entire process altogether. The clearest example is that no state that has passed a law prohibiting abortion does in fact prohibit abortion and that is because the federal courts have struck down every such state law. However, when it comes to marijuana it seems the federal courts have turned a blind eye.

Sen. Rapert stated that there needs to be some action taken to fix the current system that is disrupting insurance companies, banks, businesses, and employers. Medical marijuana is currently legal in Arkansas and there has been action taken to legalize recreational marijuana which is what the marijuana industry really wants. Sen. Rapert closed by stating that the health of our citizens should be the priority rather than what is convenient. Dir. Wing-Heier stated that the health of our citizens should always be the number one priority and one of the problems that we are running into is that marijuana is being touted as a cure-all for everything from cancer to obesity. There are opinions out there about marijuana, but no true federal studies have been undertaken as would be for any other drug coming into the market.

Rep. Tom Oliverson, M.D. (TX) stated that from a regulatory standpoint in terms of employers protecting the safety of their workers, the medical use of marijuana is much more problematic than recreational use. Marijuana now joins a whole host of other legally prescribable medications that can alter someone's mind and affect their ability to work such as stimulants, narcotics and muscle relaxers. Rep. Oliverson noted that he has seen many patients who have taken narcotics for several years to treat chronic pain and while they may seem totally functional, they would fail a drug test. That is something to be mindful of in the work comp industry. Dir. Wing-Heier stated that she does not disagree with Rep. Oliverson and the question becomes is there a lingering effect to having marijuana in one's system that was the cause of the incident that created the injury; and what do you do with the injured worker? Do you deny them a benefit? A lot of this will be determined in the courts over the next few years. Rep. Oliverson noted that what makes it even more complicated in that situation is that the employee may have been prescribed marijuana from a licensed physician.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that the whole issue surrounding marijuana legislation is very complicated. California has had medical marijuana since 1996 that was approved by a ballot proposition which promised that the legislature would establish rules for it. Almost 20 years passed without any rules. A key issue that arose in California was trying to keep all of the pieces under one agency and the rationale behind that was so that the legislature could exert more effective oversight as opposed to dealing with health issues in the health committee, the business issues in the business committee, and the tax issues in the taxation committee. If you let this subject matter start moving through your legislature through an array of committees, lawmakers lose effective oversight.

Asm. Cooley stated that it gets so convoluted because of all of the cash involved and people wanting to make money quickly. There can be environmental damage due to people growing the plants where they should not be and taking water out of the system that affects people with downstream water rights, and using pesticides that are running downstream and may be in the product itself that has not been properly tested. From a research standpoint, it is tough to do the research because of the drug being on the Schedule I list. The only official marijuana you could get for a long time was out of the University of Mississippi which is where they grow it and release it for testing. But from a California standpoint, due to individual business needs, what is being grown there is much more potent than anything in Mississippi, so you have product out there that has characteristics never before seen in anything tested on the federal level.

Asm. Cooley recommended that anyone interested in these issues read the research of Igor Grant of the University of California, San Diego. Banking and taxation issues are

also very complicated with marijuana. There is also no effective test for driving under the influence of marijuana as there is for alcohol. Asm. Cooley closed by recommending again that lawmakers try and keep all of these issues within the same committee so that the industry cannot balkanize the overall issue.

Asw. Maggie Carlton (NV) stated that as someone coming from a state that has been heavily involved with marijuana, the one piece of advice she would give is to not let legalization happen through an initiative petition. Don't let constituents and citizens get ahead of legislators. Legalization should happen from a legislative perspective – the industry should not write the petition and then bring it forward for consideration because then lawmakers will lose some of the control they thought they had. A number of unexpected issues have surfaced such as having to clean ATM machines due to the amount of marijuana residue on the cash and having special places for armored cars to park at the state house for cash to be delivered. Asw. Carlton stated that she has seen a big difference in not having marijuana in the black market any longer but there is the other side of the equation to consider as well. The one thing missing is the ability to test the product and that is throwing a wrench into everything. During Nevada's last legislative session, one member addressed the issue of drug use and job applications since marijuana is now legal in Nevada. Asw. Carlton closed by stressing again the importance of the legislature getting ahead of its citizens on this issue in order to maintain control. Cmsr. Mulready agreed with Asw. Carlton and stated that Oklahoma is dealing with the fallout of having medical marijuana legalized through a broad ballot initiative last year.

UPDATE ON NAIC RETIREMENT SECURITY WORKING GROUP

Rep. Lehman stated that the statistics we often hear about how Americans do not have enough saved for retirement are downright frightening. To that end, NCOIL applauds the NAIC for forming this retirement security working group. Rep. Lehman asked for an update with what the working group has done thus far and what its plans are. Cmsr. Mulready stated that the Working Group's members include the District of Columbia (Chair), Iowa, Maryland, Minnesota, New York, Rhode Island, Utah, and Washington. The Working Group has met twice thus far and has heard presentations from AARP, Insured Retirement Institute (IRI) and the National Financial Educators Council. The next conference call is scheduled for December 18, 2019. The working group's charge is to explore ways to promote retirement security consistent with the NAIC's continuing retirement security initiative. The working group shall promote retirement security through a work plan consisting of education, investigating the low saving rates, and research and development.

Cmsr. Mulready stated that in Oklahoma there are field representatives who are in the community every day talking to citizens about insurance and retirement planning. The Working Group's work plan also includes exploring whether women and members of the "sandwich generation" may need extra attention in this area as they often have less money saved for retirement due to being out of the work force caring for children and/or parents. The work plan also includes reviewing education/CE requirements for insurance producers to ensure requisite knowledge of suitability requirements as well as prohibitions such as unfair trade/marketing/advertising practices and determine if additional CE requirements are needed. The working group will also seek to develop an education campaign targeting employers to provide retirement plans and assist employees with saving for retirement.

Cmsr. Mulready stated that another key part of the working group is innovation with a goal of holding an Innovation Forum with industry to identify and address areas where current laws/regulations unnecessarily stifle innovation, and examining the compensation structures of insurance products and services and explore other structures and incentives to ensure better inclusiveness (e.g., to ensure that all levels of net worth have access to expert advice). The working group is also interested in exploring how new technologies and big data/analytics can be used to benefit consumers (affordability and accessibility) and the insurance industry, and researching and identifying initiatives that state and federal governments could take to assist individuals and employers to improve and increase retirement options. The final plan of action is to develop and adopt a final issue document that incorporates an education campaign, education curricula, anti-fraud alerts related to insurance and how insurance impacts and can aid with retirement security. The document should include a plan for continued support and promotion of retirement security.

ANY OTHER BUSINESS

In response to an earlier comment from Cmsr. Mulready, Rep. Lehman noted that in 2017 NCOIL adopted an Out-of-Network Balance Billing Transparency Model Act, sponsored by Sen. Jim Seward (NY), and asked if the NAIC has any plan of action in that area. Dir. Wing-Heier stated that the U.S. Senate and House and recently come to an agreement on a piece of balance billing legislation. If the legislation stays as-is, it does address balance billing protections including air ambulance balance billing by means of an independent dispute resolution (IDR) process. The IDR process is a little concerning because it may be difficult to handle on a state level. Dir. Wing-Heier stated that she believes states will get slammed the first year and then it will recede as providers start to realize how the process works. The federal bill provides for transparency including the elimination of gag clauses and provides that rebates must go back to the plan sponsor in lieu of pharmacy benefit managers (PBMs). There is quite a bit of good in the federal bill. The NAIC is hoping that by the end of the year Congress will be able to pass a bill that deals with transparency and balance billing for consumers. The draft bill takes the consumer out of the process so the IDR will be between the provider and the insurer.

Cmsr. Mulready stated that the NAIC has been heavily involved in this conversation and wrote a letter in support of ensuring that air ambulance balance billing protections was included in any federal balance billing legislation. Cmsr. Mulready stated that Oklahoma has been working very hard on this issue and noted that as he understands it, the federal legislation states that providers will be paid the median contracted rate with arbitration available for claims of \$750 or more and the air ambulance threshold is \$25,000 or more. Cmsr. Mulready also noted that the NAIC expects the federal legislation to contain network adequacy provisions but specific language has not been circulated. Lastly, Cmsr. Mulready stated that he believes that state balance billing legislation would not be preempted as the federal legislation would play a role with ERISA-plans.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
AUSTIN, TEXAS
DECEMBER 13, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the JW Marriott Hotel in Austin, Texas on Friday, December 13, 2019 at 3:30 p.m.

Representative Edmond Jordan of Louisiana, Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Gary Dahms (MN)
Sen. Jack Tate (CO)	Sen. Paul Utke (MN)
Rep. Richard Smith (GA)	Sen. Paul Wieland (MO)
Rep. Martin Carbaugh (IN)	Rep. George Keiser (ND)
Rep. Matt Lehman (IN)	Sen. Jerry Klein (ND)
Rep. Joe Fischer (KY)	Asm. Kevin Cahill (NY)
Rep. Bart Rowland (KY)	Asm. Andrew Garbarino (NY)
Rep. Dean Schamore (KY)	Asw. Pam Hunter (NY)
Sen. Dan "Blade" Morrish (LA)	Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Andy Zay (IN)
Rep. Matt Gray (CO)	Rep. Bruce Grubbs (MT)
Sen. Matt Lesser (CT)	
Sen. Dan McConchie (IL)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Sen. Gary Dahms (MN), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Martin Carbaugh (IN), and seconded by Asm. Andrew Garbarino (NY), the Committee approved the minutes of its July 12, 2019 meeting in Newport Beach and its November 19, 2019 interim committee conference call meeting without objection by way of a voice vote.

DISCUSSION ON NCOIL PEER-TO-PEER CAR SHARING PROGRAM MODEL ACT

Rep. Bart Rowland (KY), Sponsor of the NCOIL Peer-to-Peer Car Sharing Program Model Act (Model), stated that this Committee had a very productive discussion on this issue at its meeting in July in Newport Beach. At that meeting, what guided the discussion was a document, previously negotiated between peer-to-peer (p2p) car sharing companies and the American Property Casualty Insurance Association of America (APCIA), that has already served as the basis for some state p2p car sharing legislation. Rep. Rowland stated that he decided to use that document as the basis for the first draft of the Model. However, since several states are looking to adopt legislation on this issue in 2020, Rep. Rowland stated that he thought it was prudent to move quickly.

Therefore, Rep. Rowland stated that he asked NCOIL staff to put together an interim conference call meeting of this Committee, which was held just before Thanksgiving. Rep. Rowland noted that during that meeting he introduced some amendments to the Model which resulted in both sides of this issue coming to near unanimous agreement which is the version of the Model ready for discussion today. Rep. Rowland noted that since that call there has been some talk about perhaps making further amendments to the Model but stated that he believes that the Model is strong as-is and is ready to proceed to a vote. Accordingly, Rep. Rowland stated that he looks forward to the discussion today and noted to the Chair that he would entertain a Motion to adopt the Model as-is.

Ethan Wilson, Gov't Relations Manager & Senior Legislative Counsel at Turo, stated that he believes the Model is a very good piece of legislation and noted that it is important to not lose sight of the fact that it is a Model. Every state is going to have its own unique process for tailoring the Model and adopting it as appropriate for that state. Moving forward, there will certainly be issues in states that will be addressed that are not contemplated in the Model, but states offer the forum to have that debate. Mr. Wilson stated that Turo supports the Model and noted that it has been through negotiation for almost two years. Turo has seen the Model go through trial-by-fire in the 2019 legislative session and the Model came out a better piece of legislation due to that. Mr. Wilson thanked Rep. Rowland for his leadership on this issue as well as the Committee for its work on the Model.

Tomi Gerber, VP of Gov't & Public Affairs at Enterprise Holdings, thanked Rep. Rowland for his leadership and stated that the insurance aspects of p2p legislation generally are the greatest number of words on paper that have to be resolved in any state's legislative effort to deal with p2p car sharing. From Enterprise's perspective, it has been engaged in the p2p issue for four years state-by-state and Ms. Gerber noted that she is happy to state that the insurance language in the Model is one of the least contentious issues. The insurance framework is so important to get right and credit is due to the p2p companies and the insurance industry for coming together and putting forth a great framework for how insurance is handled. What allowed Enterprise to come to the table and support the Model was Rep. Rowland's leadership in bringing forth the "Scope" section in the Model. Ms. Gerber stated that the Model clearly calls out that states must reconcile other issues that are not just insurance issues as part of dealing with p2p car sharing activity comprehensively. So, whether it is airport authority to regulate p2p car sharing companies, tax implications, or other consumers protection issues, Enterprise sees that Model as the framework to bolt on those other issues state-by-state. Ms.

Gerber thanked Rep. Rowland and NCOIL staff for bringing forth the “Scope” section in order to eliminate obstacles and enable Enterprise to support it.

Frank O’Brien, VP of State Gov’t Relations at APCIA, stated that NCOIL is once again taking a leading role in the emerging sharing economy with this Model. The Model builds upon the expertise that NCOIL demonstrated when it worked to develop a transportation network company (TNC) Model act. NCOIL has again distinguished itself by developing very positive public policy on p2p issues. APCIA thanks Rep. Rowland for his leadership on this issue and APCIA believes that the Model is a good piece of legislation and would like to have the Model available to the states, noting that it is Model legislation and when it arrives in states it provides a good framework. Like all Model legislation, this Model provides a starting point and there may need to be certain changes to the Model state-by-state. APCIA supports the Committee’s adoption of the Model.

Erin Collins, Asst. VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked Rep. Rowland and the Committee for its work on the Model. NAMIC agrees that the Model is a strong piece of legislation and while NAMIC has submitted some amendments that it believes improves the Model - one which NAMIC believes solves a potential problem – NAMIC supports the Model and urges the Committee to adopt the Model with or without the amendments.

Rep. Matt Gray (CO), stated that Colorado has passed legislation that is very similar to the Model. Rep. Gray stated that p2p car sharing is a tricky issue to get through but CO ended up with broad bipartisan consensus around the issue because p2p car sharing is a service that exists in a great number of states and some of the backstops that have been put in place don’t exist in other states such as insurance requirements and safety requirements. The process of working with stakeholders was challenging but CO got through it and it is something that every state should take a look at because p2p car sharing is a very logical step in the modernization of our economy. Letting people take vehicles that are not being used and putting them into use is good not just for the people who are able to access the vehicles and for those who can make money off a vehicle that would otherwise be idle, but it also helps us in the much broader sense of having a more efficient use of roads.

Rep. Gray noted that he is Chair of the CO House Committee on Transportation and Local Government and stated that CO struggles, as many states do, with finding funding for transportation infrastructure. One of the ways to mitigate the struggles is to have more efficient uses of roads and having fewer idle vehicles. Rep. Gray again noted that p2p car sharing is a unique situation where the services exist whether or not there are safeguards put around them so safeguards should in fact be put in place moving forward.

Rep. Gray acknowledged that p2p car sharing issues will be state specific. For instance, CO has unique fiscal restraints that nobody else in the country has and it would not make sense to write those things into a Model law. The issues that had to be negotiated in CO would not make sense in other states. However, when you can create any level of uniformity and predictability for consumers of these services it makes sense. Rep. Gray stated that the foundational part of this issue is that we need to make p2p car sharing make sense for people to use the services and to have reasonable expectations of the kind of protections they are going to have when they use the services which people are

used to when it comes to other transit services. If you pay someone to have access to transportation, there is a base level of safety and insurance protections that people expect and which should be in p2p car sharing without removing the aspects of p2p car sharing that create more efficiency than other forms of transportation. Rep. Gray applauded the work of the Committee and recommended that the Committee adopt the Model as the experience in CO surrounding these issues has been very positive. Upon a Motion made by Rep. Joe Fischer (KY) and seconded by Asm. Ken Cooley (CA), NCOIL Treasurer, the Committee voted to adopt the Model without objection by way of a voice vote.

DISCUSSION ON NCOIL ELECTRIC SCOOTER INSURANCE MODEL ACT

Sen. Jerry Klein (ND), Sponsor of the NCOIL E-Scooter Insurance Model Act (Model), stated that NCOIL is once again taking the lead on an important issue and noted that he looks forward to today's discussion as being the first step towards development of a Model regarding insurance requirements for e-scooters.

Ms. Collins stated that as this burgeoning business advances, NAMIC certainly wants to embrace advancements in technology and mobility but also wants to be cognizant of any liability concerns. The first draft of the Model is a liability framework and is trying to address three different zones of liability: that which is present for the scooter rider while on the scooter and anything that happens collision-based; the second and third pieces are situations where NAMIC believes it has identified a gap in coverage from commercial activity. Ms. Collins stated that as NAMIC understands it, there is a contract in place with citizens who go out and collect the scooters and take them to another location and charge them and return them for public use. There is a potential gap in coverage based on the commercial exclusion if someone were to take the scooters to their home and engage in that commercial activity so NAMIC has attempted to address that commercial gap in the Model with liability coverage both for the collection of the scooters and for the commercial activity in the home. That is the general purpose of the Model and NAMIC looks forward to discussing it.

Ben LaRocoo, Senior Manager of State Policy at Lime, first explained some basics as to how the scooters function: you see a scooter on your phone, go up to it with an app, scan the code which unlocks the scooter; you have to be moving in order to ride the scooter which is a safety feature that you cannot just first hit the accelerator; the scooters reach a maximum speed of about 15 mph; you ride the scooters in the bike lane and are generally not allowed on sidewalks in most cities; if there is no bike lane you ride them on the street; you obey all traffic laws as you would with any other mode of transportation; when you are done you park the scooter in what is called the furniture zone which is about three feet off the curb near a bike rack that does not block ramps or fire hydrants; you then hit "end your ride" and take a picture of the scooter so that it can be verified where people actually park in case there is a problem later on; the user's credit card is then charged – the average cost is about \$1 to unlock and then 20 to 30 cents per minute; the average trip is about 1 to 1.5 miles long so the average cost of a ride is about \$3-5 dollars.

Edward Fu, Senior Regulatory Counsel at Bird, stated that together, Bird and Lime make up about 80% of the e-scooter market. One of the main things to highlight that has changed from when a Lime representative spoke at an NCOIL meeting last year is that Bird and Lime now have a greater sense of what the scale of the industry is. In the first

year, there were about 40 million rides completed in the U.S. and it is expected to be greater next year. Accordingly, this is in fact a burgeoning new industry for which there is not a lot of legislation in place and that is something that Bird looks forward to discussing. Mr. Fu stated that people have embraced e-scooters because they have eliminated tens of millions of city car trips thereby avoiding traffic; they are affordable – and Bird and Lime work with cities to make sure there are e-scooters available for those with fixed and low incomes; they boost local businesses as the e-scooters increase foot traffic since people are encouraged to shop in-person instead of online; and they are safer or at least as-safe as bicycling through a city. Mr. Fu noted that at the conclusion Baltimore’s pilot program, the city found that e-scooters were associated with fewer injuries than walking.

Mr. Fu stated that e-scooters are currently regulated at the state level and are generally treated like bicycles or e-bicycles which means that they are generally not subject to registration, titling, equipment, insurance or liability insurance requirements. The businesses that make the e-scooters available to rent, however, are typically regulated at the local level and as it pertains to insurance, every city – and several states – requires such companies to carry commercial general liability (CGL) insurance for operations. This is an area where there is certainly a patchwork of regulation throughout the entire country and the companies, along with cities and states, have asked for some level of uniformity. The companies are also engaged outside of the legal landscape with third party standard setting organizations such as SAE and ASTM to develop taxonomies and standards relating to the e-scooters themselves.

Mr. Fu stated that what is being seen now in the industry is an evolution away from the traditional idea of what a scooter may be which is to say that the real demand within American cities is for light, electric vehicles – something that you can travel on. SAE has determined what some popular examples of such transportation to be, including e-scooters so the point is that it is not just about e-scooters but rather a variety of light, electric vehicles that are seen on American streets as really changing urban transportation.

With regard to the Model, Bird and Lime believe that it is a step in the right direction in terms of legislating in an area where there has not been a lot of legislation thus far. The Model speaks to two elements – liability insurance and insurance for the chargers of the e-scooters. With regard to liability insurance, every company throughout the country carries commercial general liability insurance and, in that regard, everyone has started to realize that having a patchwork of requirements is not a great idea and they have started asking for uniformity legislation. At the same time, what has not been seen yet is rider liability requirements which is to say that you have to purchase liability insurance before you get on a e-scooter. Several states have explicitly rejected that, and the issue has been discussed but the current state of the matter is that the companies are aware of no product on the insurance market that would allow a rider to purchase that type of liability insurance. Mr. Fu also noted that Bird and Lime do not see a high level of third-party incidents resulting from the e-scooters. As mentioned earlier, Baltimore’s safety study found no third-party incidents relating to e-scooters and in Austin, the CDC conducted a study and found that over a time period of about 1 million trips, only two third-party incidents were found, both of which were minor and did not require hospitalization.

With regard to the chargers of the e-scooters, Mr. Fu stated that Bird and Lime hire

independent contractors who are on their way home from work or school to pick up scooters. After picking the scooter up, bringing it home, charging it, and bringing it back out on the street the person will get paid a flat rate of about \$2-5 depending on the scooter. Mr. Fu stated that this is not an activity that necessarily requires a car although certainly some people do. In that sense, these folks are like a traditional independent contractor and less like the modern gig worker in that the car is not integral to the services they provide, and they don't have any customer contact. With that being said, Mr. Fu stated that he believes Ms. Collins is right in that there is a concern that the commercial exclusion on many commercial auto policies may present a gap in coverage.

Mr. Fu stated that Bird and Lime look forward to working on the Model with the Committee and with interested parties moving forward. Bird and Lime understand that there is already a demand out there for uniformity in terms of commercial general liability insurance for providers and whether the issue of rider liability is dealt with is something that requires a bit more discussion. Resistance has been shown from states to get involved with that and the companies have not yet seen what that product would ultimately look like. If such a product is created, it is expected to look very different than current auto MFR requirements largely because current auto liability insurance policies are written with the idea of a 5,000 pound vehicle traveling at 65 mph as opposed to e-scooters which are closer to 50 pounds and max out at about 15 mph.

With regard to the chargers of the e-scooters, Bird and Lime recognize that the new gig economy means that there are a lot more independent contractors and a lot of them now use their car as part of their work. Bird and Lime appreciate the concern surrounding the fact that the commercial exclusion may apply to those folks and they may not be covered under their personal auto policy. Mr. Fu stated that in that regard, the best approach is probably to address the larger issue as there a lot of people who do these services – not just charging e-scooters – as they may be delivering food or supplies or just traveling to another task and many of them do those things at the same time. From surveys conducted, Bird and Lime know that a lot of its e-scooter chargers pick up the e-scooters and then drive around and do other activities whether it be for work or personal reasons. A broad framework that encompasses those realities is appropriate and something that Bird and Lime would be happy to work on in order to address the gaps in coverage we increasingly see among independent contractors in the new gig economy.

Mr. LaRocco stated that he believes much progress has been made on these issues in just the last 24 hours and he feels that Bird and Lime are in a really good place for finding something to agree upon that addresses concerns and enables the product to still be provided at an affordable rate.

Rep. Matt Lehman (IN), NCOIL Vice President, stated that he believes Indiana passed a law regarding e-scooters a couple of years ago that stayed away from insurance issues. The argument that is often heard is that bicycles are not regulated and e-scooters are very similar, but bicycles do create liability – if I leave my bicycle out on the sidewalk and someone trips over it, I am liable for that. Accordingly, Rep. Lehman asked where that liability is attaching now. Mr. LaRocco stated that the answer depends on who's negligence caused that liability. If a scooter company put a scooter out or one of its chargers put a scooter out in a way that was inappropriately blocking a sidewalk, the company would be liable, but if a rider parked a scooter in an improper way it would be their liability. That is one of the issues right now as e-scooters are sort of a new situation and are not easily defined. Part of the problem as well is that there are not society

established norms relating to scooters yet so there tends to be more issues with them than with more established technologies.

Rep. Lehman stated that this seems to be mirroring the discussion the Committee had a few years ago regarding Uber and Lyft in the sense that there was an insurance gap and now the question becomes how the gap can be bridged with scooters. There are other issues, but from the insurance side, Rep. Lehman asked if the Uber-model so to speak can be used to bridge this gap. Mr. LaRocco stated that one difference between Bird and Lime and some of the other technology companies is that Bird and Lime are not platforms. Bird and Lime own their own scooters and provide the services directly so they are not connecting two groups of customers. Accordingly, Bird and Lime have different responsibilities than companies such as Uber and they recognize that. Bird and Lime also want to ensure that people still have responsibilities for their own actions and if others are contributing to negligence which harms someone else, they want to ensure that they are responsible for their negligence and not for other's negligence.

Rep. Lehman stated that the fact that Bird and Lime own the product makes things clearer in his view. Rep. Lehman always tells his clients that ownership does not create liability, but if it's yours and liability becomes attached to it then the owner does have to respond. If I leave my bicycle in the street, I am responsible if someone trips over it and if I leave my neighbor's bicycle in the street I could be responsible as could my neighbor. Accordingly, ownership of the scooters almost seems to increase the level of responsibility to make sure they are properly maintained and to make sure there is insurance to cover all situations. Rep. Lehman cautioned Committee members when dealing with this issue in their states as it is not as simple as saying "they are our scooters but we have no responsibility beyond ownership." Mr. LaRocco stated that he does not believe anyone is claiming that and noted that e-scooters have only been around for about 26 months – it was 42 years from the car until the first car insurance law. So, the market has not had enough time to necessarily develop a lot of mechanisms that are taken for granted in other modes of transportation. Bird and Lime appreciate the expertise of the Committee members and interested parties to help decide what is appropriate on a lot of questions that are to be determined. Rep. Lehman thanked Bird and Lime for being here and stated that he believes the final product developed will be something that everyone can support if everyone stays involved in the conversation.

Rep. George Keiser (ND) stated that a few communities have banned e-scooters and others are considering it. Rep. Keiser asked how Bird and Lime's business model addresses the scenario of a user inadvertently or knowingly going into a banned community and then having liability attach from an accident. Mr. LaRocco stated that is an issue that has some nuance between the difference in scooters and scooter sharing. Some communities have banned scooters but scooter sharing, for the most part, only exists in cities that permit companies to do so and there is a regulatory framework for that. Generally, when there is a city that has permitted scooter sharing next to a city that has not, there is a technology called geo-fencing that has GPS in the scooter so it will know when the user has crossed into the city that does not allow scooter sharing. The scooter will slow down and stop and you would need to either leave the scooter there or go back to the permitted community.

Asm. Andrew Garbarino (NY) asked if someone from the hotel here took a scooter and left it outside of a bar and someone tripped over it, who would be liable? Mr. LaRocco

stated that if that person parked the scooter improperly such as in the middle of a crosswalk, they would be liable. Mr. LaRocco stated that the scooters are allowed to be parked in the “furniture zone” which is essentially three feet from the curb and is where you generally see utility poles and parking signs. Asm. Garbarino asked how the riders know where they can and cannot park the scooters. Mr. LaRocco stated that there is in-app messaging that tells them that and the rider must also take a picture of where the parked the scooter at the end of the ride. At the end of the ride there is a message that says “park appropriately.”

Ms. Collins stated that there are good policies and procedures surrounding the scooters but noted that probably almost everyone in the room today has experienced that the riders don’t always follow those policies and procedures as evidenced by a lot of them being rode on sidewalks. In that context, that is part of what is being talked about in Section 4 of the Model with liability coverage for the rider themselves. The great news about insurance companies is that they love to write insurance so they will at some point get to a specific product for something like this. In the interim, almost every insurance lobbyist present at this meeting would love to tell the scooter companies about their umbrella policies that the riders can be connected to. Ms. Collins stated that the negligence of the rider is what is trying to be addressed in Section 4 of the Model. Mr. LaRocco stated that there is an argument that there is a responsibility of the rider to park appropriately and a responsibility of the company to teach riders how to park appropriately. There is probably also a responsibility of the city as people are trained to look at signs such as speed limit signs and parking signs and no turn on red signs and none of those things exist for scooters so that circles back into what was said earlier regarding there not being societal norms established yet for scooters. What Bird and Lime hears from people is that they don’t know certain things about parking, etc. so they try to teach them certain things.

Mr. Fu stated that as this industry grows there have been tremendous strides in communities in terms of both social norms and local governments such as cities building out certain corrals to park scooters or designating one car parking spot which can be used to park up to 20 scooters. There have been dramatic decreases in sidewalk riding and parking. Accordingly, this is a shifting landscape and what we saw last year is what is different from today, and what we see next year will be much different.

Asm. Garbarino asked if it is a requirement to wear a helmet when riding a scooter. Mr. Fu stated that there is only one state in the country that requires adult scooter riders to wear a helmet – Oregon. Broadly speaking, scooters are treated like bicycles and there is no state in the country that requires adult cyclists to wear a helmet. However, Bird and Lime of course strongly encourage riders to wear helmets and have taken a lot of steps to encourage that. Bird and Lime have found out that legislation doesn’t work very well in terms of getting people to wear helmets. They tried giving helmets away but it turns out that is a great way to get rid of helmets but not to get people to wear them. Accordingly, Bird and Lime continue to work on the issue and have introduced technology that enables the rider to take a picture of themselves after the ride and if they are wearing a helmet they will get a credit on the next ride. It is looking promising thus far but it is still early. There is a burgeoning industry out there in terms of technology trying to develop more portable helmets that people can bring along with them as not everyone is always interested in carrying around a helmet all the time. Hopefully this is something that with more and more innovation, the problem will be solved.

Sen. Gary Dahms (MN) stated that he assumes Bird and Lime carry primary liability and insurance that it covers the scooters while they are out on the street. Sen. Dahms asked what kind of limits Bird and Lime have for such coverage. Mr. LaRocco stated that Bird and Lime do have commercial general liability coverage for each city it operates in and it generally is \$1 million per occurrence and then between \$2 and \$5 million in the aggregate but it varies a bit from state to state and city to city. Sen. Dahms asked if he is correct in assuming that if something happened while driving a scooter that the scooter company's CGL would be primary and that if there was some excess after that, the rider's insurance company would step in and be secondary. Mr. LaRocco stated that an important distinction is if there was negligence. If the rider is injured because the scooter malfunctioned, which is the company's negligence for putting out a scooter that malfunctioned, the CGL would cover that. If the rider was injured because of their own negligence such as not paying attention or operating it under the influence, the CGL would not cover that. Sen. Dahms asked where the liability would fall if someone rented a scooter and they don't know how to drive it and they end up getting injured while riding. Mr. LaRocco stated that he believes that it would depend on the specific circumstances.

Commissioner Tom Considine, NCOIL CEO, stated that there are obviously two different liability issues, one in which was just discussed by Sen. Dahms. Cmsr. Considine noted that there was a case in New Jersey fairly recently where a rider was riding on the sidewalk where they had no business to be and ended up hitting a stroller and injuring a baby. Cmsr. Considine stated that he in no way, shape or form attributes that liability to the scooter companies, but noted that it seems to him that the solution for rider liability is a point of sale insurance requirement similar to the rental car process. The limits of coverage would obviously be a lot less but the companies would have their liability for the \$1 million per occurrence if something happens with the scooter that injures someone, but the arms really have to get around the operator of the scooter for when she or he hits somebody. Cmsr. Considine stated that it is a generalization but he believes that a lot of people operating the scooters fall into the demographic of not having a lot of insurance coverage. So, they hit somebody and it's not the company's liability, they get sued and they are judgment proof. Accordingly, Cmsr. Considine stated that he believes adding an insurance fee/surcharge at the point of sale is probably the best way to fix that.

Asm. Ken Cooley (CA), NCOIL Treasurer, stated that on the topic of general liability it is interesting that riders may be able to take pictures of themselves wearing a helmet and then get a discount on their next ride. The fact that the riders are required to take pictures from the get-go in that they have to take a picture at the end of the ride to verify where they parked the scooter sort of opens up a potential of "did they appear to drop it off in a place that did not create liabilities" and opens up some potential to score the conduct in some small degree of riders to provide feedback to them just as Uber and Lyft drivers are scored. That sets up the potential to evaluate the conduct of riders and companies could also go in a direction of something like the old travel insurance concept in the 1960s of going to the airport and you could buy a travel policy. You could also roll coverage into the rider's charge on a cumulative basis and based upon a person's track record as a customer, have a benchmark rate or some adjustment.

Asm. Cooley stated that he sees people all the time in his city leaving the scooters in all sorts of places and impairing the ability of walkers or people in motorized wheelchairs. It is remarkable where they scooters are left with no apparent thought. Accordingly, there

are some pieces in the liability conversation that are difficult to know where they will end up through the application of tort principles because you have the company, the rider, and the business where the scooter may have been left out in front of all involved. California has a whole body of law stemming from the Easton decision in the 1980s which basically said that whenever realtors show a house to someone they cannot turn anything on or flip any switches because the house is as the house is and if the realtor touches it then they own it and they have liability for it. So, there is an aspect of if you are a street-front business and you touch the scooter outside, does the business now have liability? This also gets into the whole conversation of a local government planning standpoint of complete streets. Scooters reshuffle the deck in terms of what the plan is for where you leave them.

Mr. Fu stated that he was recently in California and understands Asm. Cooley's concerns about where the scooters are being left and noted that one of the unspoken truths of the industry is that it is not always just the companies and riders as there are sometimes third parties who don't like the devices and throw them into the street or sometimes the wind will knock the scooters over. Accordingly, it presents a difficult question that everyone can appreciate in that the scooters are of course owned by the companies which put them on the road but at the same time there is a limit of what the companies can do physically and financially as far as ensuring what their state is at all times. Bird and Lime work closely with local governments to set up 311 systems so that they can respond rapidly to something and they also hire people to patrol city streets to monitor the scooters. However, one of the conversations that Bird and Lime would love to have going forward is how to set up a sensible liability structure that protects everyone but at the same time is feasible and realistic for the industry to implement.

Asm. Cooley asked if the independent contractors who charge the scooters also take a picture indicating where they have dropped off the scooter. Mr. Fu replied yes and noted that is something that the companies have a lot more control over because they have the independent contractor relationship with the chargers and they can and often do terminate such chargers who drop them off in inappropriate locations. Mr. LaRocco stated that an important part of it is enforcement. The companies can tell customers to do things but just like many people do not read all of the terms of their agreements for many products, the riders can be told where to park the scooters but if the city government is sending the signal that they are not enforcing any rules then people are going to read that as "I don't have to follow those rules." Accordingly, there is a responsibility of local governments to establishing those enforcement mechanisms as well.

Sen. Jack Tate (CO) stated that he spends his time in two different cities where there is a difference in the user behavior and the civic response to scooters primarily regarding how often they are used on sidewalks. Sen. Tate stated that he rode scooters quite often last year and he did not remember scooter companies stating where the scooters should be ridden. Sen. Tate asked if the scooter companies now are emphasizing them to be ridden in streets and bike lanes only as the proper way to ride, and asked how the company perceives risk differences. Mr. LaRocco stated that sidewalk riding and parking are the two biggest complaints received around the world. Bird and Lime have thought a lot about those issues and believe that they are in a better place today, but what their customers say is that they often know they are not supposed to ride on the sidewalk but they don't feel safe in the street and they would much rather take their chances of getting a ticket for riding on the sidewalk than getting hit by a bus in the

street. While pedestrian-scooter conflicts are bad, car-scooter conflicts are much worse and people are not willing to take their life in their hands. Until people feel safe riding in the streets, Mr. LaRocco stated that you will probably continue to see riding on the sidewalk no matter what the rules and messaging are.

Mr. Fu stated that in several cities, if not all, there is a sticker directly on the scooter informing the rider to stay off sidewalks and noted that Bird and Lime are very hopeful to see more of what certain cities such as Atlanta have done which is a commitment to triple its protected bike lane infrastructure in the next few years as a result of the extraordinary demand for the devices. What Bird and Lime have seen is that in cities with bike lanes, even if they are not fully protected bike lanes, sidewalk riding drops a tremendous amount. Bird and Lime look forward to continuing to work on this issue and there is a lot that they can do along with cities and local governments to address the issue.

Sen. Dan McConchie (IL) stated that as someone who is in a wheelchair, Austin is the first city that he has been in that has a lot of scooters. On his first day here he was on a sidewalk on which he could not advance further because there was a scooter blocking the way forward. Sen. McConchie had to wait for someone to come along to pick the scooter up so that he could move forward. Sen. McConchie stated that he has concerns about the scooters being blown over by wind, especially in windy cities such as Chicago where the scooters just started operating. Sen. McConchie asked where that type of liability lies – if someone parks the scooter in what seems to be an appropriate spot but it is not because of wind propensity as there are certain areas in Chicago that act like wind tunnels. Someone may be able to pick the scooter up or walk around it but a disabled person cannot.

Mr. Fu stated that he does not believe the wind issue is a new issue since if you parked a bike near a bike rack and the wind blew it over into the street, the same question of liability would arise. Sen. McConchie noted that almost all bicycles are going to be tied down to guard against theft. Mr. Fu stated that this is an issue that has certainly grown since the arrival of scooters and noted that he does not believe there is a clear answer to the question of liability in that scenario. Bird and Lime would like to work with NCOIL and local governments to answer these questions. Mr. LaRocco stated that next week in Washington DC, Lime has a meeting scheduled with several members of the disability community who are affected by scooters and urged the Committee members to reach out to Lime with suggestions as to who else should be spoken to in order to make sure that everyone understands the effects of scooters in the community.

INSURANCE RATING VARIABLES: WHAT THEY ARE AND WHY THEY MATTER

Ken Williams, Staff Actuary at the Casualty Actuarial Society (CAS), stated that the topic of rating variables has been coming up frequently in a lot of legislative sessions and at the federal level so the CAS and Insurance Information Institute (III) drafted a paper on the topic earlier this year. Mr. Williams noted that there are three main actuarial organizations in the country. The American Academy of Actuaries (AAA) is sort of the CAS' public relations wing and they get involved in a lot of individual legislation and they are also CAS' professionalism wing. It is important to note that actuaries have professional standards to follow and if an actuary is found to violate those standards, the AAA takes care of the discipline. The second large group is the Society of Actuaries (SOA) which specializes in pensions, life insurance and health insurance. CAS is the

smallest of the three actuary organizations and is the only one in the world that deals with property & casualty topics. CAS has been around for about 100 years and has over nearly 9,000 members worldwide, primarily in the U.S. and Canada. CAS is growing fairly rapidly as last year it had 8,000 members. Mr. Williams noted that the goal of both CAS and III is to educate as they are not lobbying organizations. Mr. Williams noted that he is a staff actuary at CAS and prior to that he was with the Illinois Farm Bureau which was called Country Financial for 26 years working as a pricing actuary.

Mr. Williams stated that all policyholders are different and have different risks. Rating variables help insurance companies quantify that risk such that they can get the right premium for the risk. The white paper was written because there are at least two states this year, California and Michigan, that had legislation involving rating variables and there were some hearings on the issue at the federal level. The goal is not to influence legislation but to let folks know how rating variables are used today so when there are decisions made about rating variables in a regulatory or legislative environment there is a better understanding of how they work.

Mr. Williams stated that actuaries are doing two things when thinking about premiums. The first is to make sure that enough money is made at the state level so that they cover costs, expenses and make a little profit. The second thing is to charge different risks different premiums. For example, a \$300,000 car is a much different risk than a \$25,000 car so they should be charged different premiums. That is all rating variables are doing – making sure the right premium is charged for the right risk. There are four things that actuaries and regulators are going to do to make sure there is an effective rating variable. The first deals with being statistically significant. Actuaries are known as being mathematicians and this is the most important issue for them. A rating variable is not going to be used unless it shows a difference in cost. There is no incentive for insurance companies to charge different premiums unless the costs are different. So the most important question is: does this group of people have a higher or lower average risk compared to other groups of people? The unusual thing about insurance is that the product is sold before it is known what the costs are. Accordingly, it is the actuary's job to determine how much they think it is going to cost for the person to buy insurance.

The reality is that with all insurance, the majority of people are not going to have a claim and the company therefore makes money off of that; and very few people are going to have large claims that causes the company to lose money. Mr. Williams stated that one thing to think about with insurance, especially auto and homeowners, is that they are relatively low frequency policies. The data shows that usually 4 out of 100 people have claims. So, if there is a group of 1,000 insureds that are thought to have about 30 claims and then another group of 1,000 insureds that are thought to have about 33 claims, that is only a small difference but nonetheless that group with 33 claims should have a premium that is 10% higher. Accordingly, very small changes in frequency will result in premium changes.

Mr. Williams stated that once the group is selected to be put together, insurers want them to have similar characteristics. On the flip side of that, if you make the group too homogenous and too small, the data will not tell you anything. A good example is that 16 year olds who just got their license are probably not as good drivers as 17 year olds who have been driving for a year. The reality is that there are not that many 16 year olds, especially if the company is not that big so the company will group 16/17/18 year olds together and look at their loss experience because that group is big enough to have

the data tell you something. Mr. Williams stated that the issues of homogenous and credibility really battle each other. One thing that is heard a lot when talking about rating variables is that the person across the street, who is a very similar risk, has a higher or lower premium. Mr. Williams stated that the way actuaries use geography, which is one of the most important rating variables, is that lines must be set somewhere to group certain folks. The lines are often, streets, zip codes, and city boundaries. As technology gets better, it is hoped that actuaries can get more granular as to how they classify risk.

Mr. Williams stated that operational criteria is also very important when considering rating variables; operationally, can the actuary get the data and is it objective? Nobody is going to say that they are a bad driver so asking that question is not objective data. It is also important to make sure that the data is verifiable and inexpensive to administer. One of the things that is often heard is why tickets and accidents aren't being used more as a rating variable. That information is obtained from state Department's of Motor Vehicles (DMV) and some states are now charging \$50 for insurance companies to obtain ticket data. Since most drivers don't have tickets it may not be worth it for the insurer to spend that money on each application to get that ticket data. However, if the cost was \$5, it may be worth it.

Mr. Williams stated that another thing often asked is why real driver data is not being used. In the past, that data could not be obtained but as technology improves and driver apps become more common, that data will be obtainable. Companies such as Allstate and Progressive are starting to advertise these types of rates but now there are certain privacy concerns that must be addressed. Mr. Williams stated that insurers also take into account consumer considerations when developing rating variables and premiums. One such consideration is that there is a desire for insurance to be affordable, especially when it is really needed. All states have mandatory auto liability insurance rules. Also, in order to buy a house you typically have to have homeowners insurance. Mr. Williams noted that as insurers get better at segmenting risks and figuring out who will file claims, the very high risk folks may see insurance become unaffordable and that is a concern in the insurance industry and for consumers.

Mr. Williams stated that consumers also like when they are able to see how a rating variable impacts their driving. Most would agree that a 60 year old driver is not as good of a risk as a 40 year old driver, so charging the 60 year old driver more makes sense. However, people struggle with the fact as to why credit has anything to do with driving ability. Clear relationships between the rating variable and the risk is not mandatory for actuaries but they like them. Another thing that is often discussed is if the rating variable can be controlled. You can control how much you drive and the kind of car you drive and to some extent you can control where you live. You cannot control your gender and age and there is a desire to not have uncontrollable things being used as rating variables.

There is more and more discussion about wanting driver history and the use of telematic apps. Progressive has been using telematics for about 20 years but only about 1/3 of their customers use it. Consumers want their driving history to be used for insurance but are hesitant to provide the data so there is a real balance between accurate rating and privacy issues and it will be interesting how this develops as more companies get involved with driver-based premiums. Mr. Williams stated that regulations certainly impact rating variables. Most states have laws which state that rates cannot be excessive, inadequate or unfairly differentiation. The question then becomes what is

unfair differentiation? Actuaries, regulators and insurers all have different views to that question and it is important to work together to figure out what is an unfair rating variable.

Mr. Williams then discussed what can happen when states restrict rating variables. What may happen is that another rating variable becomes stronger and the example used in the white paper is if gender was banned as a rating variable in a state; and gender is an indicator as men are worse drivers than women. But men have more pickup trucks so what may show up in the data is that pickup truck rates should increase. That penalizes women who drive pickup trucks. Mr. Williams further stated that often times restricting rating variables is often pitted as insurance companies vs. consumers, i.e. the consumer is being overcharged. But it really is consumer vs. consumer because if you take away a rating variable on a higher risk group, another group is going to have to pay for it because the insurance company will ultimately meet its profit goals either way. Accordingly, you are essentially forcing a subsidization which is not necessarily a bad thing as things are subsidized all the time in society.

Mr. Williams noted that ultimately, if there is a group of policyholders known to be a higher risk, and the premium can't be obtained, then there is not much of an incentive for insurance companies to write that risk. Insurance companies like to write insurance and want to write as much as they can but if they know that they are going to lose money on a policy, they have less reason to do so. Mr. Williams then closed with some final thoughts. Insurance companies are using rating variables to try and be fair; they want to make sure the premiums that consumers should pay are based off of the actuarial calculations. That really gives consumers more choice because companies are using different rating variables and algorithms to come up with premiums and for some folks, the premiums will be lower at a different company. At the same time, to the extent that it is decided that a rating variable should not be used, everyone needs to work together to determine what a fair rate is to charge without being unfairly discriminatory.

Rep. Keiser noted that his family members do not want to share their driving history data for telematics purposes. Mr. Williams stated that is a real issue because insurers would obviously love to know how a driver drives all the time so the premium could be set very accurately, but consumers don't necessarily want the insurer to know how they drive all the time. It will be interesting to see how that issue evolves over time.

RE-ADOPTION OF NCOIL MODEL ACT REGARDING THE USE OF INSURANCE CLAIMS HISTORY INFORMATION IN HOMEOWNERS AND PERSONAL LINES RESIDENTIAL PROPERTY INSURANCE

Upon a Motion made by Rep. Keiser and seconded by Rep. Martin Carbaugh (IN), the Committee voted without opposition to re-adopt the NCOIL Model Act Regarding the use of Insurance Claims History Information in Homeowners and Personal Lines Residential Property Insurance by way of a voice vote.

ANY OTHER BUSINESS

Rep. Jordan thanked Sen. Dan "Blade" Morrish (LA), NCOIL President, for urging him to get involved with NCOIL and wished him great luck in retirement.

Alan Smith, Midwest Director at The R Street Institute, applauded NCOIL for dealing with

new issues such as p2p car sharing and e-scooters. There is a strain in public policy that wants to restrict and limit things because something may go wrong. NCOIL has done a great job of coming together to draw lines around new issues that should be discussed.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON NATURAL DISASTER RECOVERY
AUSTIN, TEXAS
DECEMBER 11, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Natural Disaster Recovery met at the JW Marriott Hotel in Austin, Texas on Wednesday, December 11, 2019 at 9:45 a.m.

Senator Vickie Sawyer of North Carolina, Chair of the Committee, presided.

Other members of the Committees present were:

Sen. Jason Rapert (AR)	Rep. George Keiser (ND)
Rep. Matt Lehman (IN)	Rep. Tom Oliverson, M.D. (TX)
Rep. Edmond Jordan (LA)	Del. Steve Westfall (WV)
Sen. Dan "Blade" Morrish (LA)	

Other legislators present were:

Rep. Deborah Ferguson (AR)	Rep. Bruce Grubbs (MT)
Asm. Ken Cooley (CA)	Rep. Tracy Boe (ND)
Rep. Doug Gutwein (IN)	Sen. Jerry Klein (ND)
Rep. Peggy Mayfield (IN)	Sen. Shawn Vadaa (ND)
Rep. Joe Fischer (KY)	Asw. Maggie Carlton (NV)
Del. Mike Rogers (MD)	Asw. Ellen Spiegel (NV)
Sen. Gary Dhams (MN)	Sen. Neil Breslin (NY)
Sen. Paul Utke (MN)	Rep. Julie Johnson (TX)
Rep. Donna Pfautsch (MO)	Rep. Eddie Lucio III (TX)
Sen. Paul Wieland (MO)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Sen. Jerry Klein (ND) the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Keiser and seconded by Del. Steve Westfall (WV), the Committee approved the minutes of its July 11, 2019 meeting in Newport Beach, CA without objection by way of a voice vote.

DISCUSSION ON NCOIL PRIVATE FLOOD INSURANCE MODEL ACT

Senator Vickie Sawyer (NC), Chair of the Committee, stated that at the NCOIL Summer Meeting in July this Committee decided to take what were amendments to the existing NCOIL State Flood Disaster and Mitigation Relief Model Act and instead develop a separate NCOIL private flood insurance model law proposal for the Committee to consider. In the 30-day materials for this meeting, the first draft of that Model law proposal was included for comment.

Sen. Sawyer stated that the sponsor of that Model, Florida Representative David Santiago, unfortunately was not able to be here today for this meeting but noted that the Committee hopes to have a very productive discussion today that will guide the Committee's direction on the Model going forward. In terms of the substance of the Model, Sen. Sawyer noted that it appears the two issues that have garnered the most attention are Sections 5 – form review – and 7 – producer duties. With regard to form review, Sen. Sawyer stated that switching from prior form approval to providing states the option of requiring review through the application of the state's existing regulatory system is appropriate. Sen. Sawyer also stated that the changes in requirements for producers in terms of their interactions with consumers when discussing flood insurance are appropriate. The changes that have been made to those sections are a step in the right direction and hopefully the final language will be something that everyone can support. Sen. Sawyer noted that there will be no vote on the Model today and that hopefully the Committee can have something ready for a vote at the Spring Meeting in March in North Carolina.

Cate Paolino, Director of Public Policy for the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for all of its work thus far on this issue and noted that NAMIC looks forward to working on the Model as it continues to move forward. Ms. Paolino stated that the language set forth in the "Purpose" Section of the Model – Section 2 – provides some important language that can help guide the Committee's efforts when working on this Model. Said Section states "in an effort to provide protection of lives and property from the peril of flood, this legislation is designed to encourage a robust private flood insurance market to provide consumer choices and alternatives to the existing National Flood Insurance Program (NFIP)." It would be very beneficial to the future marketplace if that "purpose" could be a guide in the language that follows in the Model.

Ms. Paolino stated that much of the language in the Model serves as a framework for private flood, but she is not sure if some of the language goes as far as facilitating that marketplace. For example, with regard to underwriting and the flexibility to select and reject risk, one insurer has been recounting some difficulty it has been having in terms of states perhaps not differentiating between requirements for flood and requirements for homeowner's coverage. Embedded in some state's law may be, as it relates to homeowner's, restrictions on the use of information about catastrophes and weather-related risk. We can see how this would be a pretty big barrier if applied to floods if that is the essence of what the coverage is about. Those kinds of things are important to think about as they may be contrary to the "purpose" outlined in the Model.

Another example might fall within the scope of the form-related requirements such as the design and filing regime. There may be an opportunity to work on the handling of the discretionary acceptance policies under the federal rule that relate to the NFIP that was

issued last Summer. Ms. Paolino stated that she looks forward to working on some clarification in that area. Also, as there are possibly proposals to limit the wording of the Model, Ms. Paolino stated that she is hoping for a dialogue as to what it means to be outside the scope of the Model. It is not clear whether such products may still be written in the private market or whether it somehow implies that they are not able to move forward.

With regard to the filing side of things, Ms. Paolino stated that there has been discussion of following the underlying state filing regime or perhaps including a drafting note asking for consideration of methods to accelerate that. Consistent with the “purpose” language in the Model of trying to incentivize and bring forth a marketplace on an expedited basis, NAMIC asks that the filing language be further examined. Ms. Paolino stated that she looks forward to working with the Committee going forward.

Ron Jackson, VP of State Affairs, Southeast Region, at the American Property Casualty Insurance Association (APCIA), stated that APCIA members write approximately between 76% of write-your-own (WYO) policies in partnership with the NFIP, and approximately 91% of all private flood coverage in the nation. Accordingly, this is an important issue and APCIA congratulates NCOIL for bringing the issue forward for discussion. Mr. Jackson stated that APCIA looks forward to working on the Model to, as Ms. Paolino stated, ensure that the Model’s “purpose” is properly met. With regard to rate and form filing requirements, APCIA believes it is critically important to incentivize additional writings in the private market – both in the personal and commercial side. As of today, 64% or so of the private flood writing is in the commercial realm. There is certainly still a lot of coverage in the surplus lines market. That highlights the need for flexibility as you see where the majority of the market is going where they have greater rate and form flexibility. There are approximately 15 states that do not require prior approval of personal forms so providing that flexibility is not as radical and scary as some may think. It has been done in a number of states with various lines of insurance and coverages and APCIA believes it is particularly important if you are looking to incentivize greater flood writing.

Mr. Jackson stated that it is important to educate consumers about flood insurance as we all know what the mindset has been over the years – namely that consumers think they should not buy flood insurance if they are not in a flood zone. APCIA looks forward to working with the Committee on the Model.

Wes Bissett, Senior Counsel of Government Affairs at the Independent Insurance Agents and Brokers of America (IIABA), stated that IIABA is a very strong supporter of building out the private flood insurance market and shares the desire of the Committee as outlined in the Model’s “purpose” section. IIABA’s members provide consumers choice through a variety of different companies so from IIABA’s perspective, the more options available, the better for IIABA and its clients. IIABA has been very supportive of legislative efforts in Congress and individual states to address private flood related issues that have arisen with the emergence of this market. For example, IIABA was very supportive of Rep. Santiago’s bill in Florida that was adopted a couple of years ago. However, IIABA does have some concerns with Section 7 of the Model – Duties of Producer. The reason why is because said Section does not really relate to private flood itself and does not mirror the Model’s goal of building a robust marketplace for private flood alternatives.

Mr. Bissett stated that one provision in Section 7 that appears to be specific to private flood insurance is the requirement that producers notify an applicant of the NFIP and private flood alternatives and then get them to sign a documented acknowledgement that the disclosure was made. IIABA has some concerns with that requirement. First, from a technical perspective, it is unclear when and to whom the requirement would apply. As currently drafted, it would apply to every conceivable insurance transaction of any kind. More critically, IIABA wonders about the benefit of the provision as it is really adding paperwork to what is already a paper-intensive and bulk transaction. NCOIL has also been very active in its innovation initiatives to try and make the insurance buying process more thoughtful and eliminate some unnecessary processes. IIABA's view is that adding more paperwork to this process is inconsistent with what NCOIL is doing in other areas. IIABA also believes there is somewhat of a false foundation to the provision as it ignores the idea that independent agents have a strong incentive to do these things anyway. Agents sell insurance as it is their job and if there are good and meaningful private market alternatives out there, they will talk about them with their clients.

Mr. Bissett stated that IIABA also sees some practical issues with the proposal. IIABA wonders what will happen if an agent, especially a direct agent or a captive agent, is not authorized or appointed to sell private flood insurance. Agents do not want to be in a position of talking about carriers and products they are not authorized to sell on behalf of. That is typically something that is not completely within the agent's control. IIABA is also worried if there are not good private flood insurance options in a particular state. Not every carrier is a good carrier and maybe they have a track record that for whatever reasons would cause an agent to be hesitant in placing a client with that company. Putting agents in a position of potentially highlighting and marketing products for those type of carriers is troubling.

Mr. Bissett stated that IIABA views the Model as completely well-intentioned but thinks it is unnecessary in light of some of the market forces in play. IIABA urges the Committee to consider some other issues that relate to the intersection of existing state law and the emergence of private flood. IIABA has submitted comments to the Committee in that regard. One concept relates to the idea of a continuing coverage notice which would address a private flood insurance-specific problem that was in Rep. Santiago's Florida bill and which other states are looking at. IIABA believes this issue is important because under current federal law, a consumer has to maintain consistent continuous coverage with the NFIP if they qualify and want to maintain a subsidy. If a consumer does not have continuous coverage and went to a private carrier, they would lose the subsidy. The typical consumer may not be aware of that reality. That may be something the Committee should consider with regard to considering meaningful disclosures to consumers.

Another notice-related provision to consider is that with the expansion of the private flood insurance market, figuring out how cancellation and non-renewal notice requirements apply. This is going to be particularly important for someone who might have a private flood policy cancelled and they need to then get back into the NFIP. The reason this is important is because in order to get NFIP coverage there is a 30-day waiting period from the time of purchase. So if you are in a state that only requires cancellation notices to be provided 30 days in advance of a cancellation, a person in that situation of losing a private flood policy and needs to get back into the NFIP will have a gap in coverage. IIABA has proposed that states contemplate at least a 45-day notice requirement for private flood carriers so that there is a window of time for the consumer

not to have a gap.

Mr. Bissett stated that the final provision that IIABA has proposed relates to surplus lines placements. IIABA suggests considering whether to eliminate the so-called diligent search requirement in connection with private flood placements either on a permanent or temporary basis. There have been a number of states recently that have done away with diligent search requirements altogether and that could be something that is helpful in terms of bringing about some innovation in the marketplace. Mr. Bissett thanked the Committee for its consideration and noted that IIABA looks forward to being a part of this process going forward.

Birny Birnbaum, Director of the Center for Economic Justice (CEJ), stated that CEJ applauds NCOIL for its work in trying to close the flood insurance gap. Before commenting on the Model, Mr. Birnbaum commented on a broader strategy to address the protection gap. The Committee's work is laudable, but it still is nibbling around the edges as the only way to truly close the protection gap is for the states to take back flood. There is a good model for federal-state cooperation that preserves state regulation – the Terrorism Risk Insurance Program (TRIP). State regulators should push for changing the NFIP from a direct insurer to a reinsurer that caps massive exposure coupled with mandatory offer by private insurers regulated by the states. It is unclear why the states aren't clamoring to take back flood like the states regulate every other type of property insurance peril.

Regarding the Model, Mr. Birnbaum noted that Section 4(a) states that "the [state entity for regulation of insurance] may audit an insurer's flood rates to ensure compliance with state laws and regulations" but the Model doesn't provide any consequences if the Commissioner finds that the rates are excessive or unfairly discriminatory and it doesn't give the Commissioner, for example, authority to order restitution or to order the company to refund rates that are found to be excessive. There should be something there to say what the consequences are if the Commissioner does in fact find the rates to be non-compliant.

Mr. Birnbaum stated that Section 4(b) of the Model states that the rates do not have to be filed until 30 days after the use. CEJ does not see any reason to delay the filing of the rates. If an insurer has new rates it has to communicate those rates to producers and distribute them before the effective date in order to allow the rates to be incorporated into rating software. The rates are set well before an insurer can implement them so there is no reason not to file the rates with the Commissioner at or before the implementation date. If the Commissioner finds that the rates are excessive or unfairly discriminatory, it is important to minimize the amount of times the noncompliant rates have been used and have harmed consumers.

Section 5 of the Model relating to forms says that the Commissioner may require the filing of forms, but the Model is silent as to the process. It is not clear whether this is something the Commissioner may decide on his or her own and with or without any public input such as via a rulemaking process. CEJ suggests that the Model provide some guidance as to how that decision is developed and communicated. CEJ also believes that review of forms is essential as these are complex contracts and consumers rely upon regulators to make sure that such contracts do not contain misleading or confusing terms. Mr. Birnbaum also noted that federal agencies have recently adopted rules for banks to accept private flood. One of the rules states that banks may accept

non-standard forms as long as the insurer stamps on the form that the forms have provisions that meet or exceed the requirements of the NFIP, but there is no review of that. Accordingly, CEJ asks that the Model be integrated with those federal rules to the extent necessary.

Mr. Birnbaum further stated that Section 6 of the Model talks about a plan of operation, but it is unclear how a plan of operation is different than a rate filing. Section 7 regarding producer responsibilities talks about a best practice to maintain records. CEJ is not clear what a best practice is in a statute. If it is a requirement, then it is not clear how the regulator should deal with it. If the Model is requiring that the producer make certain disclosures, then there must be some mechanism by which the regulator can determine whether the disclosures have been made. It should not be a best practice to maintain documents – it should be a requirement. Having said that, CEJ concurs with many of the things stated by Mr. Bissett regarding producers and disclosures. As someone who has been working extensively with consumer disclosures for many decades, more disclosures do not necessarily help consumers. A disclosure can simply be one more page on top of a pile of pages that the consumer is already not paying attention to. Mr. Birnbaum stated that if the Committee wants to require disclosures then this regulatory tool should have the same sort of regulatory expertise as any other type of regulatory tool which means there should be expertise in the design of disclosure format and the timing of the disclosure format. The use of electronic disclosures should also be considered which is consistent with NCOIL's insurance modernization work. This is an area where disclosure could be provided electronically that might be far more useful than a paper disclosure.

Dennis Burke, VP of State Relations at the Reinsurance Association of America (RAA), applauded the Committee for improving the Model and stated that it is important to avoid doing no harm moving forward. Past experiences have shown in some states that definitions can be too broad which can swallow the commercial market, even comprehensive auto, and it is therefore important to make sure the Model achieves the legislative objective of enhancing the regulatory structure in such a way that the market is facilitated yet still maintaining consumer protections. Mr. Burke stated that it is important to make sure that it is understood exactly what the Model is trying to achieve. If we want it to apply to all aspects of flood, we probably must make a lot of changes but if we are only trying to address the policies that are as broad as the NFIP and facilitate the use of those forms and the rates associated with them using the NFIP price as the de facto rate regulator then certain changes should be made to Section 5 which Mr. Burke noted he has submitted to NCOIL staff.

Mr. Burke noted that the "as broad as" section only applies to those who are in the special flood hazard area. It does not apply to people who don't have mortgages so you can be in that zone but if you don't have a mortgage you can buy any type of policy or no policy at all. It is important therefore to provide as many opportunities as possible for the private market and make sure certain avenues aren't closed off so that consumers can be given more choices. Mr. Burke stated that he looks forward to working with the Committee on the Model going forward.

Lauren Pachman, Counsel and Director of Regulatory Affairs for the National Association of Professional Insurance Agents (NAPIA), stated that with regard to the Model's disclosure requirement related to agents, NAPIA believes that the requirements are good for agents and they really should be doing the things required by the Model

anyway. NAPIA's members are exclusively independent agents – they are not captive agents and they routinely lay out options and provide alternatives and explain thoroughly what choices are available to their customers or potential customers. The Model requires those agents to provide information about NFIP products and private market alternatives and that is their job irrespective of the Model. Customers rely on agents to provide information and distill the complexities of the NFIP and the private flood market into a format that they can easily digest and make an educated decision based on. NAPIA's members are well versed on the market availability of various options including those in the private market as well as those through the NFIP and are confident in their ability to execute on those obligations. Any good agent is going to notify a customer that their homeowners' coverage doesn't automatically extend to flood insurance. Generally, NAPIA supports ideas that protect agents from unwarranted lawsuits by homeowners who retroactively decide that the educated decision they made at the time now seems less wise with the benefit of hindsight. When customers are fully informed and make an educated choice there is more protection for agents if there is a piece of paper that has the homeowners signature that says "I was given all of this information and I was able to make an educated decision about it." Accordingly, Ms. Pachman noted that NAPIA supports the Model's disclosure requirements.

John Meetz, State Relations Manager at the Wholesale and Specialty Insurance Association (WSIA), stated that WSIA represents surplus lines brokers and carriers throughout the U.S. Mr. Meetz stated that WSIA supports the amendment submitted by IIABA regarding surplus lines placements and the diligent search requirement. Typically, a P&C agent is required to conduct a diligent search of the admitted market before they are able to place insurance in the surplus lines market – the IIABA amendments would create an exemption for that. There are a number of states already doing that, so it is not a fringe concept (13 states; and another 7 states have a piecemeal approach to it).

Mr. Meetz noted that WSIA does not typically advocate for diligent search exceptions as it usually lets the IIABA lead as they are the source and know when these types of coverages are not available in the admitted market so WSIA is piggybacking on the IIABA. Any successful exemption is going to require some vigilance and a sunset or a limited exemption may be considered. That is a conversation to have with regulators to determine what the availability of private flood in the admitted market is in a given state. Whitney Lane, on behalf of Lisa Miller & Associates, spoke in support of the Model, particularly the consumer education provisions in Section 7. Florida already has such language and now has over 30 private flood insurance companies offering coverage. The Model will also create competition in the marketplace and allow more affordable choices for consumers. Ms. Lane stated that Ms. Miller looks forward to continuing to work with the Committee on the Model.

Rep. Keiser stated that the Model sounds so much like long term care it scares him. Also, with states that have prior approval of forms, that system tends to work because the regulators frequently catch issues and bring them to the surface and then they get changed. Rep. Keiser stated that he has concerns with the Model, particularly Sections 4(a) and (b). Section 4(a) is essentially a form of self-regulation. Section 4(b) sounds so much like long term care because it essentially states that the insurer can change the rates at any time. Rep. Keiser stated that North Dakota legislators have received so many calls from people who have paid their premiums for so many years and suddenly their rates tripled, and they cannot afford them. Rep. Keiser asked the panel if they would support the inclusion of an exception to the state guaranty fund. In long term

care, when Penn Treaty went down legislators are paying for that because it went to the state guaranty funds with a provision that insurers get credit on their premium taxes which affected state budgets. Rep. Keiser stated that he does not want to be in that position again.

Mr. Jackson stated that different states have and will, regardless of what NCOIL does with this Model, have different filing requirements for rates and forms. Florida has exempted flood rates from the prior approval statute for several years but the rates are still subject to the same standards that have been in effect for all insurance rates and the Commissioner has the authority to act if he or she finds that those rates do not meet those standards. There has been no indication that Commissioner Altmaier's office, or other states that have provided flexibility on rates, have seen problems and felt like they needed to roll the flexibility back though certainly they can do so if problems developed.

Mr. Birnbaum stated that the Model does not completely de-regulate rates as it has a use and file provision. CEJ suggests that it become a file and use provision, but it nevertheless authorizes the Commissioner to review the rates and make decisions although it does not speak to what happens if the Commissioner finds a problem. Regarding guaranty fund coverage, long term care is covered by the guaranty fund, but flood insurance issued by a surplus lines brokers wouldn't be because they are not members of the guaranty fund. If there is a concern, and it is reasonable to have one because we are talking about a catastrophic risk that can wipe out a small carrier in a major event, then the Committee may want to start thinking about ways to incorporate this into a guaranty fund framework or do what Florida does as they have an alternative to a guaranty fund for some of the surplus line business.

Rep. Keiser stated that as he understands it the Model would expand coverage options from the surplus lines to the P&C market. Mr. Birnbaum stated that an admitted carrier has always been able to offer flood if they wanted to, as have surplus lines writers. The intent of the Model is to prod both admitted carriers and surplus lines writers to offer more private flood. What we have seen is that the bulk of the new coverage, at least on the residential side, is being written by surplus lines because there is less oversight of rates and forms. The Model does not change that particularly but the theory that insurers offer is that once they get to know the business through the surplus lines market then it will migrate to the admitted market. It is not clear if that is factual, but the bottom line is that there is a need for sales of private flood and that is what the Model is trying to get at. Mr. Birnbaum stated that it is a small step but one that CEJ supports – CEJ would rather see a broader proposal.

Rep. Matt Lehman (IN) – NCOIL Vice President – stated that he believes the Model is a broad work in progress and it is something that the Committee needs to get right as it is a big issue facing the agent community, the insurers and on a larger scale, the banks. Rep. Lehman stated that he hopes the Committee can continue to make progress with the Model because as with other coverages, the true solution is the standard market stepping in with a solution. The surplus lines market has its role but ultimately as more data comes forward the goal should be figuring out how to make this product affordable in a standard homeowner's policy.

LESSONS IN NATURAL DISASTER RECOVERY

Michael Hecht, President & CEO of Greater New Orleans, Inc. (GNO), stated that the

Coalition for Sustainable Flood Insurance (Coalition) is something that was started in 2013 after Biggert-Waters was instituted with best intentions but many unintended consequences came out of it. It started because there were individuals in the New Orleans region who saw their insurance increase from \$300 per year to over \$10,000 per year for properties that never flooded. The implications for not just the homeowners but for the entire economy was awful. The Coalition ended up growing and eventually encompassed over 250 organizations across 35 states.

Led by GNO, and in partnership with the Delegation, the Coalition succeeded in passing the Homeowner Flood Insurance Affordability Act of 2014 (HFIA). The catalyst was really Hurricane Sandy as when Wall Street flooded it was then perceived as not just a problem in Louisiana but something that was a national issue. HFIA was celebrated as a victory but it really only got things back to pre-Biggert-Waters. Mr. Hecht stated that flood insurance is important because wherever it rains, flooding can occur. Accordingly, the insurance gap makes no sense and it is something that where folks who do not have flood insurance are socializing it on everyone else and that is not efficient from an economic or philosophical standpoint. Whether you want to use the words climate change, the reality is undeniable as volatile weather is increasing.

Mr. Hecht stated that one of the issues that has been difficult to explain to people, particularly in New Orleans, is that this is not just an issue of people owning their beach homes and wanting to get them rebuilt when the carpeting gets wet. The reality is that the reason why New Orleans is there and the reason why one third of the country was purchased for a very good price is because being by the water is essential for commerce and defense. If you look at the numbers, the majority of the country lives by the water and the numbers will only increase. Coastal areas have a GDP of \$11 trillion - 57% of the total U.S. GDP. Accordingly, living and being sustainable by the water is not a luxury or vacation issue but rather fundamental to the economic and security future of the nation.

Mr. Hecht stated that people do not have flood insurance because they do not think they are going to flood; a moral hazard situation of being bailed out by FEMA/the federal government; or they might simply have bad information. For all of those reasons, there has been inadequate coverage and it is an inefficient way of addressing the increasing risk of flood. Mr. Hecht stated that the Coalition believes the following key principles are critical to sustainable flood insurance (RAMP): Risk Assessment – Enhancing the way we assess and communicate risk will protect communities and the NFIP over the long-term and help to close America's flood insurance gap. Congress and FEMA should use state of the art technology to accurately and simply communicate flood risk; Affordability – Premiums must remain affordable, and people who played by the rules at the time they built or bought their flood policy should not be penalized; Mitigation – A comprehensive approach to reducing flood losses before a disaster occurs is a more effective means to reducing economic loss and protecting taxpayers interests. Federal, state, and local governments should prioritize investments in mitigation, as should home and business owners; and Participation – Adopting policies that encourage more people to carry flood insurance will ensure a greater understanding of flood risk and that individuals and communities recover more quickly and fully following a flood event.

Mr. Hecht stated that progress has been made on each of those principles. The Disaster Recovery Reform Act of 2018 was signed into law making numerous investments in mitigation and disaster recovery, including addressing the duplication of

benefits issue. FEMA should also be applauded for announcing its moonshot goals of doubling coverage and quadrupling investments in mitigation by 2022. Regarding risk assessment, the Coalition encourages all of the elements, including laser technology, to better communicate risk to individuals, communities and insurance companies. The risk rating 2.0 that is now being delayed another year by FEMA in theory fulfills this promise, but the devil is in the details. Now that we will be considering not just base flood elevation but also the threat of water above and the proximity to water, you have to have better accuracy as well.

Regarding affordability, grandfathering must be preserved. If someone moved into their house and bought the asset with a certain expectation of what they carry in costs for that home, including insurance costs, it does not make sense to blow them out of the water if that homeowner has done nothing wrong. That will only precipitate a domino effect in the community. To help with this you can allow for monthly payments of premiums, and formalize a 1% cost ratio that says premiums would be capped at 1% of the value of the policy. Affordability is going to end up being non-negotiable because ultimately it is a pocketbook issue. Bigger-Waters got turned back not because of ideology or philosophy but because of affordability.

Mitigation needs to occur at an increasing rate. A revolving loan fund needs to be established for mitigation and it is strongly encouraged to take the interest that is now being paid on NFIP's debt and put that into a mitigation fund. It is also suggested that the maximum increased cost of compliance coverage payment be increased from \$30,000 to \$100,000, and that people should be encouraged to take steps to mitigate in the first place so that they will not be in a position to file claims. Regarding participation, the trends are troubling regarding decreased participation in the flood insurance market. The Coalition has thought about ways to improve participation such as mandates, but people generally hate mandates. Accordingly, it may be better to offer a tax credit for flood insurance premiums so that people will have a proactive reason to purchase it. The numbers are still being crunched on that to determine if it will end up being a net-positive to Treasury.

Mr. Hecht stated that the Coalition wants to continue to develop a bipartisan, common sense approach to fixing an issue that is only going to become more intense going forward, and do it in a way that preserves people in their homes and ensures the ongoing sustainability of the NFIP. This is not going to happen overnight, but the problems are solvable.

Rep. Keiser stated that the number of homes in flood plains not being covered is a problem but noted that it is important to look at the flood insurance plan. In states like North Dakota, which floods a lot, homes are built with basements and people live in them. That part of the structure is not covered by flood insurance although the furnace and water heater are. Therefore, it becomes a cost-benefit analysis and in some respects, people are making good decisions to not purchase flood insurance.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
AUSTIN, TEXAS
DECEMBER 12, 2019
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the JW Marriott Hotel in Austin, Texas on Thursday, December 12, 2019 at 2:00 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)	Sen. Paul Wieland (MO)
Sen. Jack Tate (CO)	Rep. Tracy Boe (ND)
Rep. Martin Carbaugh (IN)	Rep. George Keiser (ND)
Rep. Matt Lehman (IN)	Sen. Jerry Klein (ND)
Rep. Peggy Mayfield (IN)	Asw. Ellen Spiegel (NV)
Rep. Joe Fischer (KY)	Rep. Tom Oliverson, M.D. (TX)
Rep. Edmond Jordan (LA)	Del. Steve Westfall (WV)
Sen. Paul Utke (MN)	

Other legislators present were:

Rep. Deborah Ferguson (AR)	Sen. Gary Dahms (MN)
Sen. Dan McConchie (IL)	Rep. Donna Pfautsch (MO)
Rep. Doug Gutwein (IN)	Rep. Bruce Grubbs (MT)
Rep. Chris Judy (IN)	Sen. Shawn Vedaa (ND)
Sen. Andy Zay (IN)	Sen. Cale Case (WY)
Del. Mike Rogers (MD)	

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
Paul Penna, Executive Director, NCOIL Support Services, LLC
Will Melofchik, NCOIL General Counsel
Cara Zimmermann, Assistant Director of Administration, NCOIL Support Services

QUORUM

Upon a motion made by Rep. George Keiser (ND) and seconded by Rep. Joe Fischer (KY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Keiser and seconded by Rep. Matt Lehman (IN), the Committee approved the minutes of its July 11, 2019 meeting in Newport Beach, CA and its October 10, 2019 interim conference call minutes without objection by way of a voice vote.

CONSIDERATION OF NCOIL WORKERS' COMPENSATION DRUG FORMULARY MODEL ACT

Rep. Matt Lehman (IN), NCOIL Vice President and sponsor of the NCOIL Workers' Compensation Drug Formulary Model Act (Model), thanked everyone for their work on the Model and noted that the Committee has been working on the Model since its introduction in February, and most recently on an interim Committee conference call in October. Rep. Lehman stated that he believes the Model is in a good place and proceeded to explain the changes that have been made to the Model since the Committee's last in-person meeting in July.

Section 3 of the Model was amended to provide states the option of developing their own formulary by rule. Next, in Section 3, language was added to add evidence-based guidelines among the factors that a state must consider when developing or selecting a formulary. Next, throughout Section 4, the wording of "included but not recommended in the formulary" was changed to "listed but not approved in the formulary" as that is a better description of the categories of drugs on the formulary. Further, in Section 4, the timeframe within which to notify the prescribing physician and the injured employee of the third party's determination of a request to use a drug that is listed but not approved in the formulary was shortened from five business days to three business days. Lastly, a new section – now Section 5 – was added titled "Third Party Conflict of Interest" in order to ensure that the third parties resolving formulary disputes are conflict-free.

Rep. Lehman noted that his goal when developing NCOIL Models is always to develop a framework for states to consider, knowing that states may need to make certain changes to reflect market and other realities. Rep. Lehman stated that he believes the Model is in a good place and does in fact serve as a good basis for states to consider adopting.

Upon a Motion made by Rep. Joe Fischer (KY) and seconded by Rep. Martin Carbaugh (IN), the Committee voted without objection to adopt the Model by way of a voice vote.

DISCUSSION ON POST TRAUMATIC STRESS SYNDROME (PTSD) COVERAGE AND OTHER EXPANDING BENEFIT CHANGES IN THE WORKERS' COMPENSATION INSURANCE MARKETPLACE

Professor Michael Duff of the University of Wyoming College of Law stated that it seems that the issues of PTSD coverage and firefighter presumption within the workers' compensation marketplace are growing in popularity. One might ask, why now? Prof. Duff stated that when covering these issues with his students, he often asks them what reservations they have with emotional injuries and he is surprised by what they tell him. Traditionally, we know that there is a history of our legal system going back to the early 20th century or earlier of resisting the concept of emotional harm when there is no accompanying physical harm, whether in tort or work comp. That boiled down to a few concerns such as too many fraudulent claims, too many trivial claims, and that the claims may be too hard to prove. What changes the situation is when you have a group of potential claimants who are especially sympathetic. The system really wants to do something to compensate people who are acting in the public service.

One of the things that really resonates with Prof. Duff's students is not that there will be too many fraudulent claims, but that there will be too many authentic claims which would then be very expensive. There is a U.S. Supreme Court case written by Justice Thomas

in 1994 and the issue was whether one could apply negligent infliction of emotional distress claims under a statute called the Federal Employers Liability Act (FELA) which is a railroad liability statute. There was no specific mention in the statute about whether or not it would cover mental injuries and Justice Thomas stated that he was not actually worried about fraudulent claims but rather authentic claims and how the system would deal with that. It is amazing how this issue has been with us for a long time. Prof. Duff noted that it looks like there will be hundreds of PTSD claims that could emerge from the Virginia Beach shootings. Prof. Duff again noted that his students often state they are not worried about fraudulent or trivial claims as the legal system has an obligation to remedy injuries – the system has to figure those things out just like it has to figure out authentic batteries or assaults from inauthentic batteries or assaults. We expect the judicial system and appropriate agencies to be able to do that.

Prof. Duff stated that he believes one of the things that is underappreciated is the extent to which PTSD has been driven by the viability of the negligent infliction of emotional distress claim. Once upon a time, if you were negligently harmed, but there was no physical harm, there was no recovery under tort law. Over a period of time, that began to change. When we think about the start of workers' compensation, we don't think about negligent infliction of stress as part of the quid pro quo – we thought about a broken arm and how that would be swapped out for a work comp statutory benefit. There was no question of a negligently caused emotional harm – it was not part of the quid pro quo. What started to happen, however, is that the idea of emotional harm starts to grow. Essentially, we wound up with something called the 'zone of danger' test whereby if you were never physically touched but harmed emotionally, that became a cognizable action under the law.

Prof. Duff noted that the quid pro quo we often think about is the swap of work comp for tort as it existed in 1911. However, as there are new kinds of negligence actions you must decide if you want to make employers liable in negligence or would you rather have the swap for work comp immunity. This is a conversation that never ends. A good example is from a case in Wyoming, *Collins v. COP Wyoming*, 126 P.3d 886 (Wyo. 2006), which involved a father and son being employed by the same company and the son was killed on the job by a track hoe. The father witnessed the death and brought a negligent infliction of emotional distress claim. The state and employer (WY is a monopolistic state) stated that the case was covered by the exclusive remedy rule and immunity. The WY Supreme Court allowed the action because under WY law, a definition of injury doesn't include any mental injury unless it is caused by a compensable physical injury that occurs subsequent to or simultaneously with the physical injury and it is established by clear and convincing evidence. That is often referred to as the physical-mental rule – if there is a physical injury, accompanying mental injuries, such as depression resulting from a bad back, are compensable.

Prof. Duff stated that if you agreed with what the state/employer was arguing in that case there would be no work comp remedy because work comp excludes mental-mental injuries, and there would be no negligent infliction of emotional distress. The WY Supreme Court said you cannot do that as a matter of state constitutional law. There are a number of states, about half of them, that have no coverage for mental-mental injuries. Accordingly, what do you do if there is no coverage for mental-mental but there is a viable action for negligent infliction of emotional distress? There is an asymmetry there. Prof. Duff stated that he believes part of what is driving this issue is that there is a recognition that tort liability exists – somehow you are going to have to give somebody a

cause of action for this species of injuries because that cause of action has become more viable.

Prof. Duff stated that there are some parallels between PTSD and occupational disease. One of the similarities between those two expanding issues is that just as something like PTSD or mental-mental was virtually inconceivable in 1911, that has begun to change. Early English Act covered occupational disease and even had presumptions so that the idea disease-presumption is new in the law is not true. Essentially, there is a schedule set up which says if you get a certain kind of injury and it occurred in a certain kind of process, we are going to presume that the injury or disease arose out of the employment. That presumption existed from the beginning. Why? – because that was going to be very hard and expensive to prove. And if at the end of the day you have most plaintiffs losing what are you going to do about the cost? Insurance legislators know that costs never go away – they shift.

Prof. Duff stated that American states started adopting presumptive disease models in about 1920 in New York. However, there was no mention in those early statutes about what we mean as to what a presumption really is and how does it really operate. Prof. Duff stated that there are currently a variety of statutes that set out the criteria as to when a presumption is created and what the thresholds are. The crux of most of those statutes are that it has to be an individual in a statutorily designated job classification such as a firefighter, public safety officer, or first responder – they are defined different ways in different statutes. Secondly, the individual must have had a pre-employment physical which reveals no evidence of an illness or disease for which benefits are sought. Thirdly, the individual must have been employed for a statutorily required time period before presumption can apply. Prof. Duff stated that he believes in Texas that time period is five years. Fourthly, the individual must be seeking benefits for an illness or disease covered by the law that is discovered during employment in the classification – that disease must be the right kind of disease and it must have been discovered during employment. To put this in work comp doctrinal terms, these criteria are basically seeking to take out the notion of a pre-existing condition. Usually, these presumptions deal with cancers but there are heart-lung statutes that can be broader and cover tuberculosis, heart disease, or hypertension.

Prof. Duff stated that the idea is that the criteria are the establishment for the creation of a presumption. Now the question becomes what that means – it means that we presume that the workers' disease or condition was caused by work. It is a presumption of causation, but that does not resolve the issue. In evidence law there are various types of presumptions ranging from weak to strong. By weak, it means that the employer has to do the least to overcome the presumption. By strongest, it means that the employer to do the most to overcome the presumption. The weakest kind of presumption is something called the bursting-bubble presumption, also known as the Thayer-Wigmore presumption. The idea here is that once the presumption has been created, all the employer has to do is provide some substantial evidence that is counter to the presumption that has been created. What that exactly means is determined in case law from state to state. If that happens, the presumption falls out of the case completely – the bubble has burst. Once that bubble has burst, the position that the employee is in is that it is as if the presumption never existed so the employee would then have to show additional, expert evidence to show that the disease was caused by work. That is the weakest presumption because the employer does not have to do a lot to overcome the presumption.

Prof. Duff stated that an intermediate position is the so-called Morgan presumption. The Morgan presumption is probably the type of presumption that most states are following now that have enacted presumptions. Under Morgan, after the presumption has been created, it stays in the case as positive evidence. Another way to look at it is if that when the presumption has been created, it is no different than if you had put an expert witness on as an employee and established that there was evidence in support of causation. Once that is created, it never falls out of the case – it is positive evidence of causation. Additionally, once that positive evidence exists, it shifts the burden of both production and persuasion to the employer. The employer then has to show that the disease is not caused by employment, so the shoe is on the other foot. The employee has positive evidence that the disease is caused by work, and the employer is in the position of having to disprove that it is caused by work. Just as it is hard to prove that a disease is caused by work, it can be very hard to prove that the disease is not caused by work. So, if you shift the burden to the employer, there are going to be more instances in which the employee is likely to prevail.

Prof. Duff stated that when he speaks about burden shifting and presumptions, they are all rebuttable presumptions meaning that if the other party wants to present evidence in opposition to the presumption they certainly can – but the thumb is being put on the scale one way or the other. There are also Morgan-like presumptions where there is a lot of control over what the employer is permitted to do to attempt to rebut the presumption. For example, the California Labor Code Section 3212.4 states that you cannot attribute the current disease-state to a pre-existing condition which Prof. Duff thinks means is that you are not automatically disqualified as an employee if you had a pre-existing condition. There are even presumptions that say it is not enough to show that it was not related to employment – you also have to prove a specific non-related cause. You get the sense that there is a great variety of how the presumptions are created, what they mean, and how they can be rebutted. Prof. Duff stated that another issue he has taught in his career is ERISA-employee benefits and one of the great motivators of the ERISA statute was to prevent disunity. You have a lot of disunity in the work comp presumption arena.

Prof. Duff stated that one of the things that he believes is missed in these discussions is that work comp expansion always simultaneously confers tort immunity. That is an important point because if you are going to do a full assessment and full cost-benefit analysis you are always simultaneously looking at tort liability avoided at the same time you are looking at work comp costs incurred. Prof. Duff stated that he encourages a full cost-benefit analysis of that type when considering the overall burden that presumptions put on the work comp system. Again – costs don't go away, they shift.

Robert Stokes, Esq. of Flahive, Ogden & Latson stated that he and fellow panelist Glenn Deshields, Legislative Director at the Texas State Ass'n of Fire Fighters (TSAFF), have worked on recent changes to the Texas statutory provisions involving presumptions. Mr. Stokes then provided some history on Texas presumptions. The first presumptive statutes were passed in 2005 in a major reform package that did a lot to Texas work comp. The presumption provisions were slightly buried in the reform and no one paid much attention to them for some time. For cancer presumptions – the marquee presumption that everyone seems to pay a lot of attention to, for good reason – the statute said that the presumption would attach to any form of cancer that had been determined as possibly related to firefighting, according to the International Agency for Research on Cancer (IARC). The IARC is an arm of the World Health Organization and

has studied cancer causation for decades and is a very well respected organization. The problem is that when that language was passed in 2005, there was no comprehensive study about the causation of firefighting and cancer at the IARC. They didn't publish their 98th monograph which looked at firefighting and cancer until 2010, so for five years after the presumption statute was passed, dovetailing into the IARC's determinations, there was no determination from the IARC.

Mr. Stokes stated that once that IARC made the determination, it was then realized that it was an 818-page document that started with A and went to Z and for 818 pages in between you had to interpret the document. Other states have adopted a list of cancers. The legislature in Texas felt like adopting the IARC's determinations was the process that made the best sense as it was scientific and based and grounded in a well-respected organization as opposed to going to a list that is subject to horse-trading and negotiation. The problem in Texas was that there was a fundamental disagreement about what the IARC had determined. Cities believed that the IARC had determined that there is a cause or relationship between firefighting and three types of cancer – prostate, testicular, and non-Hodgkin's lymphoma. Those cases were litigated for several years and it is no fun litigating cancer presumption cases. They are serious and tragic, and a position is taken that an employee in one of the most valued industries of service to the public is not entitled to benefits. They are hard cases to litigate and even harder for state adjudicators to decide down the middle. It is really hard for an Administrative Law Judge (ALJ) in a work comp case to rule against the firefighter or other public servant.

Mr. Stokes stated that there has been a lot of litigation going on since 2010 regarding what the monograph means. That has meant that in cases where people have serious diseases and illnesses, instead of getting the care that they need and getting back to work as quickly as they can to provide for their families, they have had to go into the work comp system, which is not a bad system, but it is not the best system for adjudicating these types of cases. There are some jurisdictions that have taken the presumption process and removed it from the work comp system entirely. That is a consideration for all jurisdictions that are looking at this problem. Mr. Stokes stated that if you are building a presumption process in the work comp system, you must look at two important things. The first is fundamental fairness to both sides – is it fundamentally fair to reverse the burden of proof and require the party who ordinarily does not have the burden of proof to bear it in a work comp claim. In some cases, it may well be. The argument is that these are hard cases to prove and when they are hard cases to prove and we want to compensate these diseases and illnesses, the way you do that is you either lower the burden of proof or reverse it.

Mr. Stokes stated that the counterargument to that is that some cases are very easy to prove, and we don't raise the burden of proof in those cases. The burden of proof is what it is and whether it's a hard case or an easy case it ought to be level. However, if you cross that policy threshold and say you want to do something to make these cases easier to prove, then you get to the three silos that Prof. Duff talked about. In Texas, the first silo requires that you have a clean bill of health, and that you have a duration of employment that is long enough so that it is fair to both sides to attribute the presumption to the employment. In Texas, the legislature deemed five years to be the timeframe for employment. Regarding the discovery of the disease during employment, that is a line that the legislature drew because they did not want to make this a retirement benefit plan and have to face cancer presumptions from employees who may not have worked for the city for 15 or 20 years. So, you have to be diagnosed with the

condition during your employment. Finally, Texas has an exclusion for tobacco use – if the employee is a tobacco user and the disease or illness that they are claiming the presumption for is known to be associated with tobacco use, then you don't get the benefit of the presumption; you get to prove your case conventionally using conventional forms of causation.

Mr. Stokes stated you then move to the second silo and that is where during this past legislative session, the Texas legislature did the Texas twostep – they removed reference to the IARC's research, but they used research that is found in that study to develop a list. The legislature developed a list of 11 types of cancer entitled to a presumption, 10 of which are solidly found in the medical research. Mr. Stokes stated that moves us to the rebuttal section which is where you have the city's opportunity to say ok, the presumption applies but because of something in your genetics or in your non-work related activity, we believe that suggests there may be another cause to the cancer and it is not fair for the presumption to apply. The bursting-bubble presumption is easy to understand and the other two are best illustrated by the movie My Cousin Vinny. The Morgan presumption is essentially the two characters in the movie saying, "we did not commit the crime and you need to balance our testimony with the prosecution's case." The strong Morgan approach is what the two characters ended up proving in the movie – not only did they say "we did not commit the crime" but they proved who actually did commit the crime.

Mr. Stokes stated that he would encourage states looking at work comp presumptions to look at all three silos and to try to apply an approach that match up well – if you create a weaker presumption then it is fair to have weaker precursors or a weaker rebuttal standard. If you give a city a situation where there is a presumption that is entirely one-sided, nobody knows what that is going to cost. That is a problem with managing risk – if you don't know what it is going to cost, you can't manage it properly and you can't finance it.

Mr. Deshields stated that the TSAFF represents 20,000 professional firefighters out of 180 locals in Texas. Regarding the 2005 Texas presumption legislation, TSAFF believed that the IARC was going to be a living document that was going to develop over time and it never really developed into anything that you could actually say which cancers were caused by firefighting. So, when TSAFF was actually going through the process with firefighters that had cancer, evidence was being used that showed what painters or roofers had to say that certain chemicals caused certain type of cancers. Those cases lasted two or three years and you would essentially have to prove causation to get a presumption.

Mr. Deshields stated that he was not a big proponent at first of having a list as he would presume that there were more than 10 cancers that could be caused by firefighting. However, in a broad field it is hard to get a path and that is where the problem was. It all boils down to money and cities were worried about going broke by paying for a lot of cancer cases and TSAFF was worried about litigation costs. Cases were starting to backlog as they go through an administrative process first and then they go into district court. Mr. Deshields does not believe one case has ever got out of district court. District court had not provided a decision that could be used going forward and going another 15 years following that path was untenable. Mr. Deshields stated that TSAFF's first shot at this during this past legislative session was basically a bill that gave the Texas Department of Insurance more authority to regulate providers such as cities and risk

pools and allow them to get legal fees in the cases. That was sought because in going through the entire process, the firefighter would be able to get back their medical costs and their lost time but the attorney would then get 25% of that so it did not make a lot of sense that TSAFF could not get legal costs. That was the original goal but then it morphed into an omnibus bill that brought in presumption, legal costs, and other things into it and looked a lot different than what TSAFF originally wanted.

Mr. Deshields stated that TSAFF started with the World Trade Center list which he believes had a list of about 24 cancers. Through compromise, the list of 11 was finalized. Mr. Deshields stated that he believes it is going to take a long time before Texas knows how things will work out with the list. TSAFF's experience with presumptions thus far has actually been pretty negative. 90% of cancer claims are denied in Texas and a lot of treatment protocols in Texas are outdated although that is starting to get better. There is no standardized bureaucracy throughout the state and there was basically a resistance from cities and risk pools for any change simply because they did not know what the cost would be - \$10 million per year or \$100,000 per year? Those providers, especially a self-insured city, has to put money aside so that they can pay for the treatment. TSAFF was essentially in a worse position than if they were going with private insurers. Mr. Deshields stated that one of the authors of the bill, Rep. Dustin Burrows (TX), actually brought that issue up.

Mr. Deshields stated that it is going to be a long road ahead for everyone involved with this Texas legislation. It will probably be five years before it is known whether the bill has worked. Regarding PTSD, Mr. Deshields noted that he is from a generation that has known nothing but war and PTSD has always been on the forefront. A lot of Mr. Deshields' friends came back from war different people and a lot of firefighters were in the military. Accordingly, TSAFF started to notice a lot more focus being put on PTSD and people in their 40s now are starting to see the strain of a career involving seeing horrible things every day. TSAFF realizes that if you want to go get a work comp claim for PTSD, you basically have to file as mentally ill and no one is going to do that so they were trying to get treatment elsewhere or they just weren't getting treated. Careers used to last 20 years but now last 30-35 years. So, trying to carry that on for that long is a drag as it costs a lot of money. If someone is not performing as they should and not doing a good job, the taxpayers are not getting a good deal.

In 2017, TSAFF looked to just get PTSD as a compensable thing in work comp. That legislation was passed and there was one hang-up with one risk pool that wanted to define one single event as being the cause of PTSD. That went against what a lot of psychiatrists said but in order to get the bill passed, it was agreed upon. Psychiatrists said that they were just going to ask the firefighter for a specific event then. Prof. Duff stated that there is a reason for that which is that historically, work comp has focused on accidents arising out of the course of employment. So, if you have multiple events then by definition it is not an accident. That is one of the ways the work comp doctrine doesn't fit and is not coherent with certain situations such as PTSD. The same thing is seen with pre-existing conditions and you have some kind of combination between an event and a pre-existing condition – it is the hardest thing historically for the work comp doctrine to deal with. Mr. Stokes stated that you have to draw the line between multiple events and generalized work stress because every state that has had a court that has adopted a system that compensates in the work comp system for generalized stress in the workplace has failed. Texas did find a way to draw the line as it adopted multiple events with language that was sought to be clear that is not an open door to generalized

stress claims.

Mr. Deshields stated that during the past Texas legislative session, legislation was passed to be clear that it had to be multiple events which is a big deal for TSAFF. Mr. Deshields stated that he is not under any illusion that a lot of people are going to file these types of claims and he does not even know of one thus far. There have been a few cases that have tried to be filed and the big issue is that if PTSD or mental illness is preventing someone from doing their job, they can get taken in to see if they are fit for duty. A lot of people are worried that if they file a work comp claim then that is going to happen. Accordingly, a lot of people are probably not going to run through that door. TSAFF's major goal was to push departments in the direction of identifying these issues before they became serious problems. Some departments have done such and actually have psychiatrists that are on staff or paid for. Mr. Deshields stated that peer to peer support has not really worked which was pushed hard for, but it has not resulted in any decline in suicides.

Accordingly, TSAFF believes that there probably needs to be a heavier focus on PTSD on the front end by the city such as de-briefing after bad situations. Mr. Deshields again stated that he will probably only see one or two claims field this year, if any, but it is something that needs to be pointed out because there are a lot of people suffering and every firefighter can tell you of a bad situation from 1987. That is PTSD but it does not need to be treated. Also, TSAFF has conducted research that has shown that PTSD is relatively cheap to treat as long as it doesn't go too far. TSAFF's issue is that if a person ends up with PTSD through work and they need to be medically retired, they must be able to still receive treatment after that.

Sen. Jerry Klein (ND), Acting Chair of the Committee, asked what the prevalence of cancer is among firefighters and also asked if they are going to be penalized, in the legal sense, for not being properly suited with necessary equipment. Mr. Deshields stated that the latter issue is a very big issue for TSAFF as it has been pushing for clean gear initiatives and measures were passed in Texas in 2018 through the Texas Commission on Fire Protection that strengthened the requirements on clean gear. The National Firefighter Protection Association just passed new, stricter rules on clean gear which every department in Texas that is regulated will have to follow. There are certain departments in Texas that have two sets of gear and if they make a fire, they are actually brought a new set of gear when they are on scene and the "dirty" gear is packed up and taken back to be cleaned. The issue of clean gear may be one of the biggest causes of cancers among firefighters. If you look at the aforementioned list of cancers in Texas, lung cancer is not on there because of proper gear. Firefighters actually have a lower rate of lung cancer, not caused from smoking, than the general public – generally because they are healthier and in better shape.

Mr. Stokes stated that the work comp system is a no-fault system so no employee should ever be penalized because the employee acted negligently that was part or all of the cause of illness or injury. Also, the nature of firefighting today compared to how fires were fought in the U.S. and across the world is important to consider as so much of the research took place quite some time ago. The studies that are looking at the way fires are fought today will tell you that the firefighter today is primarily an EMT that occasionally fights a fire. And statistically, the largest study shows that approximately 4-5% of all runs that firefighters make today involve fighting fires. Mr. Deshields stated that the old fires referenced by Mr. Stokes involve basically wood and the stuff being

fought now is plastic and tar – much worse stuff to be near. Sen. Klein noted that older communities often have asbestos present.

Sen. Cale Case (WY) asked Prof. Duff how the WY presumption law regarding “predominance” fits within the overall presumption landscape. Prof. Duff stated that WY has a particularly tough version because the predominance standard does not apply to mental-mental injuries. In other words, there is no coverage of mental-mental injuries at all. So, we are talking about a situation involving physical-mental injuries and you still have to show by predominance that the mental injury was caused by the physical injury.

Asw. Ellen Spiegel (NV) stated that there was an incident in her city in Nevada where a father and son were both firefighters. The father had PTSD from his line of work and committed suicide. The son who had been in treatment for PTSD as well also committed suicide. The city decided that they would count the son’s death as a line-of-duty death. Asw. Spiegel asked if that decision establishes a precedent that could be used in future work comp cases. Prof. Duff stated that it is tough to say without reading the case and knowing the basis for the decision, but he imagines it could be used as precedent and it is up to lawyers to parse the decision and argue.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:15 p.m.