

**30 DAY MATERIALS* AND TENTATIVE GENERAL
SCHEDULE
NCOIL “SUMMER” MEETING
SEPTEMBER 24 - 26, 2020**

As of September 11, 2020, and Subject to Change



**Hilton Alexandria Old Town
Alexandria, Virginia**



NCOIL “SUMMER” MEETING

Alexandria, Virginia

September 24 - 26, 2020

TENTATIVE SCHEDULE

THURSDAY, SEPTEMBER 24th

Registration	9:00 a.m.	-	6:00 p.m.
Joint State-Federal Relations & International Insurance Issues Committee	3:00 p.m.	-	4:00 p.m.
Special Committee on Natural Disaster Recovery	4:00 p.m.	-	4:30 p.m.
Property & Casualty Insurance Committee	4:30 p.m.	-	6:00 p.m.
Adjournment	6:00 p.m.		
Welcome Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, SEPTEMBER 25th

Registration	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.
Workers’ Compensation Insurance Committee	10:00 a.m.	-	11:30 a.m.
Health General Session COVID-19: Testing, Treatment, and Vaccination	11:30 a.m.	-	12:45 p.m.
Luncheon with Keynote Address	12:45 p.m.	-	2:15 p.m.

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

NCOIL – NAIC Dialogue	2:15 p.m.	-	3:30 p.m.
Networking Break	3:30 p.m.	-	3:45 p.m.
General Session Future Pandemics: Approaches to Dealing with Business Interruptions	3:45 p.m.	-	5:30 p.m.
Adjournment	5:30 p.m.		
CIP Member & Sponsor Reception	5:45 p.m.	-	6:45 p.m.

SATURDAY, SEPTEMBER 26TH

Registration	8:00 a.m.	-	1:00 p.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:30 a.m.
Life Insurance & Financial Planning Committee	10:30 a.m.	-	11:45 a.m.
Health Insurance & Long Term Care Issues Committee	11:45 a.m.	-	1:15 p.m.
Business Planning Committee and Executive Committee	1:15 p.m.	-	2:00 p.m.
Adjournment	2:00 p.m.		



*****Please note all speakers listed are scheduled to speak as of September 11, 2020. It is not yet finalized as to which speakers listed will be speaking in-person or virtually. There may be modifications between now and the start of the Meeting.*****

THURSDAY, SEPTEMBER 24, 2020

Joint State-Federal Relations & International Insurance Issues Committee

Thursday, September 24, 2020

3:00 p.m. – 4:00 p.m.

Chair: Sen. Bob Hackett (OH)

Vice Chair: Sen. Roger Picard (RI)

- 1.) Call to Order/Roll Call/Approval of March 6, 2020 Committee Meeting Minutes
- 2.) Discussion on Europe's Insurance Regulatory Response to COVID-19
Matt Brewis, Director of General Insurance and Conduct Specialists – Financial Conduct Authority (FCA)
- 3.) Federal Response to *Dynamex*: Discussion on U.S. Department of Labor Employee Classification Regulation
James A. Paretti, Jr., Shareholder – Littler Mendelson P.C.
Joe Capurro, President – California Applicants Attorneys Association (CAAA)
- 4.) Any Other Business
- 5.) Adjournment

Special Committee on Natural Disaster Recovery

Thursday, September 24, 2020

4:00 p.m. – 4:30 p.m.

Chair: Sen. Vickie Sawyer (NC)

- 1.) Call to Order/Roll Call/Approval of March 6, 2020 and May 1, 2020 Committee Meeting Minutes
- 2.) Consideration of NCOIL Private Primary Residential Flood Insurance Model Act
Rep. David Santiago (FL); Sen. Vickie Sawyer (NC) – Sponsors
NAMIC Representative
Frank O'Brien, VP, State Gov't Relations – APCIA
- 3.) Any Other Business
- 4.) Adjournment

Property & Casualty Insurance Committee

Thursday, September 24, 2020

4:30 p.m. – 6:00 p.m.

Chair: Rep. Bart Rowland (KY)

- 1.) Call to Order/Roll Call/Approval of March 6, 2020 and July 24, 2020 Committee Meeting Minutes
- 2.) Continued Discussion on NCOIL Distracted Driving Model Act
Sen. Bob Hackett (OH); Asm. Ken Cooley (CA) – NCOIL Vice President – Sponsors
Nicole Nason, Administrator – Federal Highway Administration
NAMIC Representative
Jennifer Smith, CEO, Co-Founder – StopDistractions.org
Bri Jesionek, P&C Product Development – Nationwide
Annalia Michelman, Senior Legislative Attorney – American Medical Ass'n (AMA)
- 3.) Discussion on the Future of Transportation and Impacts on the P&C Industry
Robin Chase – Co-Founder and Former CEO of Zipcar; Founder and Former CEO of Buzzcar
- 4.) Re-adoption of Model Laws
 - a.) Post Assessment Property and Liability Insurance Guaranty Association Model Act (originally adopted Nov. 2007; amended March 2015)
 - b.) Model Act Regarding Medicaid Interception of Insurance Payments – (adopted November 2014; amended March 2015)
 - c.) Storm Chaser Consumer Protection Act – (adopted July 2015)
 - d.) Model Act Regarding Use of Credit Information in Personal Insurance – (originally adopted November 2002; re-adopted November 2005; amended 2009; re-adopted November 2015)
 - e.) Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers – (adopted July 2015)
- 5.) Any Other Business
- 6.) Adjournment

Welcome Reception
Thursday, September 24, 2020
6:00 p.m. – 7:00 p.m.

FRIDAY, SEPTEMBER 25, 2020

Welcome Breakfast
Friday, September 25, 2020
8:15 a.m. – 9:45 a.m.

- 1.) Welcome to Alexandria
- 2.) Introductory Comments from NCOIL CEO
Hon. Tom Considine
- 3.) **Rep. Matt Lehman (IN) – NCOIL President**
 - a.) President's Welcome
 - b.) New Member Welcome and Introduction
- 4.) Any Other Business
- 5.) Adjournment

Networking Break
Friday, September 25, 2020
9:45 a.m. – 10:00 a.m.

Workers' Compensation Insurance Committee
Friday, September 25, 2020
10:00 a.m. – 11:30 a.m.

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

- 1.) Call to Order/Roll Call/Approval of March 7, 2020 and May 29, 2020 Committee Meeting Minutes
- 2.) "State of the Line" – An Update on the Status of and Trends in the Workers' Compensation Insurance Marketplace
Jeff Eddinger, Senior Division Executive – Regulatory Business Management – National Council on Compensation Insurance (NCCI)
- 3.) Scenarios for the 2030s: Threats and Opportunities for Workers' Compensation Systems
Richard Victor, Ph.D., Sedgwick Fellow – The Sedgwick Institute
- 4.) Update on State COVID-19 Workers' Compensation Presumption Executive Orders/Statutes/Regulations

Jason Marcus, Esq., Legislative Chair – California Applicants Attorneys Association (CAAA)

Erin Collins, VP, State Affairs – NAMIC

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

5.) Any Other Business

6.) Adjournment

Health General Session

COVID-19: Testing, Treatment, and Vaccination

Friday, September 25, 2020

11:30 a.m. – 12:45 p.m.

Moderator: Rep. Tom Oliverson, M.D. (TX)

*Dave Hering
Regional President, North America
Pfizer Vaccines*

*Sharon Lamberton
Deputy VP – State Gov't Affairs
PhRMA*

*Kate Berry
Senior Vice President – Clinical Innovation
AHIP*

Luncheon with Keynote Address

Friday, September 25, 2020

12:45 p.m. – 2:15 p.m.

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

NCOIL – NAIC Dialogue

Friday, September 25, 2020

2:15 p.m. – 3:30 p.m.

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

Vice Chair: Rep. Martin Carbaugh (IN)

- 1.) Call to Order/Roll Call/Approval of March 6, 2020 Committee Meeting Minutes
- 2.) Update on State Adoption of Amended NAIC Credit for Reinsurance Models
- 3.) Discussion on Pandemic Business Interruption Issues
 - a.) NAIC Position Statement
 - b.) NAIC Business Interruption COVID-19 Data Call
- 4.) Discussion on NAIC's Casualty Actuarial and Statistical Task Force (CASTF)
- 5.) Discussion on NAIC Climate and Resiliency (EX) Task Force
- 6.) Review of State Approaches to Auto Insurance COVID-19 Rebates/Refunds/Dividends
- 7.) Discussion on Proposed Changes to SSAP No. 71
- 8.) Any Other Business
- 9.) Adjournment

Networking Break

Friday, September 25, 2020

3:30 p.m. – 3:45 p.m.

General Session

Future Pandemics: Approaches to Dealing with Business Interruptions

Friday, September 25, 2020

3:45 p.m. – 5:30 p.m.

Moderator: Sen. Paul Utke (MN)

*Jeff Alpaugh
Managing Director
U.S & Canada
Marsh & McLennan Companies, Inc.*

*Jon Bergner
Vice President
Public Policy and Federal Affairs
NAMIC*

*John Fielding
General Counsel
Global Gov't and Industry Affairs
Chubb*

*Robert Gordon
Senior Vice President
Policy, Research & International
APCIA*

*Wes Bissett
Senior Counsel – Gov't Affairs
IIABA*

*Charles Landgraf
Senior Counsel
Arnold & Porter*

CIP Member & Sponsor Reception
Friday, September 25, 2020
5:45 p.m. – 6:45 p.m.

SATURDAY, SEPTEMBER 26, 2020

Financial Services & Multi-Lines Issues Committee
Saturday, September 26, 2020
9:00 a.m. – 10:30 a.m.

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

- 1.) Call to Order/Roll Call/Approval of March 8, 2020 Committee Meeting Minutes
- 2.) Consideration of NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors
Rep. Tom Oliverson, M.D. (TX); Rep. Joe Fischer (KY) – NCOIL Secretary – Sponsors
NAMIC Representative
Frank O'Brien, VP, State Gov't Relations – APCIA
- 3.) Introduction and Discussion on NCOIL Insurer Division Model Act
Sen. Matt Lesser (CT) – Sponsor
Kathy Belfi, Director of Financial Regulation - Connecticut Insurance Department
Jared Kosky, General Counsel – Connecticut Insurance Department
Bridget Dunn, Head of Government Affairs – Talcott Resolution
Karen Melchert, Regional VP, State Relations – American Council of Life Insurers (ACLI)
AHIP Representative
Paul Martin, VP, State Relations – Reinsurance Ass'n of America
- 4.) Any Other Business
- 5.) Adjournment

Life Insurance & Financial Planning Committee
Saturday, September 26, 2020
10:30 a.m. – 11:45 a.m.

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

- 1.) Call to Order/Roll Call/Approval of March 6, 2020 Committee Meeting Minutes
- 2.) COVID-19 and the Insurance Industry – Not Just a P&C Issue
Kweilin Ellingrud, Leader of Life and Annuities Practice in North America; Senior Partner – McKinsey & Company
- 3.) Presentation on Life Insurance Settlements
Wes Bissett – Life Insurance Settlements Association (LISA) Representative
Michael Freedman, CEO – Lighthouse Life Solutions, LLC
- 4.) Any Other Business
- 5.) Adjournment

Health Insurance & Long Term Care Issues Committee
Saturday, September 26, 2020
11:45 a.m. – 1:15 p.m.

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

- 1.) Call to Order/Roll Call/Approval of March 7, 2020 and August 21, 2020 Committee Meeting Minutes
- 2.) Consideration of NCOIL Short Term Limited Duration Insurance Model Act
Rep. Martin Carbaugh (IN) – Sponsor
- 3.) Introduction and Discussion on NCOIL Telemedicine Authorization and Reimbursement Model Act
Asw. Pam Hunter (NY) – Sponsor
Ann Mond Johnson, CEO – American Telemedicine Association (ATA)
AHIP Representative
Kim Horvath, Senior Legislative Attorney – American Medical Association (AMA)
- 4.) Continued Discussion on NCOIL Transparency in Dental Benefits Contracting Model Act
Rep. Deborah Ferguson (AR); Rep. George Keiser (ND) – Sponsors
Chad Olson, Director, State Gov't Affairs – American Dental Association (ADA)
AHIP Representative
Artur Bagyants, Associate Director, Gov't Relations – National Association of Dental Plans (NADP)
- 5.) Continued Discussion on NCOIL Vision Care Services Model Act
Sen. Bob Hackett (OH) – Sponsor
Robert Holden, State Gov't Affairs Director – National Association of Vision Care Plans (NAVCP)
AHIP Representative
American Optometric Association (AOA) Representatives
- 6.) Any Other Business
- 7.) Adjournment

Business Planning Committee and Executive Committee

Saturday, September 26, 2020

1:15 p.m. – 2:00 p.m.

Chair: Rep. Matt Lehman – NCOIL President

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

- 1.) Call to Order/Roll Call/Approval of March 8, 2020 and July 1, 2020 Committee Meeting Minutes
- 2.) Update on December Annual Meeting in Tampa, FL
- 3.) 2023 Spring Meeting Location
- 4.) Administration
 - a.) Meeting Report
 - b.) Receipt of Financials
 - c.) Consideration of Audit
- 5.) Consent Calendar
 - Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted therein
- 6.) Other Sessions
 - Featured Speakers
- 7.) Any Other Business
- 8.) Adjournment

Atlantic Corporate Center
2317 Route 34, Suite 2B
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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)

Private Primary Residential Flood Insurance Model Act

****Sponsored by Rep. David Santiago (FL) and Sen. Vickie Sawyer (NC)***

****Draft as of August 25, 2020***

****To be considered during the meeting of the NCOIL Special Committee on Natural Disaster Recovery on September 24, 2020***

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Rates
Section 5.	Forms
Section 6.	Duties of Insurer to Provide Regulatory Notice of Intent to Transact Residential Primary Flood Insurance
Section 7.	Notice to Consumers
Section 8.	Cancellation and Nonrenewal Notice
Section 9.	Surplus Lines Placements
Section 10.	Other Provisions
Section 11.	Rules
Section 12.	Effective Date

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 prior approval by the [State entity for regulation of insurance]. An insurer’s ~~rates~~ must attest that the rates are ~~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. ~~Further~~ 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~~ a consumer currently has no coverage under the ~~National Flood Insurance Program~~, before placing the consumer applicant with private flood insurance, the consumer must be informed of the existence of the NFIP.

(b) All consumers covered by subsection 7(a) as well as consumers who currently have that the coverage under the National Flood Insurance Program must be informed that the coverage under the NFIP 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.

(c**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] shall not apply to flood coverage under an insurance policy issued by an eligible surplus lines insurer unless and until the Commissioner certifies in a bulletin or order that the admitted private flood insurance market is adequate.

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 and accepted by the Commissioner as 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) 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.

(d) An insurer may certify that the insurance policy meets the definition of “private flood insurance,” as specified in 42 U.S.C. § 4012a(b)(7) and applicable federal regulations.

(e) 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 _____.

Atlantic Corporate Center
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CHIEF EXECUTIVE OFFICER: Thomas B. Considine



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

National Council of Insurance Legislators (NCOIL)

Distracted Driving Model Act

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

**Draft as of August 25, 2020*

**To be discussed during the NCOIL Property & Casualty Insurance Committee on September 24, 2020.*

Section 1 – Definitions

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

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

'Wireless telecommunications device' means:

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

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

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

Section 2 – Operation

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

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

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

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

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

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

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

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

- (4) Engage in any form of electronic data retrieval or electronic data communication;
- (5) Manually enter letters, numbers, or symbols into any website, search engine, or application;
- (6) Watch a video or movie on a wireless telecommunications device or stand-alone electronic device other than watching data related to the navigation of such vehicle; or
- (7) Record, post, send, or broadcast video, including a video conference on a wireless telecommunications device or stand-alone electronic device; provided that such prohibition shall not apply to electronic devices used for the sole purpose of continuously recording or broadcasting video within or outside of the motor vehicle.

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

- (1) Use more than a single button on a wireless telecommunications device to initiate or terminate a voice communication; or
- (2) Reach for a wireless telecommunications device or stand-alone electronic device in such a manner that requires the driver to no longer be:
 - (a) In a seated driving position; or
 - (b) Properly restrained by a safety belt.

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

Section 3 – Penalties

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

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

accepted to the date the current conviction is obtained or plea of no contest is accepted, a fine of not more than \$250.00 and charged three (3) points.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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 considered~~discussed~~ during the Financial Services & Multi-Lines Issues Committee on September 26~~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.

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

National Council of Insurance Legislators (NCOIL)

Insurer Division Model Act

****Sponsored by Sen. Matt Lesser (CT)***

****Discussion Draft as of August 25, 2020.***

****To be introduced and discussed during the Financial Services & Multi-Lines Issues Committee on September 26, 2020***

Table of Contents

Section 1.	Title.
Section 2.	Definitions.
Section 3.	Division authorized.
Section 4.	Plan of division.
Section 5.	Approval of division by dividing insurer.
Section 6.	Division without shareholder approval.
Section 7.	Regulatory approval of division.
Section 8.	Amendment or abandonment of plan of division.
Section 9.	Articles of division; effectiveness.
Section 10.	Effect of division.
Section 11.	Allocation of liabilities in division.
Section 12.	Simultaneous merger.
Section 13.	Appraisal rights.
Section 14.	Guaranty associations.
Section 15.	Regulations.
Section 16 .	Effective date.

Section 1. Title

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

Section 2. Definitions.

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

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

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

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

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

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

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

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

“Transfer” includes:

- (A) an assignment;
- (B) an assumption;
- (C) a conveyance;
- (D) a sale;
- (E) a lease;
- (F) an encumbrance, including a mortgage or security interest;
- (G) a gift; and
- (H) a transfer by operation of law.

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

“Admitted insurer.” [Citation.]

“Capital.” [Citation.]

“Commissioner.” [Citation.]

“Domestic insurer.” [Citation.]

“Person.” [Citation.]

“Policy.” [Citation.]

“Record.” [Citation.]

“Sign” or “signature.” [Citation.]

“Surplus.” [Citation.]

Section 3. Division authorized.

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

- (1) the dividing insurer and one or more new insurers; or
- (2) two or more new insurers.

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

- (1) a division of an insurer is authorized by the law of the domiciliary jurisdiction of the new insurer; and
- (2) the division of the domestic insurer is approved in accordance with any applicable provisions of the law of the domiciliary jurisdiction of the new insurer.

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

Section 4. Plan of division.

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

- (1) The name of the dividing insurer.
- (2) A statement as to whether the dividing insurer will survive the division.
- (3) The name of each new insurer and its domiciliary jurisdiction.
- (4) The manner of:
 - (A) If the dividing insurer survives the division and it is desired:
 - (i) Canceling some, but less than all, of the shares in the dividing insurer.
 - (ii) Converting some, but less than all, of the shares in the dividing insurer into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination of the foregoing.
 - (B) If the dividing insurer does not survive the division, canceling or converting the shares in the dividing insurer into shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination of the foregoing.
 - (C) Allocating between or among the resulting insurers the capital, surplus, and other property of the dividing insurer that will not be owned by all of the resulting insurers as tenants in common pursuant to section 10 and those policies and other liabilities of the dividing association as to which not all of the resulting insurers will be liable jointly and severally pursuant to section 11.
 - (D) Distributing the shares in the new insurer or insurers to the dividing insurer or some or all of its shareholders.
- (5) The proposed articles of incorporation and bylaws for each new insurer.
- (6) If the dividing insurer will survive the division, any proposed amendments to its articles of incorporation or bylaws.
- (7) The other terms and conditions of the division.
- (8) Any other provision required by:
 - (A) the laws of this state;

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

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

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

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

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

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

Section 5. Approval of division by dividing insurer.

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

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

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

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

(1) If a provision of the articles of incorporation or bylaws of the dividing insurer was adopted before [*the date of enactment of this act*] and requires for the proposal or adoption of a plan of merger a specific number or percentage of votes of directors or shareholders or other special

procedures, then a plan of division may not be proposed or adopted by the directors or shareholders without that number or percentage of votes or compliance with the other special procedures.

- (2) If a provision of any debt security, note or similar evidence of indebtedness for money borrowed, whether secured or unsecured, indenture, or other contract relating to indebtedness, or a provision of any other type of contract other than an insurance policy, annuity, or reinsurance treaty, that was issued, incurred or executed by the dividing insurer before [*the date of enactment of this act*], requires the consent of the obligee to a merger of the dividing insurer or treats such a merger as a default, then the provision applies to a division of the dividing insurer as if it were a merger.
- (3) When a provision described in section 5(b)(1) or (2) has been amended after the applicable date, the provision ceases to be subject to the respective paragraph and thereafter applies only in accordance with its express terms.

Section 6. Division without shareholder approval.

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

- (1) the plan does not amend in any respect the provisions of the articles of incorporation or bylaws of the dividing insurer, except amendments that may be made without the approval of the shareholders; and
- (2) either:
 - (A) the dividing insurer survives the division and all the shares and other equity securities, if any, of all of the new insurers are owned solely by the dividing insurer; or
 - (B) the dividing insurer has only one class of shares outstanding and the shares and other equity securities, if any, of each new insurer are distributed pro rata to the shareholders of the dividing insurer.

Section 7. Regulatory approval of division.

- (a) Prior to approving a division, the commissioner may hold a hearing on the terms and conditions of the proposed division after such notice as, under the circumstances, the commissioner considers appropriate. A hearing must be held if the dividing insurer so requests. In determining the appropriate notice of a hearing

that should be given, the commissioner may require that the dividing insurer submit a policyholder notification plan. The commissioner may retain such independent experts as the commissioner considers appropriate. All expenses incurred by the commissioner in connection with the proceedings under this section, including expenses for the services of any attorneys, actuaries, accountants and other experts not otherwise a part of the commissioner's staff as may be reasonably necessary to assist the commissioner in reviewing the proposed division must be paid by the dividing insurer. The expenses may be allocated in the plan of division in the same manner as any other liability.

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

- (1) *[insert standard for approval of a merger of insurers under the state's existing law]*;
- (2) as a result of the division, and any associated merger under section 12, no policyholder will lose applicable guaranty association coverage in the policyholder's state of residence with respect to policies allocated to one or more new insurers; and
- (3) the division and any such merger do not involve a *[voidable transaction]* *[fraudulent transfer]* under *[cite appropriate state statute]*.

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

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

- (1) only consider the application of *[cite state voidable transactions act or fraudulent transfer act]* to a dividing insurer that survives the division;
- (2) treat each resulting insurer as a debtor;
- (3) treat the liabilities allocated to a resulting insurer as liabilities incurred by a debtor;
- (4) treat each resulting insurer as not having received reasonably equivalent value in exchange for incurring its obligations; and

- (5) treat property allocated to a resulting insurer as “remaining assets” as that term is used in [*cite state voidable transactions act or fraudulent transfer act*].
- (e) The commissioner may not approve a division of a dividing insurer unless the commissioner also issues to each new insurer a certificate of authority, accreditation or other authorization, as necessary, to do an insurance business in this state pursuant to [*cite appropriate provision of state law*]. In the case of a new insurer that will be a non-surviving party to a merger pursuant to section 12, the commissioner may waive the application of this subsection or issue a certificate of authority, accreditation or other authorization to the new insurer that is deemed effective immediately prior to the merger.
- (f) If the commissioner approves the plan of division, the commissioner must issue an order accompanied by findings of fact and conclusions of law.
- (g) Except for the plan of division and any materials incorporated by reference into or otherwise made a part of the plan, all information, documents, materials and copies thereof submitted to, obtained by or disclosed to the commissioner or any other person in the course of the commissioner’s review and approval of a division under this section are confidential [*and subject to the provisions of [cite any applicable provision of the state’s law on confidentiality of proceedings before the commissioner]*].

Section 8. Amendment or abandonment of plan of division.

- (a) A plan of division of a dividing insurer may be amended in accordance with any procedures set forth in the plan or, if no such procedures are set forth in the plan, in the manner determined by the directors of the dividing insurer, except that a shareholder that was entitled to vote on or consent to approval of the division is entitled to vote on or consent to any amendment of the plan that will change:
- (1) The amount or kind of shares, securities, obligations, money, other property, rights to acquire shares or securities, or any combination of the foregoing, to be received by any of the shareholders of the dividing insurer under the plan.
- (2) The articles of incorporation or bylaws of any of the resulting insurers that will be in effect immediately after the division becomes effective, except for changes that do not require approval of the shareholders of the resulting insurer under other applicable law.
- (3) Any other terms or conditions of the plan, if the change would adversely affect the shareholder in any material respect.

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

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

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

Section 9. Articles of division; effectiveness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 10. Effect of division.

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

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

(A) It continues to exist.

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

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

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

- (3) With respect to each new insurer, all of the following apply:
 - (A) It comes into existence.
 - (B) Any capital, surplus, and other property allocated to it vests in the new insurer without reversion or impairment, and the division is not a transfer of any of that property.
 - (C) Its articles of incorporation and bylaws are effective.
- (4) Capital, surplus, and other property of the dividing insurer:
 - (A) That is allocated by the plan of division either:
 - (i) vests in the new insurers as provided in the plan of division;
or
 - (ii) remains vested in the dividing insurer.
 - (B) That is not allocated by the plan of division:
 - (i) remains vested in the dividing insurer, if the dividing insurer survives the division; or
 - (ii) is allocated to and vests equally in the resulting insurers as tenants in common, if the dividing insurer does not survive the division.
 - (C) Vests as provided in this paragraph without transfer, reversion or impairment.
- (5) A resulting insurer to which a cause of action is allocated as provided in section 10(a)(4) may be substituted or added in any pending action or proceeding to which the dividing insurer is a party at the effective time of the division.
- (6) The policies and other liabilities of the dividing insurer are allocated between or among the resulting insurers as provided in section 11 and the resulting insurers to which policies or other liabilities are allocated are liable for those policies and other liabilities as successors to the dividing insurer, and not by transfer, whether directly or indirectly.
- (7) The shares in the dividing insurer that are to be converted or canceled in the division are converted or canceled, and the holders of those shares are

entitled only to the rights provided to them under the plan of division and to any appraisal rights they may have pursuant to section 13.

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

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

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

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

Section 11. Allocation of liabilities in division.

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

- (1) Individually for the policies and other liabilities the resulting insurer issues, undertakes, or incurs in its own name after the division.
- (2) Individually for the policies and other liabilities of the dividing insurer that are allocated to or remain the liability of that resulting insurer to the extent specified in the plan of division.
- (3) Jointly and severally with the other resulting insurers for the policies and other liabilities of the dividing insurer that are not allocated by the plan of division.
- (4) Only as provided in this subsection (a), and not for any other policies or other liabilities under a common law doctrine of successor liability or any other theory of liability applicable to transferees or assignees of property.

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

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

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

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

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

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

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

Section 12. Simultaneous merger.

A new insurer may be a party to a merger with a domestic insurer or an existing insurer domiciled in another jurisdiction that is admitted, accredited, or otherwise authorized as necessary to do an insurance business in this state, as required by the law of this state. A merger authorized by this section takes effect simultaneously with the division. The new insurer is deemed to exist before the effectiveness of the merger, but solely for the purpose of being a party to the merger. The insurance policies, annuities, and reinsurance treaties allocated to the new insurer pursuant to the plan of division become the obligations of the survivor of the merger simultaneously with the effectiveness of the division and merger under this section. The plan of merger is deemed to have been approved by the new insurer if the plan is approved by the dividing insurer in connection with its approval of the plan of division. The articles of merger that are delivered to the Secretary of State for filing must state that the merger was approved by the new insurer under this section.

Section 13. Appraisal rights.

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

Section. 14. Guaranty associations.

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

- (1) divides under this act or a similar law of another jurisdiction, or is created in such a division;
- (2) holds or is allocated the policy obligations of an insurer that held a certificate of authority to transact insurance in this state either at the time a policy was issued or when an insured event occurred, by reason of the division, if the division was approved:
 - (A) in a jurisdiction that allows a division; and
 - (B) by an insurance regulator having jurisdiction over the division; and
- (3) against which a final order of liquidation with a finding of insolvency has been entered by a court of competent jurisdiction in the resulting insurer's state of domicile.

Section 15. Regulations.

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

Section 16. Effective date.

This act takes effect _____.

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National Council of Insurance Legislators (NCOIL)

Short Term Limited Duration Insurance Model Act

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

**Draft as of August 25, 2020.*

**To be ~~considered~~ discussed during the NCOIL Health Insurance and Long Term Care Issues Committee on ~~September 26~~ ~~March 7th~~ ~~December 11th~~, 202019. Initial ~~draft~~ as of ~~August 25th~~ ~~February 5th~~ ~~November 11th~~, 202019 based on Indiana HB 1631 (signed into law on May 6, 2019)*

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	<u>Applicability</u>
Section 4 3.	Definitions
Section 5 4.	Renewal and Underwriting
Section 6 5.	Coverage Requirements
Section 7 6.	<u>Preferred Provider Network Based Plan</u> Requirements
Section 8 7.	Disclosure Requirements
Section 9 8.	Tiering/Rating
Section 10 9.	Discounts/Rebates/Out-of-Pocket Payment Modifications
Section 11.	<u>Rescission</u>
Section 12 0.	Rules
Section 13 1.	Effective Date

Section 1. Title

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

Section 2. Purpose

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

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. Applicability

This Act shall apply to short term insurance plans delivered or issued for delivery to residents of this state, regardless of the situs of the contract or policy; however, nothing in this Section shall invalidate a plan validly delivered in another state.

Section 43. 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) “Network based planPreferred 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 54. 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 65. 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 76. ~~Preferred Provider~~ Network Based Plan Requirements

(a) This section applies to an insurer that issues a short term insurance plan and undertakes a network based~~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 network based~~preferred provider~~ plan meets the following requirements:

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

(2) The network based~~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 network based~~preferred provider~~ plan is consistent with the network adequacy requirements that:

(i) apply to qualified health plan issuers under 45 C.F.R. §~~CFR~~ 156.230(a) and 45 C.F.R. §~~CFR~~ 156.230(b); and

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

Section 87. 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 98. 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 109. 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 11. Rescission

An insurer that issues a short term insurance plan shall not rescind such plan or coverage with respect to an enrollee once the enrollee is covered under such plan involved, except

for an act or practice that constitutes fraud or intentional misrepresentation of material fact consistent with the requirements in Public Health Service Act § 2712 (42 U.S.C. § 300gg-12) and 45 C.F.R. § 147.128 or their successors.

Section 120. Rules

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

Section 134. Effective Date

This Act shall take effect [_____].

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SECRETARY: Rep. Joe Fischer, KY

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

National Council of Insurance Legislators (NCOIL)

Draft Model Act Regarding Vision Care Services

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

****Discussion Draft as of November 11th, 2019. To be ~~discussed~~introduced during the Health Insurance & Long Term Care Issues Committee on September 26th, ~~2020~~March 7th, ~~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, orthoptics, 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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Sen. Travis Holdman, IN

National Council of Insurance Legislators (NCOIL)

Patient Dental Care Bill of Rights

****Sponsored by Rep. Deborah Ferguson (AR) and Rep. George Keiser (ND)***

****Discussion Draft as of ~~August 25th, 2020~~ ~~November 11th, 2019~~. To be discussed ~~introduced~~ during the Health Insurance & Long Term Care Issues Committee on ~~September 26, 2020~~ ~~March 7th, 2020~~ ~~December 11th, 2019~~.***

****Sponsor's Note: This Model remains a significant working draft. Specific language for modification needs to be resolved and will continue to be discussed.***

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~~
- ~~DE. 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" does not include services delivered by a provider that are billed as medical expenses under a health benefits plan
~~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 ~~that specifies~~ specifying the rights and responsibilities of the contracting entity and providing for the delivery of and payment of ~~for~~ dental services to an enrollee 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" ~~does~~ shall not include any employer or other group for whom the dental carrier or 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. A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract if the requirements of subdivisions (B) and (C) are met.

~~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:~~

~~B1. 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.~~

DRAFTING NOTE: Subsection IB is intended to apply to insurers only, and not to leasing companies. Providers contract with leasing companies with the explicit understanding and expectation that they will be leased. Because applying opt out requirements to these entities would impair their central purpose as understood by all parties, they should be specifically excluded from such provisions in legislation. However, the transparency provisions outlined in Subsection IIC are intended to apply to all contracting entities, including leasing companies.

C. A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract, if all of the following are met:

12. 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."~~

~~23.~~ The third party accessing the contract agrees to comply with all of the contract's terms, including third party's obligation concerning patient steerage;

~~34.~~ 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;

~~45.~~ The contracting entity identifies all third parties in existence in a list on its internet website that is updated at least once every 90 days ~~includes on its website a listing, updated no less frequently than every 90 days, identifying all third parties;~~

~~56.~~ 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. This paragraph does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191); ~~except this requirement shall not apply to electronic transactions mandated under the "Health Insurance Portability and Accountability Act of 1996," Pub.L.104-191;~~

~~67.~~ 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;

~~78.~~ A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract. ~~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;~~

~~89.~~ The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days of a request from the provider. ~~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.

Section II. Exceptions

The provisions of this Act shall not apply if any of the following is true:
This act shall not apply to:

1. Access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list of the contracting entity's affiliates shall be made available to a provider on the contracting entity's website; or

~~21. 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 III. 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

Coverage determinations – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan or dental plan, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured’s health condition that was knowingly made by the insured or the provider of the service, supply, or other item. For purposes of this section, a pretreatment estimate means a voluntary request for a projection of dental benefits or payment that does not require authorization and a pretreatment estimate for dental services shall not be considered a coverage determination.

~~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.~~

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

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

~~Section I.~~

Method of Payment Option

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

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

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

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

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

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

~~F. Transparency of Patient Premiums Invested in Dental Care Act~~

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

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

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

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

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

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

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

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National Council of Insurance Legislators (NCOIL)

Telemedicine Authorization and Reimbursement Act (TARA)

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

**Discussion Draft as of August 25th, 2020*

**To be introduced and discussed during the NCOIL Health Insurance & Long Term Care Issues Committee meeting on September 26, 2020*

Table of Contents

Section 1.	Title
Section 2.	Purpose
Section 3.	Definitions
Section 4.	Coverage of Telemedicine Services
Section 5.	Limited Telemedicine License
Section 6.	Rules
Section 7.	Effective Date
Section 8.	Severability

Section 1. Title.

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

Section 2. Purpose

The Legislature hereby finds and declares that:

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

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

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

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

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

Section 3. Definitions

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

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

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

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

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

Section 4. Coverage of Telemedicine Services

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

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

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

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

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

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

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

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

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

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

Section 5. Limited Telemedicine License

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

Section 6. Rules

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

Section 7. Effective Date

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

Section 8. Severability

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

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers

****Adopted by the NCOIL Executive Committee on July 19, 2015. Sponsored by Rep. Michael Stinziano (OH)***

****To be considered for re-adoption by the Property & Casualty Insurance Committee on September 24, 2020.***

A. Definitions

1. "Personal Vehicle" means a vehicle that is:
 - a. used by a TNC driver to provide a prearranged ride;
 - b. owned, leased or otherwise authorized for use by the Transportation Network Company Driver; and
 - c. not a taxicab, limousine, or other hire vehicle
2. "Digital Network" means any online-enabled application, software, website or system offered or utilized by a Transportation Network Company that enables the prearrangement of rides with Transportation Network Company Drivers.
3. "Transportation Network Company" means a corporation, partnership, sole proprietorship, or other entity that is licensed pursuant to this [Chapter/Title] and operating in [STATE] that uses a Digital Network to connect Transportation Network Company Riders to Transportation Network Company Drivers who provide Prearranged Rides. A Transportation Network Company shall not be deemed to control, direct or manage the Personal Vehicles or Transportation Network Company Drivers that connect to its Digital Network, except where agreed to by written contract.
4. "Transportation Network Company (TNC) Driver" or "driver" means an individual who:
 - a. receives connections to potential riders and related services from a Transportation Network Company in exchange for payment of a fee to the Transportation Network Company; and

b. uses a Personal Vehicle to offer or provide a Prearranged Ride to TNC riders upon connection through a Digital Network controlled by a Transportation Network Company and in exchange for compensation or payment of a fee

5. "Transportation Network Company (TNC) Rider" or "rider" means an individual or persons who use a Transportation Network Company's Digital Network to connect with a Transportation Network Driver who provides Prearranged Rides to the rider in the driver's Personal Vehicle between points chosen by the rider.

6. "Prearranged Ride" means the provision of transportation by a TNC driver to a TNC rider:

a. beginning when a TNC driver accepts a TNC rider's request for a ride through a digital network controlled by a Transportation Network Company;

b. continuing while the TNC driver transports the requesting TNC rider; and

c. ending when the last requesting TNC rider departs from the Personal Vehicle

7. The term "prearranged ride" does not include transportation provided through any of the following [CITE DEFINITION IN STATE LAW OR MOTOR CARRIER ACT]:

a. shared expense carpool or vanpool arrangements

b. use of a taxicab, limousine, or other hire vehicle

c. a regional transportation

B. Transportation Network Companies

1. A transportation network company may not operate without a permit issued under [CITE DEFINITION IN STATE LAW]. 69 a. A permit is valid for one (1) year after the date of issuance.

2. A TNC or a TNC driver is not:

a. a common carrier;

b. a contract carrier; or

c. a motor carrier

3. The department shall issue a permit to a TNC that satisfies the following requirements:

- a. establishes a zero tolerance policy for drug and alcohol
- b. requires compliance with applicable vehicle requirements
- c. adopts nondiscrimination and accessibility policies
- d. establishes record maintenance guidelines

4. Before a TNC allows an individual to act as a TNC driver on the TNC's digital network, the TNC shall:

a. require the individual to submit to the TNC an application that includes:

- i. the individual's name, address, and age;
- ii. the individual's driver's license;
- iii. the registration for the personal vehicle that the individual will use to provide prearranged rides;
- iv. proof of financial responsibility for the personal vehicle described in 4(a)(iii) above of a type and in the amounts required by the TNC; and
- v. any other information required by the TNC;

b. with respect to the individual, conduct, or contract with a third party to conduct:

- i. a local and national criminal background check; and
- ii. a search of the national sex offender registry; and
- iii. obtain a copy of the individual's driving record maintained under [CITE DEFINITION IN STATE LAW]

c. A TNC may not knowingly allow to act as a TNC driver on the TNC's digital network an individual:

i. who has received judgments for:

- (1) more than three (3) moving traffic violations in the preceding three (3) years; or
- (2) at least one (1) violation involving reckless driving or driving on a suspended or revoked license in the preceding three (3) years; or

ii. who has been convicted in the preceding seven (7) years of a:

- (1) felony; or

(2) misdemeanor involving:

- (a) resisting law enforcement;
- (b) dishonesty;
- (c) injury to a person;
- (d) operating while intoxicated;
- (e) operating a vehicle in a manner that endangers a person;
- (f) operating a vehicle with a suspended or revoked license; or
- (g) damage to the property of another person; or

iii. who is a match in the state or national sex offender registry;

iv. who is unable to provide information required under subsection (b)

5. A TNC shall establish and enforce a zero tolerance policy for drug and alcohol use by TNC drivers during any period when a TNC driver is engaged in, or is logged into the TNC's digital network but is not engaged in, a prearranged ride. The policy must include provisions for:

- a. investigations of alleged policy violations; and
- b. suspensions of TNC drivers under investigation

6. A TNC must require that a personal vehicle used to provide prearranged rides must comply with all applicable laws and regulations concerning vehicle equipment.

C. Financial Responsibility of Transportation Network Companies

On or before [MONTH, DAY, YEAR] and thereafter, a Transportation Network Company Driver or Transportation Network Company on the driver's behalf shall maintain primary automobile insurance that:

1. Recognizes that the driver is a Transportation Network Company Driver or otherwise uses a vehicle to transport riders for compensation and covers the driver:

- a. while the driver is logged on to the Transportation Network Company's Digital Network; or
- b. while the driver is engaged in a Prearranged Ride

2. The following automobile insurance requirements shall apply while a participating Transportation Network Company Driver is logged on to the Transportation Network Company's Digital Network and is available to receive transportation requests but is not engaged in a Prearranged Ride:

a. Primary automobile liability insurance in the amount of at least \$50,000 for death and bodily injury per person, \$100,000 for death and bodily injury per incident, and \$25,000 for property damage.

[Drafting note: Reference by statute all other state mandated coverages for motor vehicles by state financial responsibility law, UM/UIM, Med Pay, NF and/or PIP.]

b. The coverage requirements of this subsection 2 may be satisfied by any of the following:

i. automobile insurance maintained by the Transportation Network Company Driver; or

ii. automobile insurance maintained by the Transportation Network Company; or

iii. any combination of subparagraphs (i) and (ii).

3. The following automobile insurance requirements shall apply while a Transportation Network Company Driver is engaged in a Prearranged Ride:

a. Primary automobile liability insurance that provides at least \$1,000,000 for death, bodily injury and property damage;

[Drafting note: Reference by statute all other state mandated coverages for limousines, e.g., UM/ UIM, Med Pay, NF and/or PIP.]

b. The coverage requirements of this subsection 3 may be satisfied by any of the following:

i. automobile insurance maintained by the Transportation Network Company Driver; or

ii. automobile insurance maintained by the Transportation Network Company; or

iii. any combination of subparagraphs (i) and (ii)

4. If insurance maintained by driver in subsections 2 or 3 has lapsed or does not provide the required coverage, insurance maintained by a Transportation Network Company shall provide the coverage required by Section C beginning with the first dollar of a claim and have the duty to defend such claim.

5. Coverage under an automobile insurance policy maintained by the Transportation Network Company shall not be dependent on a personal automobile insurer first denying a claim nor shall a personal automobile insurance policy be required to first deny a claim.

6. Insurance required by this Section C may be placed with an insurer licensed under [CITE STATUTE], or with a surplus lines insurer eligible under [CITE STATUTE] that has a credit rating of no less than “A-“ from A.M. Best or “A” from Demotech or similar rating from another rating agency recognized by the department of insurance.

7. Insurance satisfying the requirements of this Section C shall be deemed to satisfy the financial responsibility requirement for a motor vehicle under [STATE FINANCIAL RESPONSIBILITY STATUTE].

8. A Transportation Network Company Driver shall carry proof of coverage satisfying sections C.2 and C.3 with him or her at all times during his or her use of a vehicle in connection with a Transportation Network Company’s Digital Network. In the event of an accident, a Transportation Network Company Driver shall provide this insurance coverage information to the directly interested parties, automobile insurers and investigating police officers, upon request pursuant to [INSERT ELECTRONIC ID CARD LAW OR CREATE SUCH LAW]. Upon such request, a Transportation Network Company Driver shall also disclose to directly interested parties, automobile insurers, and investigating police officers, whether he or she was logged on to the Transportation Network Company’s Digital Network or on a Prearranged Ride at the time of an accident.

D. Disclosures

1. The Transportation Network Company shall disclose in writing to Transportation Network Company Drivers the following before they are allowed to accept a request for a Prearranged Ride on the Transportation Network Company’s Digital Network:

a. the insurance coverage, including the types of coverage and the limits for each coverage, that the Transportation Network Company provides while the Transportation Network Company Driver uses a Personal Vehicle in connection with a Transportation Network Company’s Digital Network; and

b. that the Transportation Network Company Driver’s own automobile insurance policy might not provide any coverage while the driver is logged on to the Transportation Network Company’s Digital Network and is available to receive transportation requests or is engaged in a Prearranged Ride, depending on its terms.

[Drafting note: A state should consider appropriate lienholder language to coordinate with the state’s existing law.]

E. Automobile Insurance Provisions

1. Insurers that write automobile insurance in [INSERT STATE] may exclude any and all coverage afforded under the policy issued to an owner or operator of a Personal Vehicle for any loss or injury that occurs while a Driver is logged on to a Transportation Network Company's Digital Network or while a Driver provides a Prearranged Ride. This right to exclude all coverage may apply to any coverage included in an automobile insurance policy including, but not limited to:

- a. liability coverage for bodily injury and property damage;
- b. personal injury protection coverage as defined in [CITE STATUTE];
- c. uninsured and underinsured motorist coverage;
- d. medical payments coverage;
- e. comprehensive physical damage coverage; and
- f. collision physical damage coverage

Such exclusions shall apply notwithstanding any requirement under [STATE FINANCIAL RESPONSIBILITY STATUTE]. Nothing in this section implies or requires that a personal automobile insurance policy provide coverage while the driver is logged on to the Transportation Network Company's Digital Network, while the driver is engaged in a Prearranged Ride or while the driver otherwise uses a vehicle to transport riders for compensation.

Nothing in this Article shall be construed as to require an insurer to use any particular policy language or reference to this section in order to exclude any and all coverage for any loss or injury that occurs while a driver is logged on to a Transportation Network Company's Digital Network or while a Driver provides a Prearranged Ride.

Nothing shall be deemed to preclude an insurer from providing primary or excess coverage for the Transportation Network Company Driver's vehicle, if it so chose to do so by contract or endorsement.

2. Automobile insurers that exclude the coverage described in Section C shall have no duty to defend or indemnify any claim expressly excluded thereunder. Nothing in this Article shall be deemed to invalidate or limit an exclusion contained in a policy including any policy in use or approved for use in [STATE] prior to the enactment of this Article that excludes coverage for vehicles used to carry persons or property for a charge or available for hire by the public.

An automobile insurer that defends or indemnifies a claim against a driver that is excluded under the terms of its policy, shall have a right of contribution against other insurers that provide automobile insurance to the same driver in satisfaction of the coverage requirements of Section C at the time of loss.

3. In a claims coverage investigation, Transportation Network Companies shall immediately provide upon request by directly involved parties or any insurer of the Transportation Network Company Driver if applicable, the precise times that

a Transportation Network Company Driver logged on and off of the Transportation Network Company's Digital Network in the twelve-hour period immediately preceding and in the twelve-hour period immediately following the accident. Insurers potentially providing coverage as set forth in Section C shall disclose upon request by any other such insurer involved in the particular claim, the applicable coverages, exclusions and limits provided under any automobile insurance maintained in order to satisfy the requirements of Section C.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

MODEL ACT REGARDING USE OF CREDIT INFORMATION IN PERSONAL INSURANCE

****Readopted by the Property-Casualty Insurance and Executive Committees on November 15, 2015. Originally adopted by the Property-Casualty Insurance and Executive Committees on November 22, 2002; readopted by the Committees, respectively, on November 17, 2005, and on November 19, 2005; amended on July 12, 2009, to expand on extraordinary life circumstances provisions.***

****To be considered for re-adoption by the Property & Casualty Insurance Committee on September 24, 2020.***

Table of Contents

Section 1 Short Title
Section 2 Purpose
Section 3 Scope
Section 4 Definitions
Section 5 Use of Credit Information
Section 6 Extraordinary Life Circumstances
Section 7 Dispute Resolution and Error Correction
Section 8 Initial Notification
Section 9 Adverse Action Notification
Section 10 Filing
Section 11 Indemnification
Section 12 Sale of Information by Consumer Reporting Agency
Section 13 Severability
Section 14 Effective Date

Section 1. Short Title

This Act may be called the Model Act Regarding Use of Credit Information in Personal Insurance

Section 2. Purpose

The purpose of this Act is to regulate the use of credit information for personal insurance, so that consumers are afforded certain protections with respect to the use of such information.

Section 3. Scope

This Act applies to personal insurance and not to commercial insurance. For purposes of this Act, "personal insurance" means private passenger automobile, homeowners, motorcycle, mobile- homeowners and non-commercial dwelling fire insurance policies [and boat, personal watercraft, snowmobile and recreational vehicle policies]. Such policies must be individually underwritten for personal, family or household use. No other type of insurance shall be included as personal insurance for the purpose of this Act.

Section 4. Definitions

For the purposes of this Act, these defined words have the following meaning:

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

B. Affiliate—Any company that controls, is controlled by, or is under common control with another company.

C. Applicant—An individual who has applied to be covered by a personal insurance policy with an insurer.

D. Consumer—An insured whose credit information is used or whose insurance score is calculated in the underwriting or rating of a personal insurance policy or an applicant for such a policy.

E. Consumer Reporting Agency—Any person which, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties.

F. Credit Information—Any credit-related information derived from a credit report, found on a credit report itself, or provided on an application for personal insurance. Information that is not credit-related shall not be considered "credit information," regardless of whether it is contained in a credit report or in an application, or is used to calculate an insurance score.

G. Credit Report—Any written, oral, or other communication of information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing or credit capacity which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor to determine personal insurance premiums, eligibility for coverage, or tier placement.

H. Insurance Score—A number or rating that is derived from an algorithm, computer application, model, or other process that is based in whole or in part on credit information for the purposes of predicting the future insurance loss exposure of an individual applicant or insured.

Section 5. Use of Credit Information

An insurer authorized to do business in [insert State] that uses credit information to underwrite or rate risks, shall not:

A. Use an insurance score that is calculated using income, gender, address, zip code, ethnic group, religion, marital status, or nationality of the consumer as a factor.

B. Deny, cancel or non-renew a policy of personal insurance solely on the basis of credit information, without consideration of any other applicable underwriting factor independent of credit information and not expressly prohibited by Section 5(A).

Drafting Note: This subsection prohibits an insurer from refusing to insure an applicant, insured, or other individual seeking insurance coverage because the person's insurance score fails to meet or exceed a minimum numeric threshold, unless one or more other applicable underwriting factors independent of credit information are considered.

C. Base an insured's renewal rates for personal insurance solely upon credit information, without consideration of any other applicable factor independent of credit information.

D. Take an adverse action against a consumer solely because he or she does not have a credit card account, without consideration of any other applicable factor independent of credit information.

E. Consider an absence of credit information or an inability to calculate an insurance score in underwriting or rating personal insurance, unless the insurer does one of the following:

1. Treats the consumer as otherwise approved by the Insurance Commissioner/ Supervisor/Director, if the insurer presents information that such an absence or inability relates to the risk for the insurer.
2. Treats the consumer as if the applicant or insured had neutral credit information, as defined by the insurer.
3. Excludes the use of credit information as a factor and use only other underwriting criteria.

F. Take an adverse action against a consumer based on credit information, unless an insurer obtains and uses a credit report issued or an insurance score calculated within 90 days from the date the policy is first written or renewal is issued.

G. Use credit information unless not later than every 36 months following the last time that the insurer obtained current credit information for the insured, the insurer recalculates the insurance score or obtains an updated credit report. Regardless of the requirements of this subsection:

1. At annual renewal, upon the request of a consumer or the consumer's agent, the insurer shall re-underwrite and re-rate the policy based upon a current credit report or insurance score. An insurer need not recalculate the insurance score or obtain the updated credit report of a consumer more frequently than once in a twelve-month period.

2. The insurer shall have the discretion to obtain current credit information upon any Renewal before the 36 months, if consistent with its underwriting guidelines.

3. No insurer need obtain current credit information for an insured, despite the Requirements of subsection (G)(1), if one of the following applies:

(a) The insurer is treating the consumer as otherwise approved by the Commissioner.

(b) The insured is in the most favorably-priced tier of the insurer, within a group of affiliated insurers. However, the insurer shall have the discretion to order such report, if consistent with its underwriting guidelines.

(c) Credit was not used for underwriting or rating such insured when the policy was initially written. However, the insurer shall have the discretion to use credit for underwriting or rating such insured upon renewal, if consistent with its underwriting guidelines.

(d) The insurer re-evaluates the insured beginning no later than 36 months after inception and thereafter based upon other underwriting or rating factors, excluding credit information.

H. Use the following as a negative factor in any insurance scoring methodology or in reviewing credit information for the purpose of underwriting or rating a policy of personal insurance:

1. Credit inquiries not initiated by the consumer or inquiries requested by the consumer for his or her own credit information.

2. Inquiries relating to insurance coverage, if so identified on a consumer's credit report.

3. Collection accounts with a medical industry code, if so identified on the consumer's credit report.

4. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the home mortgage industry and made within 30 days of one another, unless only one inquiry is considered.

5. Multiple lender inquiries, if coded by the consumer reporting agency on the consumer's credit report as being from the automobile lending industry and made within 30 days of one another, unless only one inquiry is considered.

Section 6. Extraordinary Life Circumstances

A. Notwithstanding any other law or regulation, an insurer that uses credit information shall, on written request from an applicant for insurance coverage or an insured, provide reasonable exceptions to the insurer's rates, rating classifications, company or tier placement, or underwriting rules or guidelines for a consumer who has experienced and whose credit information has been directly influenced by any of the following events:

1. Catastrophic event, as declared by the federal or state government
2. Serious illness or injury, or serious illness or injury to an immediate family member
3. Death of a spouse, child, or parent
4. Divorce or involuntary interruption of legally-owed alimony or support payments
5. Identity theft
6. Temporary loss of employment for a period of 3 months or more, if it results from involuntary termination
7. Military deployment overseas
8. Other events, as determined by the insurer

B. If an applicant or insured submits a request for an exception as set forth in Section 6(A), an insurer may, in its sole discretion, but is not mandated to:

1. Require the consumer to provide reasonable written and independently verifiable documentation of the event.
2. Require the consumer to demonstrate that the event had direct and meaningful impact on the consumer's credit information.
3. Require such request be made no more than 60 days from the date of the application for insurance or the policy renewal.
4. Grant an exception despite the consumer not providing the initial request for an exception in writing.
5. Grant an exception where the consumer asks for consideration of repeated events or the insurer has considered this event previously.

C. An insurer is not out of compliance with any law or rule relating to underwriting, rating, or rate filing as a result of granting an exception under this section. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

D. The insurer shall provide notice to consumers that reasonable exceptions are available and information about how the consumer may inquire further.

E. Within 30 days of the insurer's receipt of sufficient documentation of an event described in Section 6(A), the insurer shall inform the consumer of the outcome of their request for a reasonable exception. Such communication shall be in writing or provided to an applicant in the same medium as the request.

Section 7. Dispute Resolution and Error Correction

If it is determined through the dispute resolution process set forth in the federal Fair Credit Reporting Act, 15 USC 1681i(a)(5), that the credit information of a current insured was incorrect or incomplete and if the insurer receives notice of such determination from either the consumer reporting agency or from the insured, the insurer shall re-underwrite and re-rate the consumer within 30 days of receiving the notice. After re-underwriting or re-rating the insured, the insurer shall make any adjustments necessary, consistent with its underwriting and rating guidelines. If an insurer determines that the insured has overpaid premium, the insurer shall refund to the insured the amount of overpayment calculated back to the shorter of either the last 12 months of coverage or the actual policy period.

Section 8. Initial Notification

A. If an insurer writing personal insurance uses credit information in underwriting or rating a consumer, the insurer or its agent shall disclose, either on the insurance application or at the time the insurance application is taken, that it may obtain credit information in connection with such application. Such disclosure shall be either written or provided to an applicant in the same medium as the application for insurance. The insurer need not provide the disclosure statement required under this section to any insured on a renewal policy, if such consumer has previously been provided a disclosure statement.

B. Use of the following example disclosure statement constitutes compliance with this section: "In connection with this application for insurance, we may review your credit report or obtain or use a credit-based insurance score based on the information contained in that credit report. We may use a third party in connection with the development of your insurance score."

Section 9. Adverse Action Notification

If an insurer takes an adverse action based upon credit information, the insurer must meet the notice requirements of both (A) and (B) of this subsection. Such insurer shall:

A. Provide notification to the consumer that an adverse action has been taken, in accordance with the requirements of the federal Fair Credit Reporting Act, 15 USC 1681m(a).

B. Provide notification to the consumer explaining the reason for the adverse action. The reasons must be provided in sufficiently clear and specific language so that a person can identify the basis for the insurer's decision to take an adverse action. Such notification shall include a description of up to four factors that were the primary influences of the adverse action. The use of generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score" do not meet the explanation requirements of this subsection. Standardized credit explanations provided by consumer reporting agencies or other third party vendors are deemed to comply with this section.

Section 10. Filing

A. Insurers that use insurance scores to underwrite and rate risks must file their scoring models (or other scoring processes) with the Department of Insurance. A third party may file scoring models on behalf of insurers. A filing that includes insurance scoring may include loss experience justifying the use of credit information.

B. Any filing relating to credit information is considered trade secret under [cite to the appropriate state law].

Section 11. Indemnification

An insurer shall indemnify, defend, and hold agents harmless from and against all liability, fees, and costs arising out of or relating to the actions, errors, or omissions of [an agent / a producer] who obtains or uses credit information and/or insurance scores for an insurer, provided the [agent / producer] follows the instructions of or procedures established by the insurer and complies with any applicable law or regulation. Nothing in this section shall be construed to provide a consumer or other insured with a cause of action that does not exist in the absence of this section.

Section 12. Sale of Policy Term Information by Consumer Reporting Agency

A. No consumer reporting agency shall provide or sell data or lists that include any information that in whole or in part was submitted in conjunction with an insurance inquiry about a consumer's credit information or a request for a credit report or insurance score. Such information includes, but is not limited to, the expiration dates of an insurance policy or any other information that may identify time periods during which a consumer's insurance may expire and the terms and conditions of the consumer's insurance coverage.

B. The restrictions provided in subsection (A) of this section do not apply to data or lists the consumer reporting agency supplies to the insurance [agent / producer] from whom information was received, the insurer on whose behalf such [agent / producer] acted, or such insurer's affiliates or holding companies.

C. Nothing in this section shall be construed to restrict any insurer from being able to obtain a claims history report or a motor vehicle report.

Section 13. Severability

If any section, paragraph, sentence, clause, phrase, or any part of this Act passed is declared invalid due to an interpretation of or a future change in the federal Fair Credit Reporting Act, the remaining sections, paragraphs, sentences, clauses, phrases, or parts thereof shall be in no manner affected thereby but shall remain in full force and effect.

Section 14. Effective Date

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

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Sen. Travis Holdman, IN

SUMMARY: NCOIL STORM CHASER MODEL LEGISLATION

Table of Contents

Details the 13 sections of the model bill.

Section 1. Title

Currently, (State) Storm Chaser Consumer Protection Act.

Section 2. Purpose

The purpose of the Act is to protect Consumers from unscrupulous Contractor practices.

Section 3. Definitions

Creates a definition for Consumer, Contract, Contractor, and Person. Contractor includes a definition for roofing-related services, to include a subcontractor and other roofing related services and exempts a Person who meets three specific criteria.

Section 4. Written Contract Required

Determines the minimum requirements for a written Contract between the Contractor and the Consumer. Such requirements include the Contractor's contact and registration information; disclosure of the type of Contractors performing the work; the Consumer's right to pay by credit card; an itemized description of the services and costs; a separate document with a "Notice of Cancellation" statement that states the Consumer can cancel for any reason; and a right to cancel statement.

Section 5. Consumer Right to Rescind

The Consumer has the right to rescind a Contract, within three business days, for any reason, including if he or she has received a written notification from the insurer that all or any part of the claim is not covered under the insurance policy. The section also defines the procedures for a Consumer to send a cancellation notice and requires the Consumer to retain a copy of the cancellation notice.

Section 6. Consumer Right to Return of Deposit after Cancellation

Within ten days after a roofing Contract has been cancelled, the Contractor shall return deposits made by the Consumer. The section also entitles the Contractor to the reasonable value of any emergency services he or she performed.

Section 7. Registration Required

A Contractor shall not undertake any services without being registered as a Contractor with the state's appropriate accrediting body. The section requires a written application and proof of insurance to register as a Contractor. The section gives the state the right to deny or revoke a registration or refuse to issue a registration certificate if a licensee or

applicant has met certain criteria, including failure to pay taxes and fraudulent misrepresentation.

Section 8. Insurance Required

Requires the Contractor to have and maintain workers' compensation insurance, liability insurance, bodily injury insurance, property damage insurance, and surety and performance bonds. The section allows the accrediting body to determine the specific insurance amounts.

Section 9. Penalties

Penalties can be applied to a Contractor who violates the Act or Contract terms. The section also authorizes the accrediting body to consider the seriousness of the violation, the impact of the violation on the complainant, any mitigating factors on the part of the Contractor, and the Contractor's history of previous violations before issuing any penalties or revoking a registration.

Section 10. Prohibitions

Prohibits a Contractor from certain activities, including asking for a deposit of more than one half of the Contract price, and operating without a license.

Section 11. Exemptions

Exempts a residential or farm property owner who performs roofing services on their own property without the assistance of a Contractor; any authorized employee of the federal, state or local government performing a roofing service upon a government property; and any Person who furnishes material that is not incorporated into or attached to the roof.

Section 12. Enforcement

Authorizes the appropriate state body to enforce the provisions of the Act.

Section 13. Effective Date

Provides an effective date.

Section 14. Severability

Provides a severability clause to ensure that if one part of the Act is deemed invalid, the remainder of the Act remains in force.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Storm Chaser Consumer Protection Act

****Adopted by the NCOIL Executive Committee on July 19, 2015. Sponsored by Sen. Jason Rapert (AR) and Rep. Rich Golick (GA)***

****To be considered for re-adoption by the Property & Casualty Insurance Committee on September 24, 2020***

Table of Contents

Section 1. Title
Section 2. Purpose
Section 3. Definitions
Section 4. Written Contract Required
Section 5. Consumer Right to Rescind
Section 6. Consumer Right to Return of Deposit after Cancellation
Section 7. Registration Required
Section 8. Insurance Required
Section 9. Penalties
Section 10. Prohibitions
Section 11. Exemptions
Section 12. Enforcement
Section 13. Effective Date
Section 14. Severability

Section 1. Title

This Act shall be known and cited as the [State] Storm Chaser Consumer Protection Act.

Section 2. Purpose

The purpose of this Act is to establish minimum standards for roofing contracts and to promote fair and honest practices in the roofing services business.

Section 3. Definitions

For purposes of this Act:

- A. "Consumer" includes any individual who seeks the service of a "Contractor" as defined in this Act.
- B. "Contract" includes the entire cost of the construction undertaking, including labor, materials, rentals, all direct and indirect project expenses, and the parties involved in the agreement.
- C. "Contractor" means a Person, including, but not limited to, a Person that is a nonresident roofing contractor, independent contractor, day laborer, or subcontractor engaged in the business of roofing, gutter, downspout or siding services for a fee or who offers to engage in or solicits roofing-related services,

including construction, installation, renovation, repair, maintenance, alteration, or waterproofing. The term shall not include a person engaged in the demolition of a structure or the cleanup of construction waste and debris that contains roofing material, nor a person providing roofing services to a residential building of more than four units, nor a person engaged in building a new home or housing development.

D. "Person" includes any individual, partnership, corporation, business, trust, or other legal entity.

E. The words including, includes, and include are deemed to be followed by the words without limitation.

Section 4. Written Contract Required

A. Any agreement with a Contractor in an amount over [Enter Dollar Amount] shall be in writing and shall include the following documentation and information:

- (1) The complete agreement between the Consumer and the Contractor, with a clear description of any other documents which are or shall be incorporated into the agreement.
- (2) The Contractor's full legal name, business names, principal address, phone number, email, and the registration number.
- (3) The name of the Contractor's insurer, the type of insurance coverage as required by Section 8, and the insurance policy limits obtained by the Contractor.
- (4) An itemized description of the work to be done, any emergency services to be completed, and the materials to be used in the performance of the Contract.
- (5) The total itemized amount agreed to be paid for the work to be performed under the Contract, including all change orders and work orders.
- (6) A description of who will be performing the work, such as a subcontractor, independent contractor, day laborer, and/or others meeting the Contractor definition in Section 3.
- (7) An approximation of the cost expected to be borne by the Consumer.
- (8) A provision allowing payment to be made by cash, check, or credit card, at the Consumer's discretion.
- (9) The signatures of all Persons party to the Contract.
- (10) Contain in immediate proximity to the space reserved for the signature of the buyer in bold-face type of a minimum size of ten points, a statement in substantially the following form:

"You may cancel this Contract at any time within three business days of entering into this Contract with your Contractor. You may also cancel the Contract with your Contractor within three business days of being notified that your insurer has denied all or any part of your claim or loss under the insurance policy. See attached notice of cancellation form for an explanation of this right."

(11) Contain a fully completed form in duplicate, captioned "NOTICE OF CANCELLATION," which shall be attached to the Contract but easily detachable, and which shall contain, in boldface type of a minimum size of ten points, the following statement:

"NOTICE OF CANCELLATION

You may cancel this Contract at any time within three business days of entering into the Contract with your Contractor. You may also cancel the Contract with your Contractor within three business days of being notified that your insurer has denied all or any part of your claim or loss under the insurance policy. You may cancel the Contract by mailing or delivering a signed and dated copy of this cancellation notice or any other written notice to (name of Contractor) at (address of Contractor's place of business) at any time within three business days of receiving such notice from your insurer. You may also send a cancellation notice through email. If you cancel, any payments made by you under the Contract will be returned to you within ten business days following receipt by the Contractor of your cancellation notice, and any security interest arising out of the transaction will be canceled. You shall retain a copy of the notice of cancellation that is transmitted to the Contractor.

I HEREBY CANCEL THIS TRANSACTION

(Date) _____
(Consumer's Signature)"

B. At the time of signing, the Consumer shall be furnished with a copy of the Contract signed by both the Contractor and the Consumer. No work shall begin prior to the signing of the Contract and transmittal to the Consumer of a copy of the Contract.

Section 5. Consumer Right to Rescind

A Consumer has the right to rescind the Contract within three business days after he or she signs a Contract. A Consumer who has entered into a written Contract with a Contractor to provide goods or services to be paid from the proceeds of a property or casualty insurance policy may also cancel the Contract at any time prior to midnight of the third business day after he or she has received written notification from the insurer, including electronic notification, that all or any part of the claim is not covered under the insurance policy. Cancellation shall be evidenced by the Consumer giving written notice of cancellation to the Contractor at the physical address or email stated in the Contract. Notice of cancellation, if given by mail, shall be effective upon deposit into the United States mail, postage prepaid, and properly addressed to the Contractor. Notice of

cancellation need not take a particular form and shall be sufficient if it indicates, by any form of written expression, the intention of the Consumer not to be bound by the Contract. The Consumer shall retain a copy of the cancellation notice.

Section 6. Consumer Right to Return of Deposit after Cancellation

Within ten days after a Contract has been cancelled, the Contractor shall tender to the Consumer or possessor of the residential real estate any payments, partial payments, or deposits made by the Consumer and any note or other evidence of indebtedness. If, however, the Contractor has performed any services which were both acknowledged by the Consumer in writing and reflected in the original itemized estimate, the Contractor shall be entitled to the reasonable value of such services.

Section 7. Registration Required

A. No person shall undertake, offer to undertake, or agree to perform Contractor services unless registered with and approved by the [Enter Accrediting Body] as a Contractor.

B. Any Contractor who does not possess a certificate of registration from the [Enter Accrediting Body] as of [Enter Enactment Date], shall be entitled to complete any preexisting Contracts he or she has entered. However, a Contractor shall be required to register prior to bidding or entering into any Contracts within thirty days following [Enter Enactment Date].

C. In order to be registered as a Contractor, an applicant must make an application to the [Enter Accrediting Body]. The application shall set forth information that includes the following:

(1) The applicant's name, home address, business address, phone number, email address, website address, and social security number.

(2) The names and addresses of any and all affiliates, subsidiaries, partners, or trustees of the applicant including, in the case of corporate entities, the names and addresses of any and all officers, directors, and principal shareholders.

(3) A statement whether the applicant has ever been previously registered in the state as a Contractor, under what other names he or she was previously registered, whether there have been previous judgments or arbitration awards against him or her, and whether his or her registration has ever been suspended or revoked.

D. If requested, the applicant shall furnish the [Enter Accrediting Body] proof of insurance, as described in Section 8 of this Act.

E. The [Enter Accrediting Body] may fix fees, in an amount not to exceed [appropriate dollar amount], in a manner established by its rules for the registration fees and, if appropriate, renewal fees for Contractors. After consideration of administrative expenses, any fees collected under this section shall be used to enforce this Act.

F. The [Enter the Accrediting Body] may deny, restrict, suspend, revoke the registration of a Contractor, or refuse to register an applicant if he or she:

- (1) Employs the use of fraud, deceit, or misrepresentation in obtaining or attempting to obtain a registration or the renewal of a registration ;
- (2) Practices or attempts to practice roofing services by fraudulent misrepresentation;
- (3) Commits an act of gross malpractice or incompetence, as determined by [Enter Accrediting Body];
- (4) Has been convicted of or pled guilty or no contest to a crime that indicates that the person is unfit or incompetent to practice as a Contractor, or that indicates that the person has deceived or defrauded the public;
- (5) Has been declared incompetent by a court of competent jurisdiction;
- (6) Has willfully violated any provision in this Act or any rules adopted by [Enter Accrediting Body];
- (7) Has had a Contractor registration suspended in another state;
- (8) Fails to maintain insurance pursuant to Section 8 of this Act; or
- (9) Fails or refuses to pay any taxes due in this State.

G. The [Enter Accrediting Body] has the authority to accelerate registration for any Contractor that is registered and in good standing in another state with similar registration standards. The [Enter Accrediting Body] has the authority to issue a certificate of registration that will contain information deemed appropriate by the [Enter Accrediting Body]. Said certificate will be valid for [Enter appropriate term] from the date of its issuance and may be renewed upon approval of the [Enter Accrediting Body]. The certificate will not be transferable.

Section 8. Insurance Required

A. A Contractor shall obtain and maintain in full force and effect during the operation of the roofing business all of the following types of insurance:

- (1) Workers' compensation insurance in the amount of [Enter Appropriate State Amount];
- (2) Public liability insurance in the amount of [Insert the State Requirement];
- (3) Bodily injury in the amount of [Insert the State Requirement];
- (4) Property damage in the amount of [Insert the State Requirement]; and

(5) A Surety and Performance Bond is the amount of [Insert Appropriate State Amount].

Section 9. Penalties

- A. If the [Enter Accrediting Body] determines that any registrant is liable for violation of any of the provisions contained in this Act, the [Enter Accrediting Body] may suspend the registrant's certificate of registration for such period of time as shall be determined by the [Enter Accrediting Body], revoke the registrant's certificate of registration, or reprimand the registrant.
- B. The [Enter Accrediting Body] may assess an administrative penalty not to exceed [Enter state penalty] of the total Contract price, whichever is greater, payable within 30 days of their order, for each violation of any of the provisions of this Act, committed by the Contractor who is registered or who is required to be registered, plus any administrative costs incurred by the [Enter Accrediting Body].
- C. In determining whether to impose an administrative penalty, the [Enter Accrediting Body] shall consider the seriousness of the violation, the impact of the violation on the complainant, any mitigating factors on the part of the Contractor, and any previous violations by the Contractor.
- D. If any provision of this Act is violated, the Consumer has the right to rescind the agreement with the Contractor. However, the Consumer will be responsible for paying the Contractor for any work that was performed prior to the cancellation and acknowledged by the Consumer in writing, as specified in Section 4 of this Act.

[Drafting note: A state may want to consult with its attorney general's office to determine if a criminal penalty is necessary for inclusion in this Act or if an adjustment in the criminal penalty section of the current code is needed.]

Section 10. Prohibitions

- A. A Contractor shall not advertise, promise to pay, or rebate any portion of any insurance deductible as an inducement to the sale of goods or services. As used in this Section, a promise to pay or rebate includes granting any allowance or offering any discount against the fees to be charged or paying the Consumer or any Person directly or indirectly associated with the property any form of compensation.
- B. A Contractor shall not require a deposit of more than one half (1/2) of the Contract price.
- C. A Contractor shall not mandate that a particular form of payment be made in order to start roofing services.
- D. A Contractor shall not induce the sale of any goods or services by:
- (1) Offering or providing any upgraded work, material, or product;

(2) Granting any allowance or offering any discount against the fees to be charged; or

(3) Paying the Consumer, or any other person directly or indirectly associated with the property, any form of compensation, gift, prize, bonus, coupon, credit, referral fee, trade-in or trade-in payment, advertising, or other fee or payment.

E. A Contractor shall not operate without a certificate of registration issued by the [Enter Accrediting Body].

F. A Contractor shall not abandon or fail to perform, without justification, any ongoing Contract or project, or deviate from or disregard plans or specifications in any material respect without the consent of the Consumer.

G. A Contractor shall not fail to credit the Consumer for any payment the Consumer has made to the Contractor in connection with the Contract.

H. A Contractor shall not make any material misrepresentation in the procurement of a Contract or make any false promise likely to influence, persuade, or induce the procurement of a Contract.

I. A Contractor shall not violate the building code of the state or municipality.

J. A Contractor shall not fail to notify the [Enter Accrediting Body] within 30 business days of any change of trade name or address, or conducting a business in any name other than the one in which the Contractor is registered.

K. A Contractor shall not fail to pay for materials or services rendered in connection with his operating as a Contractor where he or she has received sufficient funds as payment for the particular construction work, project, or operation for which the services or materials were rendered or purchased.

L. A Contractor shall not perform the reporting, adjusting, or negotiating of a claim on behalf of the Consumer and shall not receive compensation for the referral to any entity that reports, adjusts or negotiates a claim on behalf of a Consumer.

M. A Contractor shall not fail to possess any insurance required as defined by state and federal law.

Section 11. Exemptions

The following persons are exempt from the requirements of this Act.

A. Residential or farm property owners who, without the assistance of a Contractor registered under this Act, physically perform or have employees who perform roofing, siding, gutter, or downspout services on the dwelling or on another structure located on the residential or farm property.

B. Any authorized employee or representative of the United States government, this state, or any county, municipality, or other political subdivision of this state performing a roofing service upon government property.

C. Any Person who furnishes any fabricated or finished product, material, or article of merchandise that is not incorporated into or attached to real property by the Person so as to become affixed to the property.

Section 12. Enforcement

A. The provisions of this Act shall be enforced by the [Enter the Accrediting Body].

B. The [Enter the Accrediting Body] should have sufficient funding to properly enforce the provisions of this Act.

Section 13. Effective Date

A. This Act shall take effect on [Enter Effective Date].

Section 14. Severability.

A. The provisions of this Act are severable. If any part of this Act is declared invalid or unconstitutional, that declaration shall not affect the parts that remain.

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National Council of Insurance Legislators (NCOIL)

POST-ASSESSMENT PROPERTY AND LIABILITY INSURANCE GUARANTY ASSOCIATION MODEL ACT

****Adopted by the Property-Casualty Insurance Committee on November 16, 2007, and Executive Committee on November 17, 2007. Amended by both Committees on March 1, 2015.***

****To be considered for re-adoption by the Property & Casualty Insurance Committee on September 24, 2020.***

Summary

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

Table of Contents

Section 1. Title
Section 2. Scope
Section 3. Definitions
Section 4. Creation of the Association
Section 5. Board of Directors
Section 6. Powers and Duties of the Association
Section 7. Plan of Operation
Section 8. Duties and Powers of the Commissioner
Section 9. Effect of Paid Claims
Section 10. Exhaustion of Other Coverage
Section 11. Prevention of Insolvencies
Section 12. Examination of the Association
Section 13. Tax Exemption

Section 14. Recognition of Assessments in Rates

Section 15. Immunity

Section 16. Stay of Proceedings

Section 1. Title

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

Section 2. Scope

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

- A. life, annuity, health, or disability insurance
- B. mortgage guaranty, financial guaranty, or other forms of insurance offering protection against investment risks
- C. fidelity or surety bonds, or any other bonding obligations
- D. credit insurance, vendors' single interest insurance, or collateral protection insurance or any similar insurance protecting the interests of a creditor arising out of a creditor debtor transaction
- E. insurance of warranties or service contracts, including insurance that provides for the repair, replacement, or service of goods or property, or indemnification for repair, replacement or service, for the operational or structural failure of the goods or property due to a defect in materials, workmanship or normal wear and tear, or provides reimbursement for the liability incurred by the issuer of agreements or service contracts that provide such benefits
- F. title insurance
- G. ocean marine insurance
- H. any transaction or combination of transactions between a person (including affiliates of such person) and an insurer (including affiliates of such insurer) that involves the transfer of investment or credit risk unaccompanied by transfer of insurance risk or
- I. any insurance provided by or guaranteed by government

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

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

Section 3. Definitions

As used in this Act:

- A. “Account” means any one of the three (3) accounts created by Section 6.
- B. “Affiliate” means a person who directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with another person.
- C. “Affiliate of the insolvent insurer” means a person who directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with an insolvent insurer on December 31 of the year prior to the date the insurer becomes an insolvent insurer.
- D. “Association” means the [insert name of state] Insurance Guaranty Association created under Section 4.
- E. “Association similar to the Association” means any guaranty association, security fund, or other insolvency mechanism that affords protection similar to that provided by the Association. The term also shall include any property-casualty insolvency mechanism that obtains assessments or other contributions from insurers on a pre-insolvency basis.
- F. “Claimant” means any insured making a first-party claim or any person instituting a liability claim, provided that no person who is an affiliate of the insolvent insurer may be a claimant.
- G. “Commissioner” means the Commissioner of Insurance of this State.

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

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

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

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

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

2. “Covered claim” shall not include:

a. any amount awarded as punitive or exemplary damages

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

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

Drafting Note: Express exclusions set out in (c) above for health maintenance organizations, hospital plan corporations, professional health service corporations, and self-insurers may not be included in many current state laws. Fund counsel should review

applicable case law in their states to determine if it is necessary or advisable to add them as part of an amendment package. Funds may want to consider characterizing such an amendment, if adopted, as “clarifying” or “technical.”

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

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

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

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

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

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

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

specified by such law, and which association has denied coverage to that claimant on that basis.

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

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

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

j. any claims for interest

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

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

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

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

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

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

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

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

an insolvent insurer prior to the termination or expiration of such insurer's license.

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

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

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

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

Section 4. Creation of the Association

There is created a nonprofit unincorporated legal entity to be known as the [insert state name] Insurance Guaranty Association. All insurers defined as member insurers in Section 3 shall be and remain members of the Association as a condition of their authority to transact insurance in this state. The Association shall perform its functions under a plan of operation established and approved under Section 7 and shall exercise its powers through a board of directors established under Section 5. For purposes of administration and assessment, the Association shall be divided into three (3) separate accounts: the account for workers' compensation, the account for auto, and the account for all other claims covered by the Association.

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

Section 5. Board of Directors

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

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

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

Section 6. Powers and Duties of the Association

A. The Association shall:

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

- a. the full amount of a covered claim for benefits under a workers' compensation insurance coverage
- b. an amount not exceeding \$10,000 per policy for a covered claim for the return of unearned premium
- c. an amount not exceeding \$300,000 per claim for all other covered claims; provided, that for purposes of this limitation, all claims of any kind whatsoever arising out of, or related to, bodily injury or death to any one person shall constitute a single claim, regardless of the number of claims made, or the number of claimants

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

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

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

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

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

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

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

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

3. allocate claims paid and expenses incurred among the three (3) accounts separately, and assess member insurers separately for each account, amounts necessary to pay the obligations of the Association under this Act subsequent to an insolvency, the expenses of handling covered claims subsequent to an insolvency and other expenses authorized by this Act. The assessments of each member insurer shall be in the proportion that the net direct written premiums of the member insurer for the calendar year prior to the assessment on the kinds of insurance in the account bears to the net direct written premiums of all member insurers for the calendar year prior to the assessment on the kinds of insurance in the account. Each member insurer shall be notified of the assessment not later than thirty (30) days before it is due. No member insurer may be assessed in any one year on any account an amount greater than two (2) percent of that member insurer's net direct written premiums for the calendar year preceding the assessment on the kinds of insurance in the account. If the maximum assessment, together with the other assets of the Association in any account, does not provide in any one year in any account an amount sufficient to make all necessary payments from that account, the funds available shall be pro-rated and the unpaid portion shall be paid as soon thereafter as funds become available. The Association shall pay claims in any order that it deems reasonable, including the payment of claims as such are received from the claimants or in groups or categories of claims. The Association may exempt or defer, in whole or in part, the assessment of any member insurer, if the assessment would cause the member insurer's financial statement to reflect amounts of capital or surplus less than the

minimum amounts required for a certificate of authority by any jurisdiction in which the member insurer is authorized to transact insurance; provided, however, that during the period of deferment, no dividends shall be paid to shareholders or policyholders. Deferred assessments shall be paid when such payment will not reduce capital or surplus below required minimums. Such payments shall be refunded to those companies receiving larger assessments by virtue of such deferment, or at the election of any such company, credited against future assessments. Each member insurer may set off against any assessment, authorized payments made on covered claims and expenses incurred in the payment of such claims by the member insurer if they are chargeable to the account for which the assessment is made.

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

5. not be bound by any settlement, release, compromise, waiver, or judgment executed or entered within twelve (12) months prior to an order of liquidation and shall have the right to assert all defenses available to the Association including, but not limited to, defenses applicable to determining and enforcing its statutory rights and obligations to any such claim. The Association shall be bound by any settlement, release, compromise, waiver, or judgment executed or entered into more than one year prior to an order of liquidation; provided, however, such claim is a covered claim and such settlement or judgment was not a result of fraud, collusion, default, or failure to defend. Further, as to any covered claims arising from a judgment under any decision, verdict, or finding based on the default of the insolvent insurer or its failure to defend, the Association either on its own behalf or on behalf of an insured may apply to have such judgment, order, decision, verdict, or finding set aside by the same court or administrator that made such judgment, order, decision, verdict, or finding and shall be permitted to defend such claim on the merits.

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

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

8. establish procedures for requesting financial information from insureds and claimants on a confidential basis for purposes of applying sections of this Act

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

B. The Association may:

1. employ or retain such persons as are necessary to handle claims and perform other duties of the Association
2. borrow funds necessary to effect the purposes of this Act in accord with the plan of operation
3. sue or be sued, and such power to sue includes the power and right to intervene as a party as a matter of right before any court in this state that has jurisdiction over an insolvent insurer as defined by this Act.
4. negotiate and become a party to such contracts as are necessary to carry out the purpose of this Act
5. perform such other acts as are necessary or proper to effectuate the purpose of this Act
6. refund to the member insurers in proportion to the contribution of each member insurer to that account that amount by which the assets of the account exceed the liabilities, if at the end of any calendar year, the board of directors finds that the assets of the Association in any account exceed the liabilities of that account as estimated by the board of directors for the coming year
7. bring an action against any third-party administrator, agent, attorney, or other representative of the insolvent insurer to obtain custody and control of all files, records, and electronic data ("claims information") related to an insolvent company that are appropriate or necessary for the Association, or a similar association in other states, to carry out its duties under this Act. In such a suit, the Association shall have the absolute right through emergency equitable relief to obtain custody and control of all such claims information in the custody or control of such third-party administrator, agent, attorney, or other representative of the insolvent insurer, regardless of where such claims information may be physically located. In bringing such an action, the Association shall not be subject to any defense, lien (possessory or otherwise) or other legal or equitable ground whatsoever for refusal to surrender such claims information that might be asserted against the Liquidator of the insolvent insurers. To the extent that litigation is required for the Association to obtain custody of the claims information requested

and it results in the relinquishment of claims information to the Association after refusal to provide the same in response to a written demand, the court shall award the Association its costs, expenses, and reasonable attorneys' fees incurred in bringing the action. The provisions of this section shall have no effect on the rights and remedies that the custodian of such claims information may have against the insolvent insurers, so long as such rights and remedies do not conflict with the rights of the Association to custody and control of the claims information under this Act.

C. Suits Involving the Association

1. Except for actions by member insurers aggrieved by final actions or decisions of the Association pursuant to Section 6.A.3., all actions relating to or arising out of this Act against the Association must be brought in the courts in this state. Such courts shall have exclusive jurisdiction over all actions relating to or arising out of this Act against the Association.
2. Exclusive venue in any action by or against the Association is in [designate appropriate court]. The Association may, at the option of the Association, waive such venue as to specific actions.
3. In any lawsuit contesting the applicability of Sections 3.I.2.d. and e. or 9.B.1. where the insured or claimant has declined to provide financial information under the procedure provided pursuant to Section 6 of this Act, the insured or claimant shall bear the burden of proof concerning its net worth at the relevant time. If the insured or claimant fails to prove that its net worth at the relevant time was less than the applicable amount, the court shall award the Association its full costs, expenses, and reasonable attorneys' fees in contesting its claim.

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

Section 7. Plan of Operation

- A.
 1. The Association shall submit to the Commissioner a plan of operation and any amendments thereto necessary or suitable to assure the fair, reasonable, and equitable administration of the Association. The plan of operation and any amendments thereto shall become effective upon approval in writing by the Commissioner.
 2. If the Association fails to submit a suitable plan of operation within ninety (90) days following the effective date of this Act, or if at any time thereafter the

Association fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this Act. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the Association and approved by the Commissioner.

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

C. The plan of operation shall:

1. establish the procedures whereby all the powers and duties of the Association under Section 6 will be performed
2. establish procedures for handling assets of the Association
3. mandate that procedures be established for the disposition of liquidating dividends or other monies received from the estate of the insolvent insurer
4. mandate that procedures be established to designate the amount and method of reimbursing members of the board of directors under Section 5.C
5. establish procedures by which claims may be filed with the Association and establish acceptable forms of proof of covered claims. Notice of claims to the receiver or liquidator of the insolvent insurer shall be deemed notice to the Association or its agent and a list of claims shall be periodically submitted to the Association or Association similar to the Association in another state by the receiver or liquidator
6. establish regular places and times for meetings of the board of directors
7. mandate that procedures be established for records to be kept of all financial transactions of the Association, its agents, and the board of directors
8. provide that any member insurer aggrieved by any final action or decision of the Association may appeal to the Commissioner within thirty (30) days after the action or decision
9. establish the procedures whereby selections for the board of directors will be submitted to the Commissioner
10. contain additional provisions necessary or proper for the execution of the powers and duties of the Association

D. The plan of operation may provide that any or all powers and duties of the Association, except those under Section 6.A.3. and 6.B.2., are delegated to a corporation, Association similar to the Association, or other organization that performs or will

perform functions similar to those of this Association or its equivalent in two or more states. Such a corporation, association, or organization shall be reimbursed as a servicing facility would be reimbursed and shall be paid for its performance of any other functions of the Association. A delegation under this subsection shall take effect only with the approval of both the board of directors and the Commissioner, and may be made only to a corporation, association, or organization that extends protection not substantially less favorable and effective than that provided by this Act.

Section 8. Duties and Powers of the Commissioner

A. The Commissioner shall:

1. notify the Association of the existence of an insolvent insurer not later than three (3) days after he receives notice of the determination of the insolvency. The Association shall be entitled to a copy of any complaint seeking an order of liquidation with a finding of insolvency against a member company at the same time that such complaint is filed with a court of competent jurisdiction
2. upon request of the board of directors, provide the Association with a statement of the net direct written premiums of each member insurer

B. The Commissioner may:

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

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

Section 9. Effect of Paid Claims

A. Any person recovering under this Act shall be deemed to have assigned his rights under the policy to the Association to the extent of his recovery from the Association. Every insured or claimant seeking the protection of this Act shall cooperate with the Association to the same extent as such person would have been required to cooperate with the insolvent insurer. The Association shall have no cause of action against the insured of the insolvent insurer for any sums it has paid out except such causes of action as the insolvent insurer would have had if such sums had been paid by the insolvent

insurer and except as provided in Subsection B. below. In the case of an insolvent insurer operating on a plan with assessment liability, payments of claims of the Association shall not operate to reduce the liability of the insureds to the receiver, liquidator, or statutory successor for unpaid assessments.

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

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

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

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

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

Section 10. Exhaustion of Other Coverage

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

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

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

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

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

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

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

Section 11. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

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

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

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

Section 12. Examination of the Association

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

Section 13. Tax Exemption

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

Section 14. Recognition of Assessments in Rates

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

Section 15. Immunity

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

Section 16. Stay of Proceedings

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

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

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Regarding Medicaid Interception of Insurance Payments

****Model adopted by the NCOIL Executive Committee on November 23, 2014, and amended on March 1, 2015. Sponsored by Rep. Brian Kennedy, RI***

****To be considered for re-adoption by the Property & Casualty Insurance Committee on September 24, 2020.***

Table of Contents

Section 1 Short Title
Section 2 Purpose
Section 3 Scope
Section 4 Application
Section 5 Definitions
Section 6 Match Process
Section 7 Payment Process
Section 8 Data Confidentiality
Section 9 Notice
Section 10 Request for Hearing
Section 11 Immunity

Section 1 Short Title

This Act may be called the *Model Act Regarding Medicaid Interception of Insurance Payments*.

Section 2 Purpose

In accordance with state law and applicable administrative rules, when applying for Medicaid, an applicant (beneficiary) automatically assigns his or her rights to the (NAME OF STATE AGENCY) to any payments under applicable insurance coverage. The purpose of this Act is to regulate the recovery of monies paid by (NAME OF STATE AGENCY).

Section 3 Scope

This Act applies to no-fault, personal injury protection, medical payments coverage and third party payments for bodily injury from insurers and self-funded primary plans (plan). Claims excluded from interception include liability policies that do not pay for bodily

injury, claims for property damage or loss of use of property, claims made against accident and health policies whether expense incurred or indemnity and all workers' compensation claims.

Section 4 Application

A. Nothing in these sections shall limit the (NAME OF STATE AGENCY) from recovery of any other monies allowed, to the extent of the distribution, in accordance with all state and federal laws.

B. Any action to pursue any recovery of monies paid by (NAME OF STATE AGENCY) shall be commenced within two years after the date of the accident or event causing the injury asserted by the beneficiary. Nothing herein shall lengthen any time limitations set forth in any plan or insurance policy.

Section 5 Definitions

A. Claimant--either an insured under a policy of insurance or a third party to an insurance policy requesting benefits orally or in writing in excess of two thousand dollars, \$2,000.00, for injuries received as a result of an accident or loss. Claimant includes a person's legal representative, family members or any other individual acting on their behalf.

B. Insurer--any insurance company licensed to do business in (Name of State), excluding those that do not issue coverages within the scope of the act in section 3.

C. Medicaid Beneficiary--an individual who has received (Name of State) Medicaid Medical Benefits in excess of two thousand dollars, \$2,000.00, as a result of an accident or loss.

D. Plan--any entity that is self insured for its legal responsibility without the benefit of primary insurance, through the use of a self-insured retention. This includes but is not limited to any entity that is directing the handling of its claims through a third party or as a result of a policy buy back, cost sharing agreement or coverage in place agreement.

Section 6 Match Process

A. For the purposes of this section, the matching process is limited to a beneficiary or estate making a bodily injury or wrongful death claim against a plan or under an insurance policy.

B. Claims excluded from interception include liability policies that do not pay for bodily injury, claims for property damage or loss of use of property, claims made against accident and health policies whether expense incurred or indemnity and all workers compensation claims. A payment made to fund a structured settlement annuity and payments pursuant to a structured settlement annuity are excluded from interception if established after twenty-four (24) months from date of loss.

C. At any time prior to making a total payment of two thousand dollars (\$2000.00) or more on behalf of or to a claimant, on a claim under a plan or contract of insurance, every plan or insurer issuing automobile or policies of liability insurance, shall exchange information with the (NAME OF STATE AGENCY) by the means set forth in this Act.

D. In order to facilitate compliance with this Act, (NAME OF STATE AGENCY) shall develop and operate a data match system after consultation with one or more insurers and plans, using automated data exchanges to the maximum extent feasible, to compare claimant information held by insurers and plans with the (NAME OF STATE AGENCY) database of beneficiaries.

E. In order to comply with the requirements of this section, an insurer or plan shall provide the (NAME OF STATE AGENCY) with the following information about the individual or estate determined by the (NAME OF STATE AGENCY) to be a beneficiary:

- a. Name,
- b. Address

They may provide the following optional data:

- d. Date of Birth
- e. Last Four Digits of a Social Security Number

F. An insurer or plan may provide such information by:

a. Authorizing an insurance claim data collection organization, to which the insurer or plan subscribes and to which the insurer or plan submits the required claim data on at least a weekly basis, to:

1. Receive or access a data file from the (NAME OF STATE AGENCY) and conduct a data match of all individuals who have a claim with the insurer or plan and who are Medicaid Beneficiaries and submit the required data for each such resulting data match to (NAME OF STATE AGENCY AND/OR THEIR AUTHORIZED VENDOR); or

2. Submit a data file to the (NAME OF STATE AGENCY) which contains the required data for each claim being maintained by the insurer or plan for the (NAME OF STATE AGENCY) to conduct a data match;

b. Providing the required data for each claim being maintained by the insurer or plan directly to the (NAME OF STATE AGENCY) in an electronic medium; or

c. Receiving or accessing a data file from the (NAME OF STATE AGENCY) and conducting a data match of individuals who have a claim with the insurer or plan and who are Medicaid beneficiaries and submit the required data for each such resulting data match to (NAME OF STATE AGENCY);

G. Upon receiving notice of a match as set forth in this section, the (NAME OF STATE AGENCY) shall send the insurer or plan a notice of lien pursuant to (CITATION OF STATE LAW)

H. Any insurer or plan that can show that they have made a good faith effort to comply shall be deemed to have complied unless (NAME OF STATE AGENCY) proves an intentional failure to comply by demonstrating a pattern and practice of non-compliance. A single instance will not be sufficient proof.

Section 7 Payment Process

The insurer or plan shall withhold the lesser of the amount of the claim payment or the full amount as set forth in the notice of lien and shall remit that amount to the (NAME OF STATE AGENCY) as provided by (CITATION OF STATE LAW), subject to conditions as stated below.

A. The lien shall encumber the right of the claimant to payment under the policy or plan, and the insurer or plan shall disburse to the claimant only that portion of the payment, if any, after the lien has been satisfied.

B. The lien shall be inferior to any lien or claim for attorney fees.

C. Should the beneficiary and/or their representative believe that the payment of the lien exceeds the extent of the distribution, in accordance with all state and federal laws, and notifies the insurer or plan that they intend to file an administrative appeal the insurer or plan may issue a check made payable to the beneficiary, their representative and (Name of State Agency).

D. The insurer or plan, may notify the (Name of State Agency) of its intent to issue a payment as a single check made payable to; the beneficiary, any representative, any other lienholders and the (Name of State Agency).

E. If the lien is received after the insurer or plan has issued the payment the insurer or plan will notify the (Name of State Agency) of the following information: Date of Payment, Amount of Payment, Payees(s) and Address of recipient. In no case shall the insurer or plan be obligated to make any further payments.

Section 8 Data Confidentiality

A. The information obtained by the (NAME OF STATE AGENCY) pursuant to the provisions of this section shall be used only to aid in recovery of Medicaid payments.

B. An insurer or plan, and its directors, agents or employees, and any insurance claim data collection organization and its agents and employees authorized by an insurer or plan to act on its behalf, shall keep this information safe and private in accordance with applicable state law.

Section 9 Notice

(NAME OF STATE AGENCY) shall provide written notice to the claimant and his/her attorney if represented which shall include the date, name, social security number, case number, and amount of the payment being withheld to reimburse the state, reason for the payment and opportunity to request a hearing.

Section 10 Request for Hearing

Any beneficiary aggrieved by any action taken under these procedures may within thirty (30) days of the date of the notice to the claimant request a hearing from the (NAME OF STATE AGENCY). Any payments made by an insurer or plan pursuant to this chapter

shall be made to the (NAME OF STATE AGENCY), unless there is request for hearing within thirty (30) days of the notice, or within ten (10) business days of a decision after hearing and in accordance with the decision of any hearing that takes place.

Section 11 Immunity

A. An insurer or plan, and its directors, agents or employees, and any insurance claim data collection organization and its agents and employees authorized by an insurer or plan to act on its behalf, which provides or attempts to provide data under this section are immune from any civil liability under any law to any person or entity for any alleged or actual damages that occur as a result of providing or attempting to provide data under this section. This act does not create any other obligations upon insurers or plan.

B. An insurer or plan, and its directors, agents or employees, and any insurance claim data collection organization and its agents and employees authorized by an insurer or plan to act on its behalf, under this section are immune from any civil liability under any law to any person or entity for any alleged or actual damages that occur as a result of making a lien payment to a state agency as demanded by the state.

C. Any person against whom any action is brought who is found to be immune from liability under this section, shall be entitled to recover reasonable attorney's fees and costs from the person or party who brought the action. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUSINESS PLANNING AND EXECUTIVE COMMITTEE
NCOIL SPRING MEETING – CHARLOTTE, NC
MARCH 8, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning and Executive Committee met at the Charlotte Marriott City Center on Sunday, March 8, 2020 at 10:00 a.m.

NCOIL President, Rep. Matt Lehman, IN, Chair of the committee presided.

MEMBERS OF THE COMMITTEE PRESENT:

Asm. Ken Cooley, CA, Vice President	Sen. Jerry Klein, ND
Sen. Bob Hackett, OH	Rep. Deborah Ferguson, AR
Sen. Paul Wieland, MO	Rep. Joe Fischer, KY
Sen. Travis Holdman, IN	Sen. Paul Utke, MN
Rep. Martin Carbaugh, IN	

ALSO PRESENT:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, General Counsel, NCOIL
Cara Zimmermann, Assistant Director for Administration, NCOIL Support Services

QUORUM

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

MINUTES

A motion was made by Rep. Lehman and seconded by Sen. Hackett to approve the minutes of the December 13th, 2019 Committee Meeting minutes.

FUTURE LOCATIONS

Commissioner Considine discussed the 2022 Spring Meeting location in Las Vegas, NV at Harrah's from March 3-6. The 2022 Annual Meeting will be in New Orleans, LA. Cmsr. Considine stated that as per the direction of the Officers, NCOIL needs to get back the traditional dates of having the Annual meetings before Thanksgiving, wrapping up the Saturday before Thanksgiving. Cmsr. Considine noted that it is difficult to have a December meeting because the following Spring Meeting is not far away, beginning in early March. More importantly, so many of the member legislators have prefiling deadlines in December. Models that are getting passed at an Annual Meeting in December end up missing the prefiling dates. Therefore, the traditional November dates work much better.

Cmsr. Considine discussed the 2023 Annual Meeting location in Columbus, OH from November 15–18. The following year, the 2024 Annual Meeting will be in San Antonio,

TX, down by the Riverwalk. The Spring and Summer meeting locations for 2024 have not been filled yet.

ADMINISTRATION

Commissioner Considine noted that there were 273 total registrants for the Spring Meeting, 46 legislators from 18 states including 15 first-time legislators. Six legislators participated in scholarships – five full and one partial. Five Insurance Commissioners were in attendance, 11 insurance departments were represented. About 20 registrants ultimately did not attend the Meeting due to travel restrictions and some fear of COVID19.

Cmsr. Considine gave the 2019 fourth quarter unaudited financial report through December 31st, 2019 showing a revenue of \$1,211,710.11 and expenses of \$1,075,050.56 with an excess of \$136,659.55.

He also noted that the 2021 fiscal year dues went out. It is too early to assess how the new financial structure is doing.

Asm. Cahill made a motion to accept the administration report that was seconded by Sen. Utke. It carried on a voice vote.

CONSENT CALENDAR

Rep. Lehman 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 Sen. Holdman seconded the consent calendar. The motion carried on a voice vote.

OTHER SESSIONS

Rep. Lehman noted that the Griffith Foundation Legislator Luncheon “Considering the Economic Impact of the Insurance Industry on the States: An Overview for Public Policy” with Dr. James Carson, Daniel P. Amos Distinguished Professor of Insurance at the Terry College of Business at University of Georgia, was well attended, especially by the first-time legislators.

He also thanked the featured speakers, NC Insurance Commissioner Mike Causey and Paul Tetrault from the Insurance Library, at the Welcome Breakfast and Dir. Nick Davidson from the SC Department of Health and Environmental Control for giving a fascinating and timely Keynote Luncheon Speech about COVID-19.

There were two interesting General Sessions – “LIBOR’s End: What Does it Mean?” moderated by Sen. Holdman and “What States Preparing for Opioid Lawsuit Funds Can Learn from Tobacco Settlements” moderated by Asw. Pam Hunter (NY). Both were very timely and well attended as well.

OTHER BUSINESS

Rep. Lehman thanked NC Senators Vickie Sawyer and Valerie Foushee for being great host legislators to NCOIL in Charlotte.

ADJOURNMENT

There being no further business, Rep. Lehman made a motion to adjourn that was seconded by Rep. Ferguson. The committee adjourned at 10:10 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 8, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Sunday, March 8, 2020 at 8:45 a.m.

Senator Jerry Klein of North Dakota, NCOIL Chairman At-Large, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Shawn Vedaa (ND)
Sen. Travis Holdman (IN)	Sen. Bob Hackett (OH)
Rep. Matt Lehman (IN)	
Rep. Joe Fischer (KY)	

Other legislators present were:

Rep. Deborah Ferguson (AR) Sen. Paul Utke (MN)
Rep. Martin Carbaugh (IN) Sen. Paul Wieland (MO)

Also in attendance were:

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

QUORUM

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Sen. Shawn Vedaa (ND), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Sen. Bob Hackett (OH), the Committee approved the minutes of its December 11, 2019 meeting in Austin, TX without objection by way of a voice vote.

SUPPORTING AND PROMOTING INNOVATION IN THE INSURANCE INDUSTRY

Nicole Gunderson, Managing Director of the Global Insurance Accelerator (GIA), stated that the GIA is currently operating its sixth annual accelerator program. GIA has helped to accelerate 36 companies in the first five years. By every metric, GIA is succeeding: the number of investors; the number of mentors; and impact on the market. Yet, the GIA is a startup too. While there are many opportunities, GIA is laser focused on developing companies that bring innovation to the insurance industry. GIA continues to adapt and pivot to meet the changing needs of the industry. As the leader in insurance innovation,

GIA continues to get smarter on where to put its resources to help companies thrive. GIA does this because every day, GIA's investors wake up knowing that innovation is key to survival in the insurance industry. So the GIA remains focused on how it impacts innovation specifically within the insurance industry.

Ms. Gunderson stated that Des Moines, Iowa is a hub for insurance innovation. The GIA is at the epicenter of insurtech. Iowa has 225 domiciled insurers creating a concentration of insurance professionals. Some cities have oceans, some have mountains – Des Moines has actuaries. With that set of natural resources, the GIA was founded in 2014 with the goal of bringing together insurance companies and startups focused on insurance technology. GIA has an application process where teams apply to come to Des Moines in January. The number of companies selected each year has varied between six and ten. The companies are brought to Des Moines for 100 days where intensive programming is provided to help build their business and accelerate their growth. GIA provides \$75,000 in investment which converts to 5% equity in the company.

Ms. Gunderson stated that GIA's focus is different than other accelerators. Since its founding, one of GIA's key tenets has been to help their portfolio companies build an income statement. Many accelerators spend the majority of their time helping startups perfect the pitch with the hope of gaining and moving into a venture capital investment. The GIA is different because its focus is on building the income statement with real customers paying real money for real value versus focusing on the perfect pitch to raise the next round of capital. GIA's companies clearly need funding to grow but if a company has customers and revenue, investment will more easily follow. While GIA's focus is on the income statement, GIA knows that companies need funding to keep moving on which is why GIA creates more focus on helping the portfolio companies raise capital. GIA mentors them well beyond the 100 days of the GIA program once they have begun to build that income statement.

Ms. Gunderson stated that the GIA is an innovation platform designed to serve the insurance industry by discovering, supporting, and connecting early-stage companies building new solutions. The formula matters. GIA's secret sauce is a collaboration of insurance company investors, dedicated mentors who are insurance executives and professionals, and startups who are the insurtech companies. Together, it is a unique program that focuses on each company's success. None of the program would be possible without the current investors who are 100% insurance companies. When GIA started in 2014, there were seven Des Moines based insurance companies and now in 2020 there are 15 investor companies throughout the U.S. – some are regional players and some have a global reach.

Ms. Gunderson stated that the focus of the GIA is a mentor-drive program. The startups that are brought in are not going it alone. GIA aligns them with mentors that have years of experience to help guide them. The majority of mentors are industry leading professionals based not only in Des Moines but throughout the country and the world. They dedicate their time on a volunteer basis over the course of 100 days to help the companies grow within the insurance industry. It is like building an advisory bench that helps the startups, some of which don't have insurance experience.

Ms. Gunderson stated that the makeup of the 36 companies from the first five years of the GIA spans solutions that serve P&C, health, life and annuities, and more. Some join

the GIA as a pre-product, pre-revenue company. Some have already found an early product-market fit and have initial customers and they are joining the program to look to grow and expand their revenues. The 2019 cohort of ten companies solves some big problems for the industry, such as Cowbell Cyber which is building a cyber software insurance company product for small and medium-sized businesses. Friendly offers a machine-learning technology that converts handwritten notes, even those of doctors.

GIA is currently in its sixth year which is the 2019 cohort. The active program right now just crossed the 50 day benchmark of the 100 day program. GIA evaluated a strong and growing application field and GIA is especially impressed by the quality of the founders and the solutions in terms of the industry need, product-market fit, and degree of innovation. Ms. Gunderson then provided a synopsis of the seven companies in the 2020 cohort. Caregiven is an Oregon-based startup enabling providers to offer real-time, curated guidance to individuals and families managing the end-of-life care for an ailing and aging loved one. DenScore is a Michigan-based startup using existing claims data to support dental insurers pay for performance initiatives to drive value-based scores for participating dentists. Gerald is a New York based startup offering a life event engagement and cross-sell platform for insurance providers. InsureVite is a Singapore-based startup that aids insurers in reducing friction in the insurance process and revolutionizing customer experience through social messaging apps. Kiwi is a New York-based startup focused on bringing episodic, on-demand injury insurance innovatively by using social media analytics to meet customers where they are. Summary Medical is a Wisconsin-based startup employing artificial intelligence to automate the review of medical records for the life insurance industry. Udotest is a Massachusetts-based startup via South Africa providing a business to business at-home disease testing software platform which helps enterprises improve insurance outcomes.

Ms. Gunderson stated that GIA concludes its 100 day program in a final presentation/demo day which you can watch a livestream of the companies giving a pitch on what the companies aim to do. That takes place on April 22nd.

Ms. Gunderson stated that she started her career in BMO Capital Markets operating in the U.S. analyzing companies' financial needs and helping them grow. Through her MBA at Wharton, Ms. Gunderson transitioned to the startup world where she spent five years with an early-stage venture-backed fintech company called Dwolla. Ms. Gunderson helped build out the sales and customer success teams for business to business software application programs and interfacing platforms. Ms. Gunderson had to navigate selling Dwolla's technology to banks. Ms. Gunderson stated that she also had a strong interest in mentoring and advising startups which led her to her next startup, Speeko.

Ms. Gunderson stated that she learned of the opportunity with the GIA in late 2018 and upon doing research, she realized there were a lot of parallels to what the financial services industry and fintech was experiencing with the advancements in technology as was occurring in the insurance and insurtech space. Both were just scratching the surface. Ms. Gunderson knew that she could have an impact on innovation in the insurance industry through her work with the GIA when she joined in early 2019. Ms. Gunderson thanked the Committee for the opportunity to explain more about GIA.

CONTINUED DISCUSSION ON DEVELOPMENT OF NCOIL INSURANCE
MODERNIZATION MODEL LEGISLATION

a.) Consideration of NCOIL Insurance E-Commerce Model Act

Sen. Klein noted that the sponsor of the NCOIL E-Commerce Model Act (Model), Rep. Edmond Jordan (LA), Chair of the Committee, was not able to make it to this meeting but expressed his intent to have the Model voted on by the Committee.

Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked Rep. Jordan for his efforts through the different iterations of the Model as well as the rest of the Committee. NAMIC believes that the latest draft of the Model is a balanced version that creates some foundational support for modernization packages in states and also takes into account the practicality of how insurance companies actually communicate with their policyholders. NAMIC believes that the Model is a good work product and encourages the Committee to adopt it.

Upon a Motion made by Rep. Joe Fischer (KY), NCOIL Secretary, and seconded by Sen. Travis Holdman (IN), NCOIL Immediate Past President, the Committee voted without objection to adopt the Model by way of a voice vote.

b.) Consideration of NCOIL E-Titling Model Act

Sen. Klein noted that the sponsor of the NCOIL E-Titling Model Act (Model), Del. Steve Westfall (WV), was not able to make it to this meeting but expressed his intent to have the Model voted on by the Committee. Jim Taylor, Vice President of Auto Data Direct, Inc., waived his time speaking and expressed support for the Committee to adopt the Model.

Upon a Motion made by Rep. Fischer and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee voted without objection to adopt the Model by way of a voice vote.

INTRODUCTION OF NCOIL MODEL ACT CONCERNING STATUTORY THRESHOLDS FOR SETTLEMENTS INVOLVING MINORS

Rep. Fischer, sponsor of the proposed NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors (Model), stated that the objective of the Model is to save costs associated with settling small claims, thus preserving the minor's assets. It is much like many laws in states that allow for settling small estates through affidavits. The Model would apply mostly to situations where the minimum coverage is involved and they just want to settle the estate for the minimum coverage without incurring additional costs for going into court and getting that approved. There are certain security measures in place to ensure that the settlement would be preserved for the minor.

Andrew Kirkner, Regional VP, Ohio Valley/Mid-Atlantic at NAMIC, stated that the Model deals with situations where an insurer enters into a settlement involving an individual under the age of 18. NAMIC members came forward with an interest to make that process more efficient under the idea that you had to actually appear in court and retain counsel each time you had a settlement with a minor in some states. NAMIC looked at the laws across the country to see what might make sense to serve as the basis for the Model. Oregon has a good statute which sets a threshold for any settlement under

\$25,000. To break that down, insurers and claimants would no longer need to appear in court for settlements below \$25,000. Instead, they would file with the court an affidavit that ensures there is still court approval but removes the requirement for attorneys fees and things like that. NAMIC believes that the Model will help improve efficiencies and help protect settlement funds.

Brian Waller, VP of Government Relations at Shelter Insurance, stated that Shelter is excited about the Model creating more efficiencies in this process. Some states have very low thresholds which have not been looked at in a very long time. The Model would allow both parties to settle by affidavit which would allow the matter to settle more quickly which would allow the people who are injured to get their money quicker. The insurance companies can then resolve the claims quicker and all parties can save costs and time.

CONSIDERATION OF NCOIL REBATE REFORM MODEL ACT

Rep. Lehman thanked everyone for their input thus far in the Rebate Reform Model Act (Model) and noted that this issue has been discussed for several years. There seems to be almost universal agreement that state anti-rebate laws need to be reformed, and now we are at the finish line as to what the level of reform should look like. Rep. Lehman noted that the National Association of Insurance Commissioners (NAIC) is also working on its own rebate reform model law in the form of amendments to the NAIC Model Unfair Trade Practices Act (UTPA).

Rep. Lehman then noted some changes to the Model since the Committee's last meeting in December. First, in Section 4, the word "exclusively" was changed to "primarily" as "exclusively" was a bit too restrictive. Next, in Section 4, "mitigate" was added so it now reads "...primarily intended to educate about, assess, monitor, control, mitigate, or prevent risk of loss to persons, their lives, health or property..." Next, in Section 4, the language "or that have a nexus to or enhance the value of the insurance benefits" was added so the language now reads "...primarily 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." Rep. Lehman noted that such language was proposed by the American Council of Life Insurers (ACLI) which brings in certain types of value-added services within the scope of the Model such as will preparation services and grief counseling services. Such 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.

Rep. Lehman noted that the life insurance industry also pushed back on the dollar amounts set forth in Section 3 of the Model because of the concern that the dollar amounts in the Model would exceed the total annual premium for certain products. Rep. Lehman stated that he appreciates that feedback but noted that NCOIL models typically serve to build a framework which states can then change as they deem necessary. Further, there is a drafting note in that section which states that "states may wish to alter the financial limitations set forth in this section depending upon each state's economic environment." Also, Rep. Lehman noted that he could see an insurance department splitting out different dollar amounts for different industries such as P&C vs. life.

Rep. Lehman further noted that some had called for the elimination of Section 5, or for the section to be heavily edited. Rep. Lehman stated that he believes the Section is in a

good place and is a good foundation that can be changed as necessary in states that adopt the Model. Rep. Lehman noted that since December, he included some language to clarify that the services contemplated by said Section do not otherwise qualify as permissible value added services in Section 4. Next, Rep. Lehman stated that in Section 6, the language has been altered to scale back the Commissioner's authority to promulgate regulations. Instead of reading "The commissioner may adopt rules as necessary to make reasonable modifications to the standards in this Act" – it now simply reads "The commissioner may adopt rules as necessary to effectuate the provisions of this Act."

Lastly, Rep. Lehman stated that he would like to make some technical changes to the Model. In Section 3(A), instead of reading "offer to give gifts in connection with marketing for the sale or retention of contracts of insurance..." it will now read "offer or provide gifts in connection with the marketing, purchase, or retention of contracts of insurance..." Rep. Lehman stated that he is on the NAIC's rebate model law drafting group which will be meeting at the NAIC's Spring Meeting in two weeks and he would like to have this Model adopted today in order to provide said drafting group with an example of what sound rebate reform should look like. Accordingly, Rep. Lehman asked the Chair that a Motion to adopt the Model, as amended, be entertained by the Committee after hearing from the panel.

Karen Melchert, Regional VP of State Relations at the ACLI, thanked Rep. Lehman for his consideration of ACLI's proposed amendments. Ms. Melchert thanked Rep. Lehman for noting ACLI's concerns with the dollar amounts in Section 3 and stated that ACLI would push for the drafting note in that section to be part of any state statute. ACLI would also push for bifurcating out life insurance products from that section to keep the dollar amount at \$100 or less given that most products sell for less than \$250 annual premium. Ms. Melchert thanked Rep. Lehman again for dealing with this very important issue.

Wes Bissett, Senior Counsel, Gov't Affairs at the Independent Insurance Agents & Brokers of America (IIABA), thanked Rep. Lehman for developing this Model, particularly Sections 3 and 4 as there is a growing universe of states that have adopted provisions dealing with those issues. Mr. Bissett stated that the agent community is very diverse in its thinking with regard to rebate reform. Accordingly, his comments focus on some clean-up items. One thing to note is that Sections 3, 4 and 5 apply to different universes of people and there is not consistent language that is used. For example, Section 3 states "an insurer, an employee of an insurer or a producer", Section 4 states "an insurer, by or through its employees, affiliates, insurance producers or third-party representatives" and Section 5 refers to "persons." Accordingly, IIABA recommends that consistent terminology be used in the Model. Similarly, IIABA recommends that each section make clear that the exemption in mind is the exemption from the state anti-rebate and inducement laws. Having the Model say "notwithstanding any other provision..." could be overly broad and have some unintended consequences such as exempting someone from anti-discrimination statutes.

Rep. Lehman stated that he agreed with Mr. Bissett's remarks regarding that Sections 3, 4 and 5 should have consistent applicability language. Accordingly, each Section will have "an insurer, by or through its employees, affiliates, insurance producers or third-party representatives" included. With regard to Mr. Bissett's point about having more specific exemption language, Rep. Lehman stated that he agreed but noted that is a

change that states can make if they deem necessary.

John Fielding, General Counsel at The Council of Insurance Agents & Brokers (CIAB), agreed with Mr. Bissett's remarks and stated that the Model is good work product, particularly with the changes just agreed to by Rep. Lehman. Mr. Fielding stated that he has previously called for commercial lines to be exempted from anti-rebating laws. That may be too radical but nonetheless, in Section 3 when talking about permissible gifts and prizes CIAB still believes there is a difference between the relationships in commercial lines versus personal lines. Therefore, CIAB suggests that with respect to gifts, entertainment and marketing, there should be a reasonable standard for commercial lines. In other words, dollar amounts make sense when talking about individuals because they may be more susceptible to inducement but when talking about ongoing professional business to business relationships, it is easy to go over \$100 or \$200 a year when talking to Fortune 500 companies. Taking someone out to dinner could cost more than that. Lastly, Mr. Fielding noted that the term "policy" used in Sections 4 should be "insurance coverage" because at the beginning of a relationship there might not be a policy in place and there could be a number of potential policies under discussion.

Mr. Kirkner thanked Rep. Lehman for dealing with this issue and noted that NCOIL's leadership is very important given the NAIC's involvement. Mr. Kirkner noted that some of NAMIC's members expressed concern over the impact of Section 5 on the value-added services referenced in Section 4. NAMIC understands that striking Section 5 may be a bridge too far but believes that some clarifying language that exempts Section 5 from Section 4 at the end of the Section might make sense. The concern is that the language could be interpreted as requiring insurers to give away products because they cannot make receipt of the services contingent upon the purchase of insurance per Section 5.

Lauren Pachman, Counsel & Director of Regulatory Affairs at the National Association of Professional Insurance Agents (PIA), thanked Rep. Lehman and the Committee for working on this issue and noted that it is very beneficial that NCOIL is part of the NAIC's rebate reform drafting group. Ms. Pachman agreed with Mr. Bissett's remarks regarding uniform application language in Sections 3, 4 and 5. PIA thought that "person" was too broad in Section 5. PIA also supports the drafting note in Section 3 that allows states to alter the dollar amounts depending upon each state's economic environment. Ms. Pachman noted that the introductory language in Section 3 is confusing but noted that it may be a moot point since said language will be re-worked per Rep. Lehman agreeing with Mr. Bissett's remarks. In Section 3(A), Ms. Pachman recommended changing the language to "offer to or give" so that it covers the actual giving as she believes that is what the Model is really trying to get at. Lastly, Ms. Pachman recommended changing the language at the end of Section 6 to "...consistent with changing economic times" rather than "...relevant consistent with changing economic times."

Rep. Lehman thanked the panel for their remarks and made a Motion to adopt the Model, as amended. The Motion was seconded by Rep. Fischer. The Committee then voted without objection to adopt the Model, as amended by way of a voice vote.

ADJOURNMENT

There being no further business, the Committee adjourned at 10:00 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE AND LONG TERM CARE ISSUES COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 7, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance and Long Term Care Issues Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Saturday, March 7, 2020 at 9:00 a.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)
Asm. Ken Cooley (CA)	Sen. Jerry Klein (ND)
Sen. Jack Tate (CO)	Sen. Shawn Vedaa (ND)
Rep. Martin Carbaugh (IN)	Asw. Maggie Carlton (NV)
Rep. Matt Lehman (IN)	Asw. Connie Munk (NV)
Rep. Joe Fischer (KY)	Asm. Kevin Cahill (NY)
Rep. Bart Rowland (KY)	Asm. Andrew Garbarino (NY)
Rep. Michael Webber (MI)	Sen. Bob Hackett (OH)
Sen. Paul Utke (MN)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Wieland (MO)	

Other legislators present were:

Rep. Joe Cloud (AR)	Sen. Bob Peterson (OH)
Rep. Stephen Ross (NC)	Sen. Roger Picard (RI)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a motion made by Sen. Paul Utke (MN), and seconded by Sen. Bob Hackett (OH), the Committee approved the minutes of its December 11, 2019 meeting in Austin, TX without objection by way of a voice vote.

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 at the North Carolina Department of Health and Human Services (DHHS), stated that the NC General Assembly passed session law 2015-245 in 2015 which basically directs DHHS to transition to managed care. From 2015 to 2018, DHHS engaged in extensive collaboration with getting feedback from a variety of stakeholders. In August of 2018, DHHS released a request for proposals. In October of 2018, DHHS received responses to those proposals and in February of 2019, the pre-paid health plans were selected.

The vision for the Medicaid transformation is “To improve the health and well-being of North Carolinians through an innovative, whole-person centered and well-coordinated system of care that addresses both medical and non-medical drivers of health.” That is very critical and important that there is a whole-person approach in the division’s opinion as up to this point there was some bifurcation with benefits and who paid for them and what kind of system those benefits were received. DHHS wanted to provide its beneficiaries with one place where they would get all of their care and incorporate and integrate behavioral health benefits into the managed care products so that managed care products will include a certain amount of behavioral health benefits.

Ms. Holliday stated that the transformation goals included: Ensure budget predictability through shared risk and accountability; Ensure balanced quality, patient satisfaction, and financial measures; Ensure efficient and cost-effective administrative systems and structures; and Ensure a sustainable delivery system. DHHS has certainly kept those goals in mind as it has tried to build the program with its partners and taking stakeholder input throughout the past four years. The authorizing legislation also defined the role of the General Assembly, DHHS, PHPs and DOI; Defined a timeline for transformation; Defined which beneficiaries would be transitioned to managed care and when; Defined which benefits would be covered under managed care and which would remain as part of FFS; and Defined that the capitated contracts with PHPs would be awarded as a result of a competitive proposal process. That process was not competitive in terms of a price competition but was rather about who met the standards the best in terms of showing DHHS it understood the goals. They are capitated contracts and the state defines the capitated rate that the plans are paid so there was no money per se in the bids that came to DHHS.

Ms. Holliday stated that since the authorizing legislation, DHHS has collaborated extensively with clinicians, hospitals, beneficiaries, counties, health plans, elected officials, advocates, and other stakeholders to shape the program, and is committed to ensuring Medicaid managed care plans. This has not stopped since the issuance of the RFP – efforts are consistent to make sure everyone is ready. Goals within DHHS include: Deliver whole-person care through coordinated physical health, behavioral health, intellectual/developmental disability and pharmacy products and care models; Address the full set of factors that impact health, uniting communities and health care systems; Perform localized care management at the site of care, in the home or community; and Maintain broad provider participation by mitigating provider administrative burden. NC has enjoyed very broad participation in its fee-for-service program and the hope is that will continue with managed care.

1.6 of 2.2 million Medicaid beneficiaries will enroll in Standard Plans. Tailored plans will be offered later. Beneficiaries will be able to choose from Prepaid Health Plans (PHPs). Some beneficiaries will stay in fee-for-service until tailored plans are launched or because it provides services that meet specific needs, or they have limited benefits. This

will be called NC Medicaid Direct. The authorizing legislation set up two types of PHPs, the first being a commercial plan which is “Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.” The other type is a provider-led entity (PLE) which is an entity that meets all of the following criteria: A majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts for the delivery of Medicaid and NC Health Choice services or Medicaid and NC Health Choice providers; A majority of the entity's governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program; and Holds a PHP license issued by the Department of Insurance.

Ms. Holliday stated that the standard plan RFP stated that the commercial plans would have to be statewide if they chose to bid. The PLE's on the other hand could be a state wide regional or they could bid for both. That was done so that if there were regions that were begin bid on by PLEs, DHHS wanted to be sure there was appropriate coverage under the PLE provisions. The RFP was set up such that: Total of 4 statewide contracts (CP or PLE); Up to 12 regional contracts (PLE only); PLEs encouraged to propose for more than 1 region (contiguous); Only 1 regional contract for Regions 1 and 6 (far west and far east which are predominantly rural); and Up to 2 regional contracts for Regions 2, 3, 4 and 5.

The RFP was issued Aug. 9, 2018 and responses opened Oct. 12, 2018. The Department of Procurement & Contracts section reviewed proposals for completeness per RFP requirements. Over several months, the Evaluation Committee of Department professionals: Screened proposals for minimum qualifications outlined in RFP; Reviewed proposals and developed consensus scoring; and Used scoring to develop award selections. Four statewide PHP contracts were selected: AmeriHealth Caritas North Carolina, Inc.; Blue Cross and Blue Shield of North Carolina, Inc.; UnitedHealthcare of North Carolina, Inc.; and WellCare of North Carolina, Inc. One regional provider-led entity was selected: Carolina Complete Health, Inc. for Regions 3, 4 and 5 – a joint venture between the NC medical society and Centene. The regions have actually been in effect for a long time – six regions were set up in total.

Ms. Holliday stated that all Standard Plan PHPs will be subject to rigorous oversight by DHHS to ensure a successful managed care program. DHHS is leading intensive onboarding through the end of February, including introducing key staff, reviewing contract requirements and aligning on key milestones and deadlines. Unlike other states, DHHS essentially takes on all oversight of PHPs other than licensing and solvency which is done by the DOI. DHHS reviews network adequacy, contracting, benefit standards, and other aspects. DHHS has onboarding with the plans in February 2019 and since then DHHS has been working with them across all aspects of the PHP contract. The plans will need to pass a Readiness Review before Medicaid Managed Care launch. Most of that review was completed before the launch was suspended last fall. It is expected that when things pick back up, some minimal readiness review will have to be done. An inability to fulfill contract provisions can result in corrective action plans, financial penalties and other sanctions.

Integration is necessary for improved health. The three products that will be available once all plans are launched are: Standard Plans for most Medicaid and NC Health Choice beneficiaries; BH I/DD Tailored Plans for qualifying high-need populations with a serious mental illness, serious emotional disturbance, substance use disorder, I/DD, or traumatic brain injury - tentatively scheduled to launch about 1 year after SPs; and Statewide Foster Care Plan for children in foster care - tentatively scheduled to launch shortly after the launch of BH I/DD Tailored Plans. All three types of products will offer a robust set of behavioral health benefits; however, certain more intensive behavioral health benefits will only be available through BH I/DD Tailored Plans. There will be a continued focus on high-quality, local care management in all three types of products. Improving provider engagement and support is very important because going from one payor to five payors is going to increase some of the administrative burden that the providers will be experiencing. That is sought to be achieved by actions such as: Incorporating a centralized, streamlined enrollment and credentialing process; Standardizing and simplifying processes and standards across Health Plans; Ensuring transparent payments for Health Plans and fair contracting and payments for clinicians; and Standardizing quality measures across Health Plans. These actions were important to address concerns from the providers who are very needed in the program and they are obviously encouraged to participate. Accordingly, training and outreach to them was conducted.

Ms. Holliday stated that the Medicaid transformation opportunities include: Focus on Population Health; Focus on Quality; Address Unmet Social Needs; and Pilot new initiatives i.e. Telemedicine, access to SUD and behavioral health treatment through IMD, in-lieu and value-added services. Ms. Holliday stated that the current status of the transformation is that it is suspended. Managed Care cannot go-live under a Continuing Resolution Budget. A new budget must include: Authority to pay capitation payments and claims run-out; Authority to utilize Transformation dollars; PHP tax authorization which is already included in the capitation rates; and Authority for the appropriate Hospital assessments. There is no specific launch date yet and DHHS is continuing to work with the PHPs to prepare them and test them for things such as network adequacy and IT issues. Ms. Holliday noted that there was significant progress made in anticipation of the February 2020 launch data but that has been put on hold without a budget.

Ms. Holliday noted that there have been significant suspension activities such as: Open Enrollment cancelled - Notified 1.6 million beneficiaries about the suspension; Held webinars, all-state calls and other engagement activities with provider and members explaining what was happening and what to expect; Continue to meet regularly with the health plans to move forward; Reduced vendor contracts with specialized skillsets; Engage with counties and other stakeholders to continue to facilitate the transition to managed care, including non-emergency medical transportation, ambulance, behavioral health crisis, health care systems; Moving forward with managed care related procurements including Member Ombudsman, External Quality Review Organization (EQRO), Healthy Opportunities Pilots.

Restarting wont be easy and there will have to be significant work in areas such as: CMS Readiness Review - Assess ability/capacity to operationalize Managed Care; Inbound Deliverables - Review and/or approve contractual deliverables as part of DHHS oversight (e.g., clinical coverage policies, annual compliance plans, etc.); System Testing - Assess ability to ingest, process and transmit data and information with DHHS

and vendors; Network Adequacy - Ensure we have sufficient providers contracted to provide services to Medicaid beneficiaries; and Technology Operations - Monitor call center/website issues and technology-related defects/issues (e.g., daily file exchanges, file defects).

Asw. Hunter asked if there is any idea as to when the suspension will end. Ms. Holliday stated that DHHS doesn't have a date in mind but knows that the NC General Assembly will return in April for short session. There is hope that a budget will be taken up but it is not clear.

CONTINUED DISCUSSION ON NCOIL SHORT TERM LIMITED DURATION INSURANCE (STLDI) MODEL ACT

Rep. Martin Carbaugh (IN), sponsor of the NCOIL STLDI Model Act (Model), thanked everyone that has worked on this Model thus far and noted that the Committee has been discussing the Model since last July and it is almost ready to put the Model forward for a vote. Since the Committee's last meeting in December, one change has been made to the Model. A drafting note has been added to the "Purpose" Section to make clear that States are not required to offer short term limited duration insurance plans. Rather, 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.

Rep. Carbaugh stated that he believes the drafting note is important because he knows opinions differ as to the value of short term insurance plans, and some states have in fact prohibited their sale. Rep. Carbaugh disagrees with those states as he is a strong believer in the product, but stated that nonetheless it's important for the Model to be clear that states are not required to offer these plans and the Model is meant to be a framework for states that do offer such plans. Rep. Carbaugh stated that he is open to making some further changes to the Model but would like to have the Model ready for a vote at the Summer Meeting in July. Accordingly, Rep. Carbaugh encouraged anyone seeking changes to the Model to submit those changes to him and NCOIL staff by May so that the Committee is ready to roll in July.

DISCUSSION ON NCOIL PATIENT DENTAL CARE BILL OF RIGHTS MODEL ACT (MODEL)

Asw. Hunter noted that the sponsor of the Model, Rep. George Keiser (ND), was unable to make it to the meeting and then turned it over to Rep. Deborah Ferguson (AR), Vice Chair of the Committee and co-sponsor of the Model. Rep. Ferguson stated that in the interest of full disclosure, she is a dentist but sold her practice so she will not financially benefit from anything in the Model. Rep. Ferguson stated that the Model is really about clarifying coverage when patients come into the office. Transparency is wanted from insurance companies so that providers accurately tell the patient what to expect. If you get a prior authorization you want to make sure that if they approve it, they pay for it, and it does not end up being a surprise bill for the patient. All of the Model's provisions have been adopted in some states and it really is about protecting the consumer and making sure there is transparency for dental insurers and providers so that coverage is understood and information is conveyed correctly.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), stated that ADA is here today because there is a problem. Dental coverage in America

is going in the wrong direction and needs correction in order to begin working for people again. In a paradox, dental coverage is expanding, meaning the number of people covered is expanding, but it is becoming less meaningful. For example, annual maximums on a typical dental insurance haven't gone up since the 1960s but the cost to purchase dental insurance has certainly risen. Couple that with the inflation of the dollar and you can see how the coverage that Americans are getting just doesn't add up to what it once did. To put this simply, patients deserve coverage that protects them, removes financial uncertainties rather than creating them, and is clear about what is covered and how to properly use the coverage. With those goals in mind, Mr. Olson stated that he is here today to speak about the Model which would collectively work to establish clear, simple, and transparent processes for dental coverage plans. These reforms set up protections for consumers and providers to ensure more reliability and predictability in the coverage. The Model focuses on five reforms: Network Leasing, Medical Loss Ratio, Retroactive Denial, Virtual Credit Cards and Prior Authorization. The five reforms have been passed in various states across the country.

Mr. Olson stated that he will focus today on three of the reforms but all five will help patients understand the coverage that they have. The first is network leasing. Dental carriers occasionally lease or rent the in-network relationship they have established with a provider to another entity such as another carrier or a TPA. Right now this can happen in many states without the provider's consent or knowledge. This hidden approach to building networks erodes patient-provider trust which can lead to incorrect assumptions about treatment plans and costs when the provider has no idea a patient is moving in or out of network. Network leasing laws, such as the one proposed in the Model, would expand transparency before networks are leased and provide an opportunity for providers to accept or refuse these contracts. This reform would reduce occurrences for unexpected bills for example following a procedure.

The second issue is retroactive denial. Currently, dental plans can require providers to repay claims payments when the dental plans discover they paid a claim erroneously even if the claim was processed years ago. This often results in a surprise bill for the patient. In the Model, dental plans would be limited to a reasonable time period such as 12 or 18 months where they can request refunds from providers where they have paid the claim in error.

The third issue is medical loss ratio (MLR). Currently, most major medical plans must abide by standards of how much the premiums paid must be applied to the medical care received versus the administrative cost. Dental plans are not currently held to this standard. However, two states – WA and CA – have already acted to require that dental plans report the vital information for those purchasing the benefits. This reporting-only requirement, which is in the Model, would allow purchases, whether employers or consumers, to know whether their plan is going to meet their needs in one easily accessible spot. One easily accessible spot is key – not hunting inside the DOI reporting on one individual carrier – to ensure that the dental plans are more transparent to the people they serve. The other two issues, prior authorization and virtual payment through credits cards, would meet the same goals of increasing transparency and removing barriers to accessing benefits.

Before concluding, Mr. Olson stated that he would like to address some comments submitted regarding leasing asking for an exemption in the Model for self-funded plans. 75% of dental benefits in this country, and growing, are now provided in self-funded

arrangements. Putting that exemption in the Model would pull the teeth out. NCOIL currently has a Resolution adopted criticizing the reach of ERISA preemption in allowing carriers to avoid state law. There is no reason to provide an exception in this Model, particularly when it undercuts the role of state legislators in providing protection to the citizens in their states. Mr. Olson thanked the Committee for listening and stated that ADA believes that the reforms in the Model will work together to enable patients to feel more confident in their ability to receive and pay for care, enable dentists to more reliably plan for and provide care that fits their patient's needs because. That is a key point as dentists are often the ones explaining the coverage to the patient so they should know as much about it as possible. The reforms will also encourage a more stable and satisfied customer base for patients and providers to reliably participate in their dental coverage plans.

Eme Augustini, Executive Director of the National Association of Dental Plans (NADP), stated that she is here today with a coalition of trade associations that also includes America's Health Insurance Plans (AHIP) and the American Council of Life Insurers (ACLI). The coalition is opposing the Model because it conflates several very complex issues and would impose burdensome regulations on carriers without a benefit to consumers. However, the coalition is not just here to oppose – it has an alternative. As background, NADP's members provide dental HMO, PPO, indemnity, and discount dental products to 90% of Americans that have dental benefits. At the end of 2018 there were approximately 260 million Americans, or about 80% of the population, that have dental benefits. Two thirds of that group have benefits through a private sources, most getting coverage through an employer or another group plan or program.

Ms. Augustini stated that in the majority of cases, employees pay some portion or all of the premium of their benefit. We know that consumers are twice as likely to go to the dentist when they have coverage and as prices increase on what is effectively a voluntary benefit, consumers are more likely to drop their benefits and lose the financial protection that affords access to their dentist and ultimately not get the dental care that they need – care that helps to prevent dental disease, helps to stave off pain and help manage some chronic medical conditions. Given this, and the voluntary nature of the benefit, it is good that premiums have remained low and stable with negative growth in some years. This is some important context to consider when looking at new regulations for dental plans. There should be balance in looking at consumer protections and provider protections with the cost to administer and ultimately any impact to premiums.

The Model has been presented as a transparency measure but the issues are much more complicated than that. The Model has five different unrelated subject areas some of which are problematic and have not been vetted. Others have appeared as legislation in a handful of states and have required a very lengthy and complete analysis. The Model contains extensive provisions on dental network leasing for example. A network leasing bill was introduced in NJ in April 2018 and wasn't enacted until more than a year later in August 2019 after a long and deliberative process that included many stakeholders. The model also has a section on prior authorization. Similar language was introduced in Arizona earlier this year. After the bill was vetted in meetings with providers and the insurance industry, the sponsor decided to pull the bill and instead form a study committee that will meet for the remainder of this year to more fully vet and explore the issues.

The Model also has a section on MLR. The Affordable Care Act (ACA) did not apply

loss ratio requirements to HIPAA excepted benefits including dental. While some of the other topics in the Model have at least appeared in a number of states, legislation implementing ACA-like MLR for dental plans have hardly been considered with only one state enacting a law in reporting. Most of the topics in the Model are disparate, complex, and don't belong in the same Model. While the Model is framed as a pro-patient measure, most of its provisions are really focused on regulating how dentists interact with their insurance carriers. With that being said, the coalition is not here to just oppose. Of all the issues in the Model, network leasing is one that has recently received quite a bit of attention. Over the last few years, several state dental associations have expressed concerns about leasing practices. Dentists have told NADP that they want more transparency in network leasing as well as the opportunity to opt out of leasing entirely. NADP worked with dental associations in those states to create compromise legislation that resolves the issues while also protecting network leasing as a practice which is beneficial to everyone including employers, consumers, and dentists. The collaborations have been productive and since 2018, six states have enacted similar laws.

While not all of those laws are necessarily the same, the ones in NJ and CA are considered the gold standard. Those laws are more extensive than those in any other state and represent the most aggressive regulation of dental network leasing in the U.S. the laws include stringent transparency requirements and opt out provisions that allow dentists to not participate in leasing at all if they so choose. That is why the coalition drafted alternative model text based on those laws which were the result of very lengthy discussions and contributions from many stakeholders including carriers and dentists. If the Committee wants or chooses to adopt a dental network leasing model, the coalition strongly encourages it to consider the alternative language. The coalition remains committed to working with the Committee to address the needs of providers while also protecting patients and dental consumers.

Karen Melchert, Regional VP of State Relations at the ACLI, stated that ACLI looks forward to continuing to work with NADP and AHIP to develop a Model that will actually help patients and also protect the dental insurance that ACLI's members provide.

Brendan Peppard, Regional Director of State Affairs at AHIP, stated that the fact that the issues in the Model are disparate and complex does not mean that they are not important. The coalition is not stating that it does not want to work on the issues, it's just that each issue is controversial. A lot of time has been spent on just the dental network leasing issue. Mr. Peppard stated that he worked on the NJ law when it was passed and he can assure the Committee that it required a lot of in depth work and compromise and it did not happen quickly. So, taking that issue first – as there are some legitimate issues that need to be addressed – and tackling that in a rationale way makes sense but it is going to take a lot of work. MLR is pretty well understood on the medical side but if you try to apply that to a benefit like a dental benefit, it is not straightforward and that will take a lot of time and work by itself. If you try and tackle all of these issues in one Model, the Committee may be biting off more than it can chew and the coalition believes that it is best to first deal with the leasing issue. That issue has received a lot of attention and there are legitimate issues to be worked on to see if a compromise can be reached.

Andy Guggenheim, VP and Senior Counsel at the American Bankers Association (ABA), stated that he is here today to discuss Section E of the Model – Virtual Credit Card –

Claim Payment/Transaction Fees Options. ABA fully supports the idea that dentists and other providers should have full transparency as to the methods of payments available to them and any fees related to those methods. ABA also believes that providers are best served when they have choices between payment methods and the ability to freely choose the method that best fits their needs. The marketplace is effective in determining payment options on commercial transactions. All payers are not alike. All providers are not alike. Payer must be able to address and utilize a variety of electronic funds transfers to address the cost and providers should be free to select the payment method that best serves their needs after considering relevant factors including the cost of acceptance.

The payment method a healthcare provider selects may depend on a variety of considerations, including the type of payer whether it's a health plan, a TPA or government entity, how often the provider gets paid by the payer, the type of provider, whether it's a hospital or solo practitioner, the amount of the claim, the process by which the healthcare provider reconciles the payment, and the practice management system utilized by the healthcare provider. In many cases, healthcare providers may determine a blend of electronic funds transfers, ACH and virtual credit cards across the spectrum of payers is the best course of action for them. Mr. Guggenheim stated that every payment method has a cost of acceptance. Healthcare providers pay banks lockbox services and revenue cycle management companies to process their check and ACH payments.

There are holds on funds when depositing checks and internal staff time to re-associate remittance advice with ACH. If healthcare providers accept a virtual card, merchant fees, also referred to as interchange, will be assessed on the transaction. The amount of the interchange is dependent in large measure on the agreement the healthcare provider has with the business that provides them the card terminal. The rates for these merchant services are also negotiable.

With respect to Section E of the Model, Mr. Guggenheim stated that he would suggest the following amendments. Delete the requirement in section 3 for the following reasons: the provisions could require the disclosure of confidential information in violation of contractual covenants and/or trade secrets and proprietary information of the payor otherwise protected under state law. What a provider may change is unique to that provider. It's not one credit card company involved in the transaction. The card network is one participant but there also might be an issuing bank, a merchant acquirer, and perhaps others involved in every single card transaction. Also, the provision is not in any federal or state law pertaining to healthcare claim payments. If the goal of the Model is to create uniformity across all jurisdictions, the provision is inconsistent with nine jurisdictions that have enacted statutes regulating virtual credit card payments for healthcare claims.

The ABA also suggests removing the statement that lists offering by a dentist's agent for the following reason. Many parties that assess a fee pursuant to an agreement with a provider may not be an agent as that term is generally understood applicable law. In order to reflect the intent of the Model the section should guarantee that any party that has made an agreement with a provider to provide any services with a payment should be required to disclose what fees may apply. This broader guarantee in the first sentence of the section requiring a provider to consent to the fee. To sum up, ABA agrees with the transparency provisions that are in the Model but they are not consistent

with jurisdictions that have taken up the issue of virtual card payments and transactions that are associated with them.

Asw. Hunter asked how the Model specifically helps advance the rights of patients. Mr. Olson stated that it is important to understand that dental care and the transaction of dental care is an environment – it is not happening in isolation. It is correct to say that it appears that this is all related to transactions but those are so critical to patients to understanding what care they are receiving. The dentist is often the explainer of the care because dental insurance like medical insurance is often opaque to the people that are receiving the care. So, all of the Model's provisions are about shining as much light as possible on what is occurring in the background of the dental care being received and how the patients are paying for it.

For example, on prior authorization, a patient and a dentist will get a notice as to how much they are expected to pay for the care. If the insurance company walks back on that both the patient and provider are in a situation where what they expected to pay and what they expected to receive in the form of payment does not occur. In the case of retroactive denial, it is an error by the insurance company on a payment. The provider is then notified about the error and that they are going to have to go after the patient if they want the money. So again, that becomes a patient issue because downstream, there is the impact of whether the provider perhaps sours the relationship with the patient by going after the payment. Another example is with MLR. If you are a consumer who is maybe purchasing an individual plan and you have no idea that only 30% of what you are paying in premium is actually going towards you receiving care, that is information a patient should have and should know before they purchase a plan. Again, it is an environment and everything is interrelated so that is how it would impact patients as well.

Rep. Tom Oliverson, M.D. (TX), stated that he fundamentally doesn't understand the objection to a situation where a provider simply asking for clarification and the ability to opt out in terms of if I sign a contract with you to lease out your condo, that doesn't give me the right to sublease that condo to someone else without your permission. This is very similar and it is also essentially settled law on the medical side as the silent PPO issue has been dealt with and NCOIL has a model law on it which was recently readopted in 2017 settling the issue of whether providers should have certain rights and certain abilities to opt out and certain protections as far as notification with regard to leasing agreements.

Rep. Oliverson stated that to his way of thinking, these contracts are instruments that have been created between two parties, voluntarily, and as such those contracts have, in his opinion, ownership for both parties – it was a mutual agreement. And yet we're talking about leasing which means one party is taking that contract and financially benefitting from it without the permission or sometimes even the knowledge of the other party – that is egregious and incredibly unethical. The issue is not about the dental issue per se as much as it is parity. There is already law on this for the medical side in several states and what is being presented here with respect to dental leasing is more so parity between dental and medical issues. With respect to the virtual credit card issue, Rep. Oliverson stated that issue has been looked at in Texas and there are significant cost differences for a provider in terms of an ACH payment which transaction may cost pennies versus a virtual credit card payment which may cost 3-5% in some circumstances. When its an ACH payment, you're talking about a charge that is paid for

by the party that is initiating the payment but a virtual credit card payment always seems to fall on the shoulders of the person receiving the payment. That is a way to chip away at reimbursements for providers unnecessarily. Rep. Oliverson stated that he takes issue with the ABA's proposed deletion in Section E of the Model as it would be important to know of an additional source of revenue if that is the reason why the virtual credit card payment might be preferred since it does result in a significantly higher fee or reduction in payment to the provider on the backend which is completely different than the way an ACH transaction is handled.

Ms. Augustini stated that dental plans want participation in dental PPOs to be a positive experience for dentists and to be beneficial for their practices. There are several industry best practices carriers and network companies do employ to ensure transparency in the process of leasing. Original contracts do and should disclose that the network unless the provider agreement and the fee schedule can or will be leased. There are also usually ways for a provider to find out what third parties have access to the network. Carriers also disclose the source of the discount on remittance advice and much of this is reflected in the alternative language that the coalition has provided to the Committee. These types of provisions can ensure transparency in the process that is consistent with industry practice and doesn't necessarily challenge or diminish all the benefits that can come from leasing in terms of broadened access to dental benefits and dental care. Ms. Augustini stated that hopefully the alternative language provided can be useful when exploring this issue.

Rep. Matt Lehman (IN), NCOIL President, asked the panel to touch upon the issue referenced earlier regarding self-funded plans and how that relates to ERISA-preemption.

Ms. Augustini stated that she is not aware of any provision in the Model or the alternative language relating to ERISA plans. Mr. Peppard stated that he is not aware of any provisions either.

Mr. Olson stated that he was referring earlier to a drafting note in the coalition's alternative language regarding self-funded plans and that is how the coalition is trying to capture that. Ms. Augustini stated that may be something that the coalition will want to look at because that is not the intent of the drafting note. The intent is to clarify the difference between carriers and leasing companies. Leasing companies are not carriers and they don't write insurance. Those companies recruit and develop dental networks which are leased to third parties like insurance carriers, TPAs, and self funded groups. Providers contract with leasing companies with the explicit understanding that and expectation that they will be leased. These companies are not under the alternative language exempt from the entirety of the Model but rather the one specific piece on opt outs which was established in the CA and NJ legislation. Applying opt out requirements to those entities would impair their central purpose as understood by all parties so they need to be specifically excluded from that specific provision. Ms. Augustini stated that she would be happy to return to the language to examine it to determine if it needs clarification.

Mr. Olson stated that the companies most impacted by that are self-funded – those that take advantage of the leases. Also, what the companies attempt to do when they don't have an opt out is get a network established in the blink of an eye without any notification to the providers. Why should providers be treated two different ways

depending on how the recruiting mechanism occurs? That is why ADA would oppose the exclusion being sought in that drafting note.

Rep. Carbaugh asked with regard to MLR, if it is the long term view that an ACA-like MLR should be imposed on the dental side and if so, how would that lower costs as we have seen MLR actually increase costs under the ACA. Rep. Carbaugh stated that in his conversations with insurance companies in IN, MLR has actually created a required spending that otherwise could have been lower but the companies have been forced to spend more and many studies have shown that it has actually contributed to the increase in healthcare costs. Accordingly, Rep. Carbaugh stated that he wants to be careful when discussing MLR that a cost increaser is not created when trying to make sure people just know what is going on. Mr. Olson stated that the experience in CA was that the dentists were initially on board with establishing something similar. However, something that everyone on the panel understands is that dental benefits are not dental insurance – it is a different animal in many regards and that is why MLR reporting is what was landed on. The ADA would find it a benefit just to have the transparency and have no inclination at this time to look for an imposition of an actual MLR requirement.

J.P. Wiese of the Health Benefits Institute stated that on the issue of opting out and self-funded plans, the institute has very serious concerns that the drafting note mentioned earlier will destroy pieces of that self-funded market. If you look at self-funding you are seeing groups that are getting down to five and six lives for a level funded premium. In the institute's interpretation, the alternative language would require approved permission for every single time an insurer is offering those programs to get new permissions in new networks for each one of those clients which makes it virtually impossible for the insured to maintain a good network and the administrative burden will be significant.

DISCUSSION ON NCOIL VISION CARE SERVICES MODEL ACT (Model)

Sen. Bob Hackett (OH), sponsor of the Model, stated that several years ago NCOIL adopted the Model Act Banning Fee Schedules for Uncovered Dental Services in an effort to prevent discounts from being forced on dentists. Forty states have adopted that Model but not Ohio as it has been very difficult to get it adopted. Accordingly, Sen. Hackett stated that he tried to enact legislation in Ohio using the same concept but on the vision side. The best bills that he has worked on have been when you get the interested parties in a room and see if they can work out a solution. That worked in Ohio because the optometrists and the vision plans got together to work things out. Sen. Hackett stated that this Model is still a work in progress as both sides are still discussing the issues. Sen. Hackett noted to the American Optometric Association (AOA) that if you get benefits you have to realize that it is a give and take world. The Model is similar to what passed in Ohio and it is also important to remember that the vision and dental industries are totally different. Vision deals more with materials where with dental you are talking more about services.

Robert Holden, State Gov't Affairs Director for the National Association of Vision Care Plans (NAVCP), stated that he is happy to work on this Model and noted that he worked on the Ohio legislation referenced by Sen. Hackett. NAVCP represents the 17 largest national vision care plans; they provide coverage to 178 million Americans; the networks include Optometrists and Ophthalmologists providing routine vision care – the routine care being eye examinations and the purchase of eyewear, not medical illness to the

eye; NAVCP does not represent retailers, eyewear manufacturers, or discount plan organizations. Mr. Holden noted that the dental Model referenced by Sen. Hackett has indeed been very successful and after it was adopted a number of folks looked at its application to the vision industry. There were some unintended consequences when that happened and that was due to the very different way that the vision industry has set up its benefits. The dental model was intended to prohibit services that were not covered from having a specific reimbursement. Since the success in Ohio, there has also been some success in other states with regard to negotiating language such as Arizona where a bill has passed the House and is expected to pass the Senate soon.

Mr. Holden stated that vision coverage addresses routine coverage and preventative care. Vision is frequently sold as a voluntary benefit. An employer may have vision coverage but the individual employee will decide whether they want to pay an additional premium to have that coverage. There is some self selection there. Folks that need eye wear or have some known corrective vision issues are very likely to purchase it. 74% of all vision benefits are done through standalone plans so it is not embedded in a medical plan, it is a separate document. The average premium is very low in comparison to medical – typically one-tenth of medical.

Unique to vision care, there are typically two transactions that occur. One is the annual eye examination and the other is the purchase of a retail item eye wear. That is very different from the dental environment. Vision benefits as plans reflect that so there is coverage for the annual examination, there is an allowance for choosing your frame for your glasses and then there is covered spectacle or contact lens additionally. One of the issues that the model attempts to address and has been addressed in other states is that there are options available to the enrollee to purchase on that covered lens.

Typically, the enrollee pays out of pocket for those options. There is a covered lens but those options are something that they choose to pay for in addition to that. Vision plans are trying to limit that out of pocket cost because enrollees are coming in with a benefit to purchase a covered lens and they want to make sure that the overall cost is still within certain parameters. The other discount that vision plans will frequently negotiate with optometrists and ophthalmologists in their network is the ability to come in later once they have used their benefit to buy a second pair of frames and that is usually a discount on the usual and customary rate that the optometrist or ophthalmologist has in their office and they can choose how to offer that to the patient.

Mr. Holden stated that the advantage to this model is that as a preventative care vehicle, folks are four times more likely to get their eye exam compared to a physical. Eye exams detect a lot of changes in vision but diseases can also be identified like diabetes and hypertension ahead of time. The advantage of the benefit is that Americans are much more likely to get that eye examination if they have coverage and also to purchase eyewear if they have that coverage. The networks are structured to make sure that benefit is available. Providers are credentialed to make sure they can operate under their scope of practice. Access to certain materials and eyewear is also guaranteed to enrollees and it is made sure that they meet quality standards. The benefits to providers are also significant. Patients are being directed to network providers and those patients are visiting more frequently and they are also purchasing eye wear more often. They are more likely to buy eyewear from their provider in-network and they are also much more loyal.

Mr. Holden stated that the Model defines critical terms that are unique to vision which are not in the dental model and it provides providers the flexibility to choose not to offer these discounts and yet join the network. That is the fundamental compromise that was made – to make it optional. If providers want to provide discounts and correspond to plan pricing they may and if they don't they don't have to. The requirements on plans is that they can't discriminate against those providers and can inform enrollees that there is a different pricing model for the providers that choose not to participate. But that, as well as a notification at the point of service, are minimum consumer protections that need to be there so that they know what their options are and they know what the pricing might be instead of plan pricing.

Mr. Peppard stated that AHIP agrees with the points made by Mr. Holden and noted that part of the value of what plans provide to its members is the network itself. The ability for plans to communicate information about the network to members is essential in allowing members to get the full value of the benefit. To that point, the Model goes with the aim of consumer protection and interest first and foremost. A lot of what is in the Model does get at providing consumers the appropriate information. AHIP supports the Model but has just one clarifying amendment that it offered with regard to striking the last sentence in Section E as it is not necessary and the Section would read more simply if that sentence was deleted.

Dr. Rebecca Wartman and Dr. Steve Eiss, practicing optometrists, then spoke on behalf of the AOA. There are over 44,000 optometrists in the U.S. providing primary eye health and vision care that people need. Doctors of optometry are located in more than 10,000 communities and in counties covering 99% of the U.S. population. Many optometrists run independent, small businesses typically serving thousands of local patients unlike the consolidation you see in hospitals and medical doctors. Some optometrists are employed in chain stores and in big box settings controlled by large, vertically integrated corporations. Overall, optometrists serve millions of Americans families. Vision plan companies are billion dollar companies, some of which are foreign-owned who cover, administer or control vision benefits for nearly 200 million Americans. They typically do not spread the risk of catastrophic medical costs like health insurance does but instead act more like pre-paid benefit and discount plans. Like dental plans, they are typically not held to the same rules as group health plans or health insurance companies. In fact, the two largest vision plans alone claim to serve 145 million people and are arguably even more dominant in the market for materials such as frames and lenses – they have extraordinary market power.

Dr. Wartman stated that 40 states have adopted the aforementioned NCOIL dental Model and about 23 states have enacted similar laws to corral the self-serving tactics of vision plans with non-covered vision services and materials. If NCOIL did nothing else but repeat the same law for eye doctors and vision plans as NCOIL did for dentists and dental plans and applied it to the services and prescription of eye glasses and contact lenses then you would be helping patients and doctors.

Dr. Eiss stated that a vision plan is mainly a prepaid benefit discount plan. Patients pay for discounts the vision plans negotiate with doctors. However, vision plan companies have gone a step further and set prices for services and materials that are not covered. In other words, vision plans – as dental plans once did – aggressively used their market power to set prices for additional services and items and neither patients nor the plans provide any additional considerations to the doctors. But the vision plan companies will

try to tell you that this lowers the prices for patients but it actually does the opposite. More often, doctors have to raise their prices for all patients just to make up the artificial discounts the vision plans require. Just like employees in other small businesses ask for cost of living pay increases every year, discounting these extra services all across the board has the negative effect of having to raise prices in order to cover the cost of your employees and your business.

Dr. Eiss stated that all these increased costs tend to fall on patients that are not covered by the plans and that tends to fall on the elderly and the low income patients who don't have the vision plans to give them the extra discounts. A few moments ago, it was mentioned that vision plans are part of large corporations who also control the market for frames and lenses and that some optometrists work for chains and big box stores.

Those same companies that control benefits for 145 million Americans also own those chains and as a result also employ optometrists. These large companies surely have the freedom to set their prices in retail stores but by way of these discounts for noncovered services they are also setting prices for their competitors – the independent eye doctor. They use these anti-competitive contract provisions to make sure that tens of thousands of independent eye doctors can't lower their prices. In other words, vision plans set the discounts. These discounts prevent doctors from setting their own prices which in some cases may actually be less than the contractual discounts. The result is vision plans setting prices for both optometrists both outside and inside the store chains. You can't really charge less or more because of the plan-made discounts for the noncovered services.

Another disadvantage for the private family eye doctors is that the same vision plan companies control much of the supply chain including the frame manufacturers, lens manufacturers and the labs where they are assembled. In the Model before the Committee, the vision plan companies want to create loopholes – loopholes that don't appear in the NCOIL dental model – so these large companies can continue to steer patients to the most profitable company owned sites. Vision plans will also try to tell you that they want to add provisions that allow doctors to choose to give discounts. If you put an end to these corporations controlling the prices then doctors will actually have the freedom to compete and to lower prices sometimes below what the vision plans dictate you to pay.

Dr. Eiss then spoke to issues of enforcement. The AOA has submitted comments as to how to improve the Model to better meet the goal of protecting patients. The vision plan companies oppose these laws in every state so the fact that they support the Model as written should tell you something. Even when they have agreed to language they don't want to actually abide by it. Vision plans have objected to legislation in every state, have resisted compliance and sought to write loopholes and poison pills into bills. Ohio optometrists are struggling to have their state law enforced even though the vision plans hailed it as a compromise. In Ohio and nearly every other state that enacted a prohibition on setting prices for noncovered services, optometrists have struggled to get the vision plan companies to follow the intent and letter of the law. The AOA recommends an amendment to the Model regarding enforcement so that state regulators can force the vision plans to comply. This is important because vision plans are typically exempted from many of the rules that apply to health insurance. Even better, allow a private right of action so independent family optometrists can go to court if

need be to stop the vision plans from trying to control what the doctor charges for services and material that the vision plans don't cover.

Dr. Wartman stated that the vision plan companies will try to tell you that their schemes are good for doctors but the AOA represents the doctors they are here to say they disagree. The AOA is also here to say that the gigantic vision plan companies use their market power to demand so called discounts for services and items they don't cover is actually harmful to independent doctors, patients, consumers, legislators and the families and constituents they represent. The Model should closely follow the dental Model for noncovered services but include prescription contacts and eyeglass lenses and include an enforcement provision.

Asw. Hunter stated that going forward perhaps more discussion should be spent on online services because it seems that is now a large part of the market and consumers are taking advantage of the lower costs in that space.

Sen. Hackett stated that in Ohio there was not much pushback from the optometrists and asked the AOA why that was the case. Dr. Eiss stated that may be because the Ohio law addressed the noncovered services in that they were able to be part of the panel and not have to offer the noncovered services. The concern with some of the language in the Model is that there is some grey area and some loopholes where the doctors may not necessarily be able to opt out of those noncovered services the way they could in Ohio and a lot of other states without it either affecting their network status or affecting how they are reported. Sen. Hackett stated that he does not want any unintended consequences and he thinks NAVCP doesn't – if they choose not to offer the noncovered services they should still be able to be part of the network.

Dr. Wartman stated that one of the reasons that optometry will participate in networks is because of access to patients because we all know that if there is a difference in a \$5 copay, a patient is going to pick a different provider. But as a consumer, if I look in a provider manual and see provider A offers a discount and provider B doesn't, that is like putting a scarlet letter on the one that doesn't offer a discount when indeed they may not abide by the contracted discount or accept the contracted discount and provide higher discounts or other ways of getting materials that are actually better for the consumer and more cost effective for the consumer.

Asm. Andrew Garbarino (NY) asked what has happened with reimbursement rates over the past several years. Dr. Eiss stated that he has been in practice for awhile and has a multi-location practice and participate in quite a few networks. The majority of vision plans in that timeframe have not increased any reimbursement and there is one that has gone down since starting practice in 1995. A couple have gone up percentage points but you're talking minimal increases occasionally and nothing consistent. Dr. Wartman stated that overall there has been downward pressure or at least certainly no increase in medical reimbursement across the board during that time while cost of living certainly goes up.

Rep. Ferguson asked if she is understanding correctly that even if you wanted to sell services at less than the vision plan fee you could not tell the patient that; almost like a gag clause in the PBM-pharmacy context. Dr. Wartman replied yes – if I have a contract that says I am going to give you a 20% discount on a noncovered service then I have to give you a 20% discount when normally I might give a bigger discount. Also if I am not

forced to give discounts on noncovered services then the cost of those services may indeed be priced less to begin with because I don't have that pressure to make sure that I can stay in business to be able to serve those patients.

Mr. Holdman stated that the Model as proposed would allow for all providers to opt out of any discounts that they did not want to give on a noncovered service. The concern of NAVCP is that such information be made available to the enrollees because in a dental context, if I go in for a teeth cleaning or something else and there is another service that the dentist provides to me that is not covered, that is its own transaction/service. Here, an enrollee is walking into their optometrist's office and purchasing a covered lens and there are upsell options that can be delivered on that lens to the enrollee. Plans have negotiated prices on those options to limit the overall cost and they would like to continue to do that but that is only with the permission of the optometrist. Plans are not making participation in the network contingent on them agreeing to that so they can have their own discounts and set their pricing at whatever they want. Plans just want the ability to notify their enrollees of that. Also, with regard to lowering fees in response to Dr. Wartman's comment, that would be fine under the Model, and there is also language in the Model that states that no gag clauses are permitted in any agreements.

Dr. Eiss stated that what is a little different with the noncovered services for glasses is that when the patient comes in and orders the glasses they are given the cost and the fees upfront before they even order the glasses. So, there is not a situation of surprise billing where they will get a bill afterwards that says "this wasn't discounted or covered the way you expected" – they'll have all of that information upfront and can make that

decision before they order the glasses.

CONTINUED DISCUSSION ON NCOIL HEALTH CARE SHARING MINISTRY (HCSM) REGISTRATION MODEL ACT (Model)

Rep. Carbaugh, sponsor of the Model, stated that the Committee has had two very productive discussions on this issue at its past two meetings. Rep. Carbaugh stated he wanted to make clear that in no way shape or form is this Model seeking to legitimize or authorize the bad actors that we have unfortunately read about in the news the past several months. The Model instead is intended to do the exact opposite – build a legislative and regulatory framework applicable to HCSMs so that public policymakers are better informed of how they operate. Indeed, the Committee may hear from some members of the industry suggesting ways to add to the Model. The Model is a good starting point for what that framework can be, and some states have actually already introduced a version of this draft Model. That is a good sign that the work of this Committee on this issue is very important and is being received well across the country. Rep. Carbaugh stated that he hopes this Committee can continue to make progress with the Model and he looks forward to hearing from the panel today.

Scott Reddig, CEO of Christian Care Ministries (CCM), stated that CCM operates the health care sharing program, Medishare. Mr. Reddig thanked Rep. Carbaugh, Asw. Hunter, and the Committee for allowing him to speak on this panel pertaining to health care sharing and possible model legislation. Mr. Reddig stated that fundamentally, health care sharing ministries are communities of members who have come together to share in each other's medical expense burdens. The members typically agree with and confirm a particular set of religious beliefs; and the type of medical expenses they share are influenced by and/or are an expression of those religious beliefs. Medi-Share is a

health care sharing ministry administered by CCM, based in Melbourne, FL. It have over 400,000 members throughout the United States. As a Christian faith community, MediShare has been facilitating the voluntary sharing of medical expenses among its members since 1993 as an exercise and expression of the members' beliefs. Since its inception, MediShare's members have shared over three billion dollars of medical expenses incurred by its members. Indeed, during that time Medi-Share members have fully shared every incurred medical expense eligible for sharing in accordance with guidelines adopted by the members, which CCM believes reflects God's faithfulness to the ministry.

Though different than insurance, CCM believes Medi-Share, as well as other ministries, offer a health care financing solution that serves at least a couple public policy goals. One, it provides another choice for some US residents to meet their medical expense burdens, and two, it provides people of faith a mechanism that meets their health care needs that is more consistent with their religious beliefs. It is a different solution than health insurance, particularly in that the members of health care sharing ministries are not legally obligated to pay other members' burdens. But, member to member sharing and/or belonging to a community that very visibly and tangibly supports one another, and the sincere belief that these ministries provide a vehicle for God to provide support for the members in need. All this gives members a very positive experience and confidence that their needs will be met.

Mr. Reddig stated that he might add a couple facts about Medishare that will underscore this point. The program consistently receives A+ ratings with the BBB; and the satisfaction scores that we receive from members, using a scoring system similar to how many businesses monitor customer experience, is very high. Also, if you were able to listen to calls into the member service center, you would hear member representatives praying and offering care and encouragement to members all day long every day. It have a chaplain who came on board last year who observed that those member reps do more ministry in a week than a church pastor does in a year. Mr. Reddig stated that his message in sharing this background is to say CCM wants to help address concerns, but also wants everyone to appreciate these ministry programs are a very positive option in the marketplace, particularly for people of faith.

There is a history of legal and regulatory discussions surrounding HCSMs such as how to have oversight over them and what is different about them compared to insurance. There are safe harbor laws in about 30 states and the ACA provided an exemption for HCSMs from the individual mandate and provided a useful definition of a HCSM. But in the last year, several state regulators have investigated complaints about the Alieria companies and Trinity Healthcare and expressed frustration over consumer confusion and even possible unlawful conduct committed by Alieria or Trinity.

Mr. Reddig stated that with that background, CCM would like to respectfully submit a proposal to address the questions that have arisen, partly those from the last year, but even some that have lingered from prior years. Before the details, few aspects of the thinking behind this proposal is that CCM is positioned well to offer a proposal for crafting model legislation regarding Health Care Sharing, partly because it holds a leadership position within this small "market space", partly because it has participated in numerous conversations about current issues with other health care ministries through different forums in the last year and feels it has a pretty good handle on the various

perspectives, and partly because it has begun to gain a greater appreciation for what is on the minds of regulators or legislators that have given some attention to these issues.

The proposed model legislation, which builds from what NCOIL discussed at its December meeting, offers a form of so-called “registration” as an alternative form of regulating this small part of the overall market of health financing alternatives. There are several ministries who will argue that registration, or any form of regulating health care sharing, is unnecessary. They note, in particular, that existing laws already empower Attorneys General to take action when there is true fraud and deceptive practices committed by a HCSM, and Insurance Commissioners have similar authority over producers like Alieria, and over insurance products that merely purport to be sharing programs. CCM is very sympathetic to this argument. And, if a state deems this additional legislation unnecessary, CCM would understand and support that conclusion.

However, CCM also recognizes that this idea of registration offers a means to make the health care sharing space a bit less mysterious. If, by offering some information through this registration mechanism, we can increase transparency for how the ministry programs work, what medical expenses they share, etc...and just simply set some ground rules so that state officials can understand who is operating such programs, that is a good thing. On behalf of Medi-Share, CCM is happy to provide such information and can support a mechanism for extra transparency.

However, CCM notes that it doesn't think it's wise or necessary to make this legislation overly detailed and prescriptive. CCM has seen or heard proposals that, for example, propose to ban HCSMs from using insurance agents. CCM thinks that's an overreaction and mis-reading of the lessons learned from Alieria. In fact, CCM thinks the use of properly trained agents (or as CCM calls them, new member representatives) could be a positive force in clearing up consumer confusion. In CCM's case, it finds that equipping an insurance agent (who, by definition, is an expert about the insurance product) with knowledge of its Medishare health sharing program provides the consumer with a well informed comparison of Medishare to insurance, allowing them to make a much more informed decision. Bottom line, CCM thinks it have crafted an update to the model legislation that provides a balanced way to address a whole host of questions that have accumulated in recent years, and especially in the last year because of the Alieria/Trinity situation.

Stuart Lark, Sherman & Howard, L.L.C. and General Counsel to CCM, stated that CCM's draft proposal was recently submitted to Rep. Carbaugh and NCOIL staff. Generally, the draft requires that sharing programs provide information to members and to state officials that are relevant to the ministry, prohibits sharing programs from engaging in deceptive practices, provides enforcement authority to state officials to enforce the operation and registration requirements. Mr. Lark stated that CCM looks forward to working on the draft with the Committee going forward.

Robert Baldwin, COO of Sharable, stated that his perspective on these issues is a little different from the HCSMs that the Committee has heard from today and in previous meetings. Mr. Baldwin stated that he and a colleague used to run CCM from 2004-2016 so he has had a lot of experience in the industry and have interfaced extensively with regulators and legislators. Sharable is a consulting and software company that was formed to help existing and new health care sharing organizations to practice health care sharing in a way that complies with the state safe harbor provisions. Mr. Baldwin stated

that he is here today to thank Rep. Carbaugh for introducing the Model, support it, and suggest a few changes. Mr. Baldwin thanked Rep. Carbaugh for addressing some misconceptions about the industry. There are legitimate HCSMs out there and everyone in the industry wants to see the good actors promoted and not the bad actors. Sharable exists to advocate for responsible growth in the industry and to help guard against bad actors.

Mr. Baldwin then suggested a few changes to the Model. First would be to remove the reference to U.S.C. 26 § 5000 which is the ACA's individual mandate exemption section and the 1999 date-stamp. That is a provision that requires HHS to recognize only those organization that existed prior to 1999 that met certain definitions. That code in particular is facing stiff legal headwinds today and therefore Sharable believes the Model would benefit from having its own definition of what constitutes health care sharing. To that point, Sharable also recognizes that the safe harbor state statutes probably are going to be usurped by the Model so there is value in looking at those safe harbors and integrating as the new definition of health care sharing the majority of provisions that are contained in them such as: having a common set of ethical and religious beliefs; an annual audit; being a 501(c)3 not for profit organization; where the HCSM acts as a facilitator of matching members who have needs with those who have financial resources to satisfy those needs; and no assumption of risk or promise to pay. Those are all provisions that are present in the majority of safe harbor statutes.

With regard to the Model's anti-fraud provisions, Sharable agrees with the language and also supports the inclusion of anti-fraud provisions that protect the organizations themselves such as those relating to consumer-fraud against the HCSM and/or providers committing fraud against the HCSM. Finally, the inclusion of a member's bill of rights would be a great addition to the Model. That kind of consumer protection and transparency could take the form of points of transparency in pricing – when a member receives their monthly share notice, they should be told how much they pay each month goes directly towards the payment of medical bills of other members as well as to the administrative and program expenses and those are easy things to do. Including the provision for consumers to have binding legal arbitration would also be beneficial which is present today in the typical insurance space. Mr. Baldwin noted that many ministries have multiple steps that benefit the consumer member even before they get to the point of wanting binding legal arbitration.

Disclosing medical bill payments and to whom those payments are going to support would also be beneficial. That is one of the differentiators between health care sharing and health insurance – it really is a community of people coming together to share each other's bills. Next would be a provision that states members can keep their membership even if they get sick. That is also a provision that is in many safe harbor statutes. Also, things that would be considered abuses in the insurance world such as two-tier rating structures could be included in the Model. Also, Mr. Baldwin stated that regulators have often asked him if the ministry denies a bill for sharing and deems it not eligible for sharing pursuant to the ministry's guidelines, does anyone in the organization benefit from that being denied. Mr. Baldwin stated that as far as he knows that is not a practice in any ministry but if that is a concern then perhaps that could be included in a member's bill of rights.

Matthew Smith, Executive Director of the Coalition Against Insurance Fraud (Coalition), stated that the Coalition and its member organizations do not take any position in favor

or opposed to HCSMs. That is not the Coalition's role – it is a consumer advocacy organization fighting all forms of insurance fraud across the nation. One of the largest areas, especially after Alera, that the Coalition and as a consumer representative to the NAIC that Mr. Smith has seen is consumer complaints and fraudulent practices surrounding HCSMs. That is not an indictment to anyone here but a reality that fraud needs to be addressed. Mr. Smith stated that this cannot be left to the State Attorneys Generals. Because when you talk to players in this space and ask for their anti-fraud plan, no one has one and no AG has the power to mandate that. When you talk to players in this space, and you use the term special investigative unit (SIU), no one knows what you are talking about. No AG has the power to impose a duty to have special investigations conducted both to preserve providers and to protect consumers. When you ask providers in this space to show an anti-fraud plan – where are your written efforts to show that you are undertaking to protect your members and your company, no one can produce a plan. No AG has the power to order that.

Mr. Smith stated that in working with leadership behind this effort, language has been crafted that was provided by the Coalition that if adopted, would be groundbreaking. The language recognizes that HCSMs are not insurance carriers and not regulated insurers but voluntarily submits them to 100% of the state's laws and regulations protecting consumers from fraudulent practices. Mr. Smith stated that absent that language, the Coalition would be opposed to any type of provision moving forward that does not contain anti-fraud protections. The language reads: Each health care sharing ministry registered in [state], even though not an insurance company, shall be subject to, and comply fully with, the same anti-fraud provisions and requirements that otherwise apply to insurance companies in [state]. Each member of a registered health care sharing ministry shall covenant not to engage in or assist others in commission of fraudulent practices, including but not limited to the processes of enrollment, seeking medical treatment and reimbursement for medical care.

Mr. Smith also noted that it is important to have on every state DOI website language which states that HCSMs are not insurance programs. Such language does not indict those programs but simply and fairly informs the consumers that if they go with an alternative plan that the DOI may not be able to help them.

Asw. Hunter noted that the Committee was running past its allotted time and accordingly encouraged all Committee members to reach out to the panelists if they have questions and to ask NCOIL staff for their contact information if they need it.

Rep. Joe Fischer (KY), NCOIL Secretary, stated that when we talk about things like antifraud and a bill of rights, what promises do the HCSMs make that could be the basis for a claim of fraud or a claim of misrepresentation. What rights do the members have in the HCSMs to make those claims; is there a legal basis for making the claims? Mr. Baldwin stated that while health care sharing is not insurance and not a promise to pay, there is an implied commitment by the organization to process medical bills fairly, consistently, and according to the organization's guidelines. If an organization decided to process a medical bill pursuant to those guidelines for one member but not another, then that could be fraud. Rep. Fischer asked if that means that the guidelines are sort of a quasi contractual obligation. Mr. Baldwin stated that the guidelines are the rules for how medical bills are shared among the members so that is what the organization uses to determine if a bill is eligible or not to be shared.

Asw. Maggie Carlton (NV), stated that hearing this reminds her of having to unwind confusion surrounding medical discount plans. Because that information was on the DOI website, everyone thought that a medical discount plan was insurance so it ended having to be moved to consumer protection so people didn't automatically conflate it with insurance. Accordingly, full disclosure is great but once it is on the DOI website people automatically think that is where they should go to file a complaint. Asw. Carlton stated that she has concerns with this being with the department of insurance and thinks that the consumer protection division would handle any complaints appropriately.

Rep. Carbaugh asked Mr. Smith if the Coalition has a position regarding the request referenced earlier to strike the 1999 timestamp in the U.S. Code. Mr. Smith replied no.

Rep. Carbaugh stated that he looks forward to continuing to work on the Model and encouraged anyone with comments on the Model to direct them to him and NCOIL staff.

ADJOURNMENT

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES
COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 6, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Friday, March 6, 2020 at 5:00 p.m.

Senator Bob Hackett of Ohio, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Asw. Connie Munk (NV)
Asm. Ken Cooley (CA)	Asm. Kevin Cahill (NY)
Sen. Travis Holdman (IN)	Asm. Andrew Garbarino (NY)
Rep. Matt Lehman (IN)	Sen. Roger Picard (RI)
Sen. Jerry Klein (ND)	Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Kevin Coleman (MI)	Rep. Stephen Ross (NC)
Rep. Brenda Carter (MI)	Sen. Shawn Vadaa (ND)
Sen. Paul Utke (MN)	Asw. Pam Hunter (NY)
Rep. Garland Pierce (NC)	Sen. Bob Peterson (OH)

Also in attendance were:

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

QUORUM

Upon a motion made by Asm. Kevin Cahill (NY), NCOIL Treasurer, 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. Lehman (IN), NCOIL President, and seconded by Rep. Tom Oliverson, M.D. (TX) the Committee approved the minutes of its December 12, 2019 meeting in Austin, TX without objection by way of a voice vote.

CONSIDERATION OF NCOIL INSURANCE BUSINESS TRANSFER (IBT) MODEL ACT

Asm. Andrew Garbarino (NY), Sponsor of the NCOIL IBT Model Act (Model), thanked everyone who has worked and commented on the Model thus far. The Committee has actually been discussing the issue of insurance business transfers since December of

2018; and has been discussing this Model since March of last year. Asm. Garbarino then discussed the changes that have been made to the Model since the Committee's last meeting in December. In Section 6D., the language has been changed to require the insurance commissioner to promulgate rules, rather than only granting the insurance commissioner the authority to do so. Also, another change to that section is that the language was changed from "The Commissioner shall promulgate rules that are not inconsistent with the provisions of the Insurance Business Transfer Act" to "The Commissioner shall promulgate rules that are consistent with the provisions of the Insurance Business Transfer Act." Asm. Garbarino noted that he wanted to make that change because sometimes when the phrasing "not inconsistent with" is used, some departments view that as having authority to essentially promulgate any regulation provided it doesn't directly conflict with the statute.

Asm. Garbarino noted that he decided to make another change since the issuance of the 30 day materials: include language which states that "It is the intent of this Model that Insurance Business Transfer plans should not be approved in a State unless and until the Commissioner has promulgated rules that are not inconsistent with the Model."

Asm. Garbarino noted that such language appears currently as a drafting note but stated that he would prefer that language be converted to bill language. Asm. Garbarino stated that he believes the changes are fairly self-explanatory – he wanted to make clear that regulations need to be promulgated and that insurance business transfers should not be approved until such time. These are complex transactions and making sure the appropriate regulations are promulgated first before an IBT is approved in an important step to ensuring both businesses and consumers are properly protected.

Asm. Garbarino then commented on the issue of guaranty association coverage and noted that several interested parties have weighed in on that issue and have requested that more language be included in the Model. Asm. Garbarino stated that the issue is indeed a very important one, and noted that he thinks the Model adequately addresses it. Section 6.A.4. of the Model states that "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." As part of the Plan submitted to the insurance commissioner, language was included requiring that there must be a description of how the transferring and assuming insurers will be licensed for guaranty association coverage purposes. Further, guaranty association coverage was specifically included in the topics of regulations to be promulgated so that this issue would be further addressed by the Commissioner. Accordingly, as currently drafted, a Commissioner cannot approve an IBT plan if there is not appropriate guaranty coverage; approving such a plan would have a material adverse impact on the interests of policyholders or claimants.

Asm. Garbarino stated that he understands some interested parties may wish that there was different language, but again noted that he thinks the current language adequately addresses the issue. Furthermore, as is always the case with NCOIL models, states are free to change any provisions as they deem appropriate. Asm. Garbarino stated that he thinks it is important to send this Model to the states now as state interest in IBTs continues to grow. Asm. Garbarino stated that he looks forward to hearing brief comments from the panel, and then asked that a Motion be entertained by the Committee afterwards to adopt the Model with the amendments.

Karen Melchert, Regional VP of State Relations at the American Council of Life Insurers (ACLI), thanked Asm. Garbarino for his willingness to work with ACLI throughout this process. ACLI presented its principles and guidelines on IBTs and corporate division statutes at the NCOIL Summer Meeting in July, in addition to submitting a red-lined version of the Model. ACLI worked with Asm. Garbarino to try and incorporate its principles into the statute. Ms. Melchert noted that ACLI had hoped it could have until July of this year to further work on the Model but understands the sponsor's desire to move forward. When ACLI looked at the Model again in advance of this meeting, it discovered that its principles are not easily translated into statutory language which was previously discussed with Asm. Garbarino. ACLI is working on improving that language.

Ms. Melchert noted that in Colorado there is currently a corporate division proposal which ACLI is working on language for that NCOIL may benefit from seeing. ACLI will bring that language to NCOIL going forward. Ms. Melchert stated that as these types of bills are introduced in states and ACLI has finalized its statutory language, ACLI will seek to make changes as it deems necessary.

Paul Martin, VP of State Relations at the Reinsurance Association of America (RAA), stated that RAA often gets questions as to what the genesis is of RAA's concerns with the Model. Mr. Martin pointed the Committee to Section 2 of the Model which states that "[T]hese 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." Mr. Martin stated that if your homeowners or auto company were to send you a notice that simply says "we are setting up a new insurance company that you have never done business with before; we are transferring your policy to that company and you do not get a say in that transaction", he suspects that some may have some questions about that. RAA understands that there are some situations where there is a public policy benefit to having this sort of analysis and the overall concerns are ensuring that there are adequate protections for all parties involved, particularly reinsurers. Mr. Martin stated that RAA has some minor suggestions to include in the Model such as simply adding "and reinsurers" to existing provisions where it says "policyholders and claimants." RAA is working with ACLI on the aforementioned Colorado bill, sponsored by Sen. Angela Williams, to make sure the guardrails are in place so that when there is a division or an IBT, everyone is made aware and all the parties are put on notice and there is a fair and transparent process by which these transactions take place.

Bob Ridgeway, Senior Gov't Relations Counsel at America's Health Insurance Plans (AHIP), stated that the big picture is that a contract is being changed without the policyholder's permission. That is the bottom line and it is rare. From AHIP's position, we cannot be too careful. Mr. Ridgeway thanked Asm. Garbarino for the changes to the Model referenced earlier, particularly the regulatory language. Mr. Ridgeway noted that another important issue to be addressed is that of guaranty association coverage. AHIP is looking at that issue of you cannot have the language too tight because the consumer's interests are in play. Instead of saying, in Section 6A.4., "The Commissioner shall authorize the submission of the Plan to the court unless he or she finds..." AHIP proposes saying "The Commissioner shall not authorize the submission of the Plan unless he or she finds that the existing guaranty fund coverage of policyholders will not be jeopardized or adversely impacted by the transaction, and policyholder's eligibility and coverage will be the same after the transaction as before."

Mr. Ridgeway stated that the point there is that if you are reading subsection 4 as currently written, you are probably wondering what is a circumstance where the Commissioner might find that there wasn't an adverse impact when potentially there was. Mr. Ridgeway stated that he has a lot of faith in regulators and legislators but sometimes they might not read something as carefully as they should or sometimes they might just miss something. Mr. Ridgeway stated that a scenario might arise with a transaction where the Commissioner might determine that there might be some issues with guaranty coverage, but after analyzing each insurer, he or she thinks that they will be ok for purposes of guaranty association coverage and the only insurance where such coverage will be needed is very remote so the transaction will be approved. The current language would allow that transaction to be approved but AHIP's proposed language would accommodate that risk, however small it may be. The point raised may be small, but is a point nonetheless, particularly when viewed from the views of the policyholder who gets a notice in the mail saying they are now insured by a company they never heard of and they did not get a chance to say no or opt out.

Asm. Cahill then made a Motion to adopt the Model, as amended, which was seconded by Asm. Ken Cooley (CA), NCOIL Vice President.

Sen. Klein stated that he understands that Asm. Garbarino has worked very hard on the Model, and that states can always adjust a Model as they deem necessary, but noted that he is a little uncomfortable with finalizing the Model today as currently drafted. The current draft is a tremendous outline but he believes that some tweaks can be made in order to address concerns that have been raised.

Returning to the Motion made by Asm. Cahill and seconded by Asm. Cooley, the Committee voted to adopt the Model, as amended by way of a voice vote with Sen. Klein being the only Committee member who voted "no."

CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL MARKET CONDUCT SURVEILLANCE MODEL ACT

Sen. Travis Holdman (IN), NCOIL Immediate Past President and sponsor of the proposed amendments to the NCOIL Market Conduct Surveillance Model Act (Model), thanked everyone who was worked on the Model and noted that the Committee has been discussing the proposed amendments since last March. The Committee has worked hard to get the proposed amendments to a place where Sen. Holdman believes they are ready for consideration. Comparing the current version to what was originally proposed shows the level of diligence displayed throughout this process. Sen. Holdman stated that he thinks everyone here today appreciates the value of market conduct exams and understands that they provide both regulators and consumers the protection and confidence they need in the companies to move forward. However, the impetus for proposing amendments to the existing Model was that there were concerns regarding the vagueness of the triggers for market conduct exams, as well as the timing, frequency and costs of them. Accordingly, the overall theme of the amendments is to clarify that market conduct exams should not be conducted unless there is a demonstration of material violations of state laws or regulations as opposed to mere technical violations or vague terms such as "market conduct problems."

Sen. Holdman then discussed the changes that have been made to the Model since the Committee's last meeting in December. In the first bullet point of Section 2, language

was added to clarify that actual violations of laws or regulations should serve as the basis for a market conduct exam. In the last bullet point of Section 2, language was added to clarify that a market conduct examination of the insurer's cybersecurity protection measures can be conducted if a separate cybersecurity market conduct examination is precipitated by a cybersecurity breach. Sen. Holdman stated that he knows that there has been some pushback on this language as regulators don't want their ability to examine these issues curtailed, but noted that he thinks the new language appropriately addresses those concerns. For example, a number of regulators stated that they would need to preserve their authority to examine Anthem in light of its breach; this new language expressly preserves that authority. It's also important to note that the language is seeking to ensure 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.

In Section 5(a)(2), the language there was clarified to again reiterate that material deviations from state laws or regulations should be considered by regulators. In Section 5(e)(1), the word "material" was removed because a pattern of unfair trade practice act violations is by definition material. Section 7(l)(2)(H) was amended to clarify that review of prior market conduct examinations should be limited, not prohibited, to the extent such review will expedite the subsequent examination. Sen. Holdman stated that he also made one change after release of the 30 day materials – in Section 5(e)(5), everything after the first sentence has been deleted. The phrase "de minimus" and accompanying language was vague and in his mind gave too much leeway for those that violate the code multiple times. Sen. Holdman stated that he looks forward to hearing comments from the panel today and then asked that a Motion be entertained afterwards to adopt the proposed amendments discussed today.

Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC greatly appreciates the sponsor's work on the Model, both initially and with the latest version which NAMIC believes is responsive to the concerns it has heard in the past. NAMIC believes that the changes to the Model represent a balanced way to try to ensure that there are appropriate communications amongst all parties in the market conduct process and that the process has appropriate definitions as well.

The Honorable Chlora Lindley-Myers, Director of the Missouri Department of Insurance and Secretary-Treasurer of the National Association of Insurance Commissioners (NAIC), thanked the Committee for being able to provide regulatory feedback on the proposed amendments to the Model. Regulators first and foremost believe that there needs to be an appropriate balance between creating an efficient market regulation process for both regulators and companies while also maintaining effective consumer protections. Dir. Lindley-Myers stated that NAIC staff recently had a call with NCOIL staff and shared some initial thoughts about the proposed amendments. The NAIC is glad to see that several of the NAIC's suggestions made it into the draft Model as the NAIC believes they make the intent of the Model clearer and believe that they will prevent unnecessary restrictions being placed on insurance departments.

Dir. Lindley-Myers stated that she would like to offer some perspective on a few of the remaining amendments to the Model. With regard to the fourth bullet point in Section 2, while the NAIC agrees that the market conduct exams normally should focus on past breaches, the NAIC has some concerns that the language explicitly limiting actions that

a Commissioner can take without a breach might curtail some of the instances where Commissioners find it necessary to act. The NAIC is not convinced as we sit here today that it fully comprehends all of the potential data breaches and cybersecurity scenarios that exist that could impact the complicated, intertwined industry. Next, with regard to the second bullet point of Section 2, Section 3(g), Section 5(a)(2), and Section 5(e)(4), the NAIC believes that references to “material” violations of state law might lead to procedural issues and inhibit the resolution of underlying substantive issues which could be detrimental to consumers and potentially increase the regulatory cost to companies. The NAIC believes that striking references to “material” and referencing violations of state law is sufficient.

Next, while insurance departments must remain efficient in how they perform their work through proper budgeting, it is inappropriate to limit upward deviations from estimated budgets to 10% and only with substantial documentation as an arbitrary cap. Ten percent is likely to have an unintended consequence of inflated examination budgets rather than lowering them. Therefore, the NAIC believes that there should be some clarifying language in Section 7(e)(1) regarding budget and costs. The NAIC is concerned that limiting that capacity could inhibit what regulators are able to do. The NAIC looks forward to learning more about the underlying issues to be solved by the suggested revisions and would caution against any inadvertent restrictions of regulatory authority. Dir. Lindley-Myers thanked the Committee for the opportunity to comment.

Sen. Holdman stated that significant changes to the Model have been made when comparing the first version to the current version at the request of the NAIC and NCOIL has been very accommodating. Sen. Holdman stated that he has had problems in the past with market conduct issues and what precipitates them and the cost of them towards the companies. There is no doubt that the cost gets passed on to the consumer. Sen. Holdman stated that he has some firsthand knowledge of some issues that have gone on with market conduct issues and noted that policymakers have an obligation to keep a tight reign on that issue. Sen. Holdman then made a Motion to adopt the proposed amendments to the Model discussed today which was seconded by Sen. Klein.

The Hon. Tom Considine, NCOIL CEO, stated that one of the first things he did as Commissioner of the NJ Dep’t of Banking and Insurance was to put a cap on market conduct exams and regular exams. The estimate was the limit and unless the examiners could come forward with finding new things, that is it. During Cmsr. Considine’s tenure there, no one went overbudget. There were a couple of times when new things were found and the appropriate steps were taken which Cmsr. Considine stated he believes is envisioned in Sen. Holdman’s proposed amendments. Cmsr. Considine stated that there are a lot of instances where people say the exam was supposed to cost \$40,000 but it will now cost \$400,000.

Returning to Sen. Holdman’s motion, the Committee then voted to adopt the proposed amendments discussed today without objection by way of a voice vote.

BRIEFING ON NCOIL COMMENT LETTER ON THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT’S (HUD) DISPARATE IMPACT RULE

Cmsr. Considine first gave instructions on how to access the comment letter on the NCOIL website and then noted that there has been a back and forth on this issue for a

number of years with HUD and its disparate impact rule (rule). Cmsr. Considine stated that NCOIL was planning on submitting a letter to HUD about the rule but then conversations with The Hon. Nat Shapo, Partner at Katten Muchin Rosenmann LLP and former Director of the Illinois Department of Insurance, changed the substance of the letter. The letter is not an instance of asserting intrusion into the state-based system of insurance regulation. Rather, this is an instance where Congress has already taken substantive action to regulate in the area of discrimination – the Robinson-Patman Anti-Discrimination Act.

Dir. Shapo stated that he was not aware of Robinson-Patman until he was preparing his presentation on McCarran-Ferguson for the 2018 NCOIL Annual Meeting. HUD has put out the rule implementing the Fair Housing Act (FHA) which called for disparate impact liability on whatever entities are scrutinized under the FHA. Such claims have been brought in litigation for years and the rule would be a more formal way of stating that there is disparate impact liability. The U.S. Supreme Court in *Inclusive Communities* in 2015 stated that the FHA does recognize disparate impact liability. The FHA, unlike state unfair discrimination insurance laws, has language specifically evincing congressional intent that disparate impact be recognized. Disparate impact is what you would call effect rather than intent. The state unfair discrimination laws do not have language and have not been interpreted to have disparate impact cognizable. A claim of disparate impact is when you say this has an impact on a protected class. The states laws say that you cannot discriminate based on a class – that would be intent liability. Examples include, race, national origin, and religion. Under the state laws, if it is not direct, intentional discrimination then it is not cognizable.

Dir. Shapo stated that the FHA has language which the Supreme Court has decided leads to disparate impact being cognizable. HUD's rule would apply to insurers because HUD has taken the position that homeowner's insurance will be subject to disparate impact liability. So what you have here is state laws governing insurer discrimination practices that are only based on intent versus HUD saying that FHA would recognize disparate impact liability for homeowner's insurance. The question is how do you do a preemption/conflict of laws analysis for that? Traditionally, you would use a reverse preemption standard under the McCarran-Ferguson Act. Said Act stated that states shall be preeminent in policymaking in insurance regulation, but it also reserves the ability for Congress to pass a law, like Obamacare or flood insurance, that would apply to insurance. The Act then sets up an unusual reverse preemption standard under which a state law specific to insurance can trump a federal law not specific to insurance. That standard is evaluated under the "impair, supersede, invalidate" provision which has been heavily litigated throughout the years. That is the usual way people consider what the preemption standard is.

However, in this instance, there is a more potent preemption standard that can be used. The theory is that the usual way that preemption comes up is when you have a federal law that is not specific to insurance and a state law that is specific to insurance. Then you do the reverse preemption analysis. However, this instance presents an unusual circumstance because the state unfair discrimination laws did not arise in the normal course of action which is you decide individually, on your own, pursuant to McCarran-Ferguson's structural rule that state regulation is favored, each state would decide on its own what it wants to do in a particular area. The state unfair discrimination laws did not come from independent choices from the states, rather, they came from what is often called the anti-trust exemption in McCarran-Ferguson which is best known for a partial

anti-trust exemption from The Sherman Act. Basically, what happened was that with McCarran-Ferguson in 1945 Congress said it was going to suspend the anti-trust laws for three years and states need to occupy the field and if they do then The Sherman Act will not apply to insurance.

That produced the excessive and inadequate standard. The third prong, unfairly discriminatory, came about from Congress' direction in McCarran-Ferguson saying that the Robinson-Patman Act will apply to insurance unless the states occupy the field. States were given three years to pass laws to essentially mimic the Robinson-Patman Act which, among other things, requires cost-based pricing in the selling of commodities. The legislative history is very clear that the purpose in McCarran and the purpose of the states when they decided to pass the model rating laws was that the unfairly discriminatory prong of the state rating laws was passed at Congress' direction for the states to occupy the field and to mimic the Robinson-Patman Act. As a result, the NAIC President said in 1948 that the rationale of the Robinson-Patman Act, the NAIC model bills, and rating laws is generally the same – namely that we are varying prices on the same articles that are quoted to different buyers, the sellers should be able to establish the different variations in price are fair and reasonable: cost-based pricing. The purpose of the state unfair discrimination laws was to follow a federal mandate favoring cost-based pricing in unfair discrimination laws in the states.

Dir. Shapo stated that the state legislators dutifully implemented the federal policy by passing state unfair discrimination laws. The key point is that cost-based pricing is an economic discrimination standard, not a social discrimination standard. It does not include an element of protected, social classes. The point is that federal policy under the McCarran-Ferguson Act specific to insurer discrimination practices was the incentives placed on the states to pass an economic based discrimination standard. The Robinson-Patman Act does not recognize disparate impact. The conflict of laws analysis is such that you have a federal policy of cost-based pricing specific to insurance, the McCarran-Ferguson Act which incorporates by reference the Robinson Patman Act, and you are comparing that to a federal law, the FHA, which recognizes disparate impact liability for social classes. But the FHA is not specific to insurance and the McCarran-Ferguson Act is. Statutory construction states that specific trumps the general. So, with respect to insurance, the theory is that the insurer discrimination standard is cost-based pricing and that is a specific Congressional directive for insurance that trumps the more general social disparate impact liability in the FHA. Dir.

Shapo stated that this theory has not been used yet so NCOIL is ahead of the curve.

ADJOURNMENT

There being no further business, the Committee adjourned at 6:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE AND FINANCIAL PLANNING COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 6, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Friday, March 6, 2020 at 3:45 p.m.

Assemblywoman Maggie Carlton of Nevada, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)	Sen. Jerry Klein (ND)
Asm. Ken Cooley (CA)	Sen. Shawn Vedaas (ND)
Sen. Jack Tate (CO)	Sen. Bob Hackett (OH)
Rep. Jim Lilly (MI)	Rep. Tom Oliverson, M.D. (TX)
Rep. Michael Webber (MI)	

Other legislators present were:

Sen. Angela Williams (CO)	Rep. Garland Pierce (NC)
Sen. Paul Utke (MN)	Asw. Connie Munk (NV)
Sen. Valerie Foushee (NC)	Sen. Robert Ort (NY)
Rep. Stephen Ross (NC)	Sen. Roger Picard (RI)

Also in attendance were:

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

QUORUM

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Rep. Michael Webber (MI), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Deborah Ferguson (AR) and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee approved the minutes of its December 12, 2019 meeting in Austin, TX without objection by way of a voice vote.

REFORMING THE LIFE INSURANCE APPLICATION PROCESS

Porter Nolan, Head of Legal at Ethos, stated that he is here today to provide some notes from the field from the perspective of being head of legal at Ethos, an insurtech that has been around for about three years. Mr. Nolan noted that the views he expresses today are his own and not necessarily those of the company. Mr. Nolan stated that the

challenges presented to an insurtech company startup can essentially be bucketed into three big groups: internal, external, and the legal/regulatory landscape. Mr. Nolan stated that he will mostly focus on the legal/regulatory landscape today. For purposes of that, he will focus on three main areas: licensing, subcontracting, and marketing.

With regard to licensing, Mr. Nolan stated that in some states Ethos has seen some time restrictions when applying for a license. For example, you have to have two years of audited financials which seems fairly innocuous and a reasonable requirement but at the same time that means just to engage in business in certain states you have to have been operating for two years so clearly that can be an impediment to getting started. It can create delays and there can be a chicken and egg problem if there are similar rules in each state how could you start and have two years of audited financials if you don't have a license to operate in all states. The chicken and egg problem is definitely real.

Similarly, there are capitalization requirements in some states whether it is minimum capitalization which can make it difficult for less funded entities to get started or requirements to show two years of consecutive positive net worth. The difficulty with that is that a lot of companies in their first year won't show positive net worth and even if you have to show two years of audited financials showing positive net worth, the important one would be in the second year. The first year being a startup year it is not unusual to take out loans or debt to get started. Again, that could kick out the timeline before you satisfy the requirement to three or possibly four years making it increasingly difficult to get licenses.

Mr. Nolan stated that for something like doctors and lawyers, regional licensing certainly makes sense based in a jurisdiction regulated locally by things such as bar associations, but a state-based system becomes inherently incongruous for tech companies that operate online. Mr. Nolan stated that he is not advocating for an overhaul – state licensing certainly makes sense – but the effort should be at more harmonization and consistency in the licensing rules because the difficulties previously mentioned are not present in each state. There have been efforts at this before with National Association of Insurance Commissioners (NAIC) model regulations or the Compact for purposes of products, but for licensing it is the lack of consistency that essentially benefits largely outside lawyers and consultants who advise on licensing requirements.

Mr. Nolan then turned to subcontracting difficulties. Several states have adopted language consistent with “An administrator may act only if there is a written agreement between the administrator and an insurer.” That certainly makes sense for the primary third party administrator (TPA) but the difficulty comes in if you want to subcontract a portion of the work. This has been interpreted in some states to say that a TPA may not subcontract its work to another licensed TPA but when you read the statutes there is not a strict restriction on doing that so it is the interpretation that seems to perhaps veer from the strict language of it. If you look at the secondary effects of this, it seems to have some unintended consequences. One is that you can then subcontract work to an unlicensed party but not to a potentially more qualified and licensed TPA. Arguably, if the design of the law is to protect consumers, it seems to have the opposite effect. The primary TPA is also then no longer responsible to oversee what was previously the secondary TPA. Perhaps if you subcontracted out underwriting to a different company, now you will have a consumer who works directly with you as the primary TPA because you may have been producer on the account but you have no relationship and

contractually no privity anymore with the other TPA that is providing different services because they now have had to contract directly with the carrier.

Turning to marketing regulations, Mr. Nolan stated that interestingly, the NAIC has a model regulation which states that “An advertisement shall not disparage other insurers, insurance producers, policies, services or methods of marketing.” The idea of that makes sense – what is good for the goose is good for the gander and we shouldn’t undermine the authority of life insurance business and we should maintain the public’s confidence in the industry. But arguably if you look at Coke vs Pepsi advertisements, there has arguably not been undermining of public faith in sodas. The argument is that of healthy competition – if anything that can draw more attention to life insurance, the benefit then is better knowledge for consumers and increased demand across the board. Some unintended consequences of this may be a chilling effect on commercial speech because there are certain things you are not allowed to say. It also impairs new player’s ability to distinguish themselves from historical industry practices. This issue is now under review with the NAIC’s EX Task Force and that is a positive development. Consistency across the board certainly reduces marketing costs because you don’t have to tailor ads to each state.

Mr. Nolan then provided some examples of statements that may run afoul of regulations depending on how interrupted by state regulators. “Traditional life insurance companies are slow to innovate.” Arguably that could be interpreted as disparaging.

“Commissioned agents may not have the customer’s best interests in mind.” For companies like Ethos, it does not use commission-based agents. Reasonable regulators can disagree as to whether those statements violate rules which seems to bolster the argument that increased specificity in the law or even a removal of that provision would make sense. Part of the reason is also because there is already a rule in the NAIC marketing regulations that requires a duty of candor that all advertisements have to be honest. So, that seems to satisfy any underlying concerns. Mr. Nolan stated that the two options presented to an insurtech company would be to: roll the dice – state your value proposition and how it distinguishes you in the market and why it is different from certain industry historical practices or certain competitors but that comes with healthy risks in the form of time and money to potentially defend marketing conduct; or adopt a conservative approach which most companies seem to have done and it arguably stifles innovation as you can question whether there is a real customer benefit in you not being able to state certain value propositions. The result that most companies have taken is to comply with the strictest potential interpretation of these regulations.

Mr. Nolan stated that going forward, the most important thing for this committee and for legislators in general is to communicate with insurtechs and regulators through conferences, circulars, being able to submit questions on a no-name basis to departments of insurance and get timely responses. Some states have been outstanding with that and companies like Ethos appreciate that. Phased implementation and comment periods for new laws are also important such as what has happened with the California Consumer Protection Act (CCPA). The biggest takeaway is to consider second order impacts or effects and how they impact insurtechs or any new startup as opposed to how they impact legacy players.

Asw. Carlton stated that she understands where Ethos is trying to go with regards to being able to make certain statements but she would not compare buying life insurance

to buying Pepsi or Coke. A Pepsi or Coke may cost \$4 at the most expensive rates but people are investing a lot of money in life insurance so perhaps another analogy would be better.

Asw. Carlton stated that in Nevada, some licensing regulations allow folks to put up some type of bond or personal responsibility waiver for timing requirements. Asw. Carlton asked if that is prevalent in other states. Mr. Nolan stated that Ethos has seen that as an option in certain states and in others states interesting carveouts have been created such as if the company creates a subsidiary entity that is brand new and has no financials of any kind, then you can license that entity and that will be given as an exception. Mr. Nolan stated that he is not really sure how that improves anything as that seems like purely substance over form but companies are often encouraged to take that route.

Asw. Carlton asked if the reasoning behind that would be that there would be someone there with the financial responsibility if things went down the slide too fast? Mr. Nolan stated that is a good question and he is not sure of the reasoning behind it and perhaps that is part of the problem. Ethos was not even required to provide a parent company guarantee to support the subsidiary entity which Mr. Nolan thought would have been the next requirement but even then if a parent company guarantee is required for the new subsidiary, why not just license the parent?

LIFE INSURANCE UNDERWRITING 101

Dr. Robert Gleeson, Medical Consultant for the American Council of Life Insurers (ACLI), stated that he is a physician and spent 27 years doing medical underwriting at Northwestern Mutual Life Insurance. He then spent 10 years as an associate professor at The Medical College of Wisconsin. Dr. Gleeson stated that life insurers are in the business of selling life insurance. They are often accused of looking for ways and reasons to decline life insurance or disability or long term care. Nothing could be further from the truth. Life insurers work hard to sell products and they are in competition with each other to offer a lower offer than the next company. Another key point is that with the advent and growth of medical knowledge for the last 75 years, life insurance has continually become more affordable and more widely available. Fifty years ago, people with a history of a heart attack were uninsurable. Today, most of those people get very good rates.

Dr. Gleeson stated that individual means that each person gets to decide when they want to buy and how much to buy – it is a voluntary system. That means that insurers underwrite or assess the risk only once and that is at the time of the application. Once underwritten, the price and terms cannot be changed even if the health of the applicant, or now insured, changes within two days after the insurance was issued. All companies expect to pay death claims on policies that are less than one year old because that is the nature of life – bad accidents happen and that is why you buy the product. Insurers also expect to pay claims in 60 years because that is the nature of life expectancy when you buy a policy when you are young – that policy stays in force.

It is important to remember that while there are some people who have trouble buying life insurance, there are options to individual life insurance. Almost anyone can get life and DI products through their work or union or association. The group is underwritten but the individual is not underwritten. That means that there is almost always some

coverage available everybody. The main reason that people don't have life insurance or disability or LC is that they don't buy it; they don't apply.

Dr. Gleeson stated that life insurers and health insurers are often conflated but there are important differences. For life insurance, the buyer chooses when and how much to buy. Health insurance is an annual enrollment. Underwriting of life insurance can only be done at the time of issuance. There is no underwriting for health insurance. The rates for life insurance are set at the time of purchase or issue and cannot be changed. Health insurance premiums are reset annually based on the prior years' experience. For life insurance, the full contract benefit will be paid to named beneficiaries on the death or disability. For health insurance, there is no self interest and the benefits are paid to third party providers for services provided.

Dr. Gleeson then discussed some underwriting basics. It is important to remember that life insurers are required to by law and regulation to treat individuals with similar risks similarly. The treatment has to be justified by sound actuarial principles or reasonably anticipated experience. State auditors will come in and go through books to make sure manuals and actions taken for individuals lined up. Applicants understand this and for over 100 years they have shared personal information and they trust insurers with that information as they know it is needed to make the system work well. Life insurers use personal information to assess applicant's risk but for different applicants of different ages or different dollar amounts of insurance the requirements may differ widely. If you are a 30 year old applying for \$200,000 a simple non-medical application may be sufficient. For a 65 year old applying for \$8 million, the life insurer should get more information that they because they have to do an accurate risk assessment since the risk is larger.

When an applicant is underwritten, all underwriters follow written guidelines that determines what kind of information they seek and how they assess the risk. For new medical developments or difficult or complex cases, virtually all life insurance companies have medical directors, many of them full time, who are trained in life insurance and are there to ensure that the highest standards in quality are followed. As science and knowledge advances, so does underwriting and insurers look for better and more aggressive ways to make policy offers. Fifty years ago essentially all heart attacks were uninsurable but today we know that heart attacks can be treated with stents and some of them have minimal damage to the muscle, some of them have moderate damage, some of them have rhythm damage, and some of them have other health problems. All of those things are now considered when looking at a heart attacks – the heart attack by itself is never looked at. It is always necessary to go deeper to understand the heart attack and the goal is not to find a reasons to decline coverage but rather to issue insurance at the lowest possible rate because if one company does not, another company will underwrite more aggressively and get the business.

Dr. Gleeson stated that medical tests help physicians treat diseases better and also help underwriters more accurately assess the risk. For a diabetic, an A1C can be looked at. For breast cancer, you can look at hormone markets of the tumor. For lymphoma, you can look at the genetic markers of the tumor. The genetic tests done as part of the clinical practice are increasingly becoming a part of the medical record. They are not standalone information; they help everyone understand the disease better.

Dr. Gleeson stated that he was first asked to testify about genetics in the early 1990s in

Wisconsin and there was a representative there who said that you can draw a drop of blood on a child today and determine the year of their death – that genetics was that powerful. He last heard that argument last month in Florida. We are nowhere close to that. All of the scientists in the world have no interest in determining life expectancy. That is not on anyone's radar. Also, the human genome is 23 billion base pairs long. It exists in every cell of your body. Something determines why that gene makes enamel in your teeth and bile in your liver because you don't want to get it backwards, but it never happens. We have 20,000 genes but the real magic is what gene gets turned on when and what gene gets turned off when and in what series that builds. There is a phenomenal amount that we don't understand and this is anything but simple. The minority of your DNA, only 5%, are the genes. The rest of it is material that turns genes on or off so this is an incredibly complex process.

Dr. Gleeson stated that a gene mutation may be inherited and may be turned on or off by lifestyle choices. Not everyone who smokes gets cancer but some people who smoke have a mutation in a gene that grows to become a cancer. Only rarely are inherited genes determinative. Unfortunately, Huntington's disease is a tragic example. There is no single gene for getting a heart attack. There is the interplay of your lifestyle choices and then probably hundreds of genes that determine whether you get a heart attack such as lipids, inflammatory markers, good cholesterol, bad cholesterol, nitric oxide production, endothelial functions. It is much more complex than a lot of people want to make it. It is not as if we can look at a gene and make an absolute prediction. Many diseases can be diagnosed by genetic, protein, or blood tests. All three can test for the same disease but it is important to not make one of the tests more special than the other.

Dr. Gleeson stated that it is very important to remember that genetic tests can be helpful for people. If you have a gene for Familial Hypercholesterolemia, aggressive treatment with statins starting at age 20 normalizes your risk. There are colon cancer syndromes that are inherited. Increased colonoscopy starting at age 35 prevents the disease. So, when we know about the test it is to that person's benefit and the life insurance company looks at that same information favorably if the applicant is doing the correct follow up. Life insurers sell a lot of insurance to women and men with breast cancer. A BRCA test only indicates an increased risk, not a certainty, that breast cancer will develop some time before age 80. Life insurance medical directors are used to those statistics and understand how to work with them. But if you have a family history of three first degree relatives with breast cancer, that application is automatically going to be thought of as at risk. If they walk in with a genetic test that is negative for BRCA gene, that risk is going and that person did not inherit the gene and they get the insurance. So, that is an example of a genetic test helping people. Genetic tests can also subtype some forms of cancer. Today, there are some lymphomas that we now know we almost don't have to treat.

With regard to direct to consumer tests, Dr. Gleeson stated that life insurers do not want information from a direct to consumer testing company. Life insurers interest is raised when they report to the person that they got at home, you should discuss this with your personal physician. The consumer will take the test and go discuss it with their doctor and she is going to order a repeat of that test through her lab which is university based or certified and she will get the correct test. That is what life insurers want -the results that are in the medical record that correlate with their history that are performed by the personal physician. Life insurers want to know what the applicant knows and they want

all relevant information that is in the medical record as they have today. To say some of it is more special or different creates all kinds of problems including adverse selection and equity. Life insurers really want the confirmed test of any sort that is in the physician's medical record. If you go to have the neck ultrasound in the church parking lot, life insurers don't want that test – they want the test confirmed by the physician. Dr. Gleeson stated that restrictions on insurer's use of genetic testing create a special risk class that would receive more favorable treatment and rates than they would otherwise and those costs would be paid by other policyholders.

Dr. Gleeson then offered the following points in conclusion. Life insurers want to issue policies and coverage. Underwriting is one of the cornerstones of financial stability for the industry. The others are investment returns and expense control. Underwriting is strictly regulated by state law. Like risks are to be treated the same, and insurers must be able to show they treated similar risks similarly. Genetic tests are one more bit of underwriting information in the medical record where they help physicians and underwriters better understand the disease.

Rep. Oliverson stated that one of the concerns that he has had with genetic testing is that there is a small percentage of the genome that we actually know what it does and what the effect is going to be. Even if we had a panel of oncologists here, they would probably say yes, a BRCA mutation increases your risk for breast cancer but it doesn't guarantee that you will develop it. Accordingly, to what extent are they actually consistently reliable markers in terms of being able to underwrite. And to what extent are the markers and tests used exclusively, especially in an environment where we have been underwriting without this information, such that we take so much of the risk out and that benefits the policyholder. To what extent does that go to lower premiums versus making it a slam dunk for the insurer that it is a policy that will never be called into force.

Dr. Gleeson stated that life insurers use any test when it is in the literature, has been reproducibly studied, is recognized by maybe the U.S. Task Force or the American Cancer Society as reliable and useful information. It is not as if insurers are taking the first genetic test they hear of and grabbing it. Further, life insurance medical directors' coursework spends a lot of time on specific analysis, statistical positive predictive values and similar things so that insurers really understand the BRCA test or positive stress test indicates a future risk of disease and not a certainty. Insurers look at that and will come up with a price. If you have someone who has a genetic test BRCA, they already had the risk from their family history so now they are no worse off. Half of the family just got better because their test was negative. So, life insurers will look at that and say I have a woman who is 30 years old and starting to get mammograms at a good mammography center and she is compliant with all follow up – her risk is lower. Insurers think in pricing in terms of deaths per thousand people per year. If insurers say that the 30 year old is one expected death per thousand per year in that first year, with her BRCA test it might go up to 1.1 – it is a little higher but not very much higher in the same way that a bad asthmatic could double the risk. Insurers don't look at all or none.

Rep. Oliverson stated that the reason that physicians might advise someone to get tested is because there are prophylactic treatments that can be performed to lower the risk. For example, with Huntington's disease, there are genetic markers for that but a person may not want to know the answer because there is no cure for that. Rep. Oliverson stated that he wonders sometimes what insurers think about the situations where some people do not want to know that type of information. Dr. Gleeson stated

that life insurers are not asking anybody to get a genetic test. Rep. Oliverson stated that he thought Dr. Gleeson stated that if someone has a family history, and they wanted to mitigate that, it could be achievable but only if they are willing to submit to a genetic test.

Dr. Gleeson stated that if someone with a disease wants to purchase \$1 million in life insurance coverage, which is pretty easy to do today, if they want the best rate and they go to a genetic counselor and their test is negative, insurers are going to look at the test but to get that test they will have gone through consultations with the genetic counselor to make sure they are ready for the test. Life insurers are not in the position to say people should go get the test. Life insurers would view that as they were a decline anyway, with respect to Huntington's, and now we are going to be able to offer insurance to half.

Dr. Gleeson stated that he understands some people might not want to know results but Huntington's disease is almost the only disease like that. Rep. Oliverson asked if they are uninsurable if they choose not to know. Dr. Gleeson replied yes. Rep. Oliverson stated that it then seems that if they want to be insured they have to submit to the test. Dr. Gleeson stated that they can go get coverage through their group insurance but any legislation would not single out Huntington's disease; it would be all inclusive for all genetic tests that Dr. Gleeson stated that he thinks it is too large a number of tests for a small segment of the population. Rep. Oliverson stated that it seems like it is a way of backing into a requirement for genetic testing in order to be insured. Dr. Gleeson stated that the only example of that is for Huntington's disease.

Asw. Carlton thanked Dr. Gleeson and stated that if she has grandchildren she will have them insured when they are baptized. Dr. Gleeson stated that he did that.

INTRODUCTION OF PAID FAMILY LEAVE INCOME REPLACEMENT BENEFITS MODEL ACT

Taylor Walker, Legislative Director at the ACLI, stated that ACLI is very excited about its paid family leave income replacement benefits model act proposal. ACLI and its member companies have been working diligently to address the need for paid family and medical leave benefits for working Americans. Last year, 26 states considered paid family and medical leave legislation. Unfortunately, most of those bills failed to acknowledge the strong role that private insurance already plays in insuring the medical portion of paid family medical leave and that is through private short term disability coverage. Nationwide, 47% of full time private sector workers have short term disability coverage. In fact, the highest volume of claims are pregnancy and maternity related. While disability insurance covers the medical side of paid family medical leave benefits, insurers do recognize the importance of providing the other half of the equation which is paid family leave benefits such as taking care of a loved one when sick or taking care of a new child.

In an effort to expand insured benefits for family leave, ACLI has drafted a model that would enable licensed disability carriers to file products with the state insurance departments to offer paid family leave insurance benefits. Specifically, the model would permit disability income insurers to provide wage replacement for family leave purposes either as a rider to a disability policy or on a freestanding basis as a separate policy. Ms. Walker stated that ACLI believes that disability insurers are best equipped to offer these family leave benefits because disability insurers already have the experience and

expertise and infrastructure in place to begin working towards providing these benefits either through employer sponsored group insurance policies or voluntarily purchased policies. Further, disability insurance currently provides the most extensive coverage for employees for wage replacement purposes. Insurance carriers are already providing similar family leave benefits in New York as part of its paid family medical leave program. In addition to New York, Massachusetts has also been working with the insurance industry to develop family leave products. ACLI's members have emphatically indicated that their interest in offering these types of insurance products.

Ms. Walker stated that ACLI has begun to have conversations with legislators and regulators in a number of states considering or interested in offering paid family medical leave programs. The ACLI's proposal has largely been well-received as a practical and well thought out solution. It is important that NCOIL members and fellow insurance legislators who already appreciate the role that insurers play in providing medical leave benefits are involved in this discussion surrounding family leave insurance benefits. ACLI asks that NCOIL consider model legislation that would enable insurers to offer an insurance solution for paid family leave, providing additional options and benefits for more consumers to meet their paid family leave needs.

Asw. Carlton stated that Nevada is one of several states that is working on passing paid family leave legislation. Asw. Carlton asked for clarification that the ACLI's proposal would not be competing with those statutes, but would rather be in addition to them. Ms. Walker replied yes and stated that it would be a voluntary program. Asw. Carlton asked whether the states that have considered this type of model legislation currently have paid family leave or are they looking at it as an alternative to employer-paid family leave. Ms. Walker stated that the states she has spoken to do not currently have those programs but are interested in learning about various solutions and are concerned with some of the costly state-run programs that are in place. For example, there is a bill pending in Minnesota that would create a paid family medical leave program but would also provide a private option. The sponsor is very much considering the template outlined by ACLI so there very much can be both.

Asw. Carlton asked if there would be an option for employers to purchase this for their employees as one of their benefits. Karen Melchert, Regional VP of State Relations at the ACLI, stated that is the intention of the proposal. Just like employers purchase disability insurance for their maternity leave, this would be something they could add on so if they wanted to provide family leave in addition to personal sick leave this would be a product that they would buy. Asw. Carlton stated that in Nevada you can also independently buy disability coverage so if you can independently buy that you could also independently buy this. Ms. Melchert stated yes and noted that you can already buy individual leave type of products but she is not sure of any offering family leave. This would be something you could add on as a rider to a personal policy. The ACLI is coming at this from the perspective of that it is seeing states wanting to create a state run paid family medical leave which does cut into disability and other products. The private industry already knows how to do that and it does not have to set up a whole claims function and pay for that. So, rather than have a state do that it is better to turn to the private market that already does it in a more cost-efficient way.

Sen. Jack Tate (CO) asked what the industry's observation is in terms of states measuring and managing risk properly and their estimates of the cost exposure being correct. Ms. Melchert stated that she is not sure she is qualified to answer that but can

certainly check on that and report back. Ms. Melchert stated that she is not sure how many states have had mandatory family leave in place for long enough to be able to do that. From the insurance perspective, ACLI has not seen many states dip their toe into the insurance overall other than work comp in a handful of states – most of it is taken care of by the private market. Accordingly, the private market has the expertise to do this and will take on the burden from the state.

Ms. Walker stated that, to give a comparison, some states are running state-run retirement plans and there is evidence that those are not gaining the number of employees they originally thought they would get. Accordingly, the private market knows how to do this and it has the education and knowhow.

Sen. Angela Williams (CO), stated that Colorado has introduced a paid family medical leave act and there is a public-private partnership in the bill. Sen. Williams stated that she is happy to hear a private model promoted because the social model takes so long and you have to fund it with premiums before you can get it to market. Accordingly, the bill calls for a public-private partnership with some public oversight so there is a place for complaints and compliance. Sen. Williams stated that she believes the private model is the way to go because it structures them within the insurance industry to offer that product and lets employers purchase that product. The Colorado bill also had guaranteed issue on it so that no one can be denied to be sure that marginalized communities have access. Ms. Walker stated that Colorado is one of the states ACLI has been working with and it would love to see other states follow suit.

Rep. Deborah Ferguson (AR) asked if determinations have been made with respect to how expensive the policies will be. Ms. Melchert stated that the actuaries would determine that and it is also not an open ended period of time so you have a set cost. Just like anything you are going to look at what the uptake is and how many people will use it. Parameters will have to be set around claims to make sure that it is not being triggered for a non-coverable event but it would be just like pricing any other event based on expected claims frequency. The industry knows the duration and knows salary and replacement cost. There might be a dollar limit but just like any other insurance, actuarial justified probability of claims will be looked at and the cost will be determined.

UPDATE ON NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) ACCELERATED UNDERWRITING WORKING GROUP

The Honorable Glen Mulready, Oklahoma Insurance Commissioner, stated that the NAIC Accelerated Underwriting Working Group (WG) was created this past Summer and it came out of the NAIC's Big Data Working Group. In the context of life insurance, accelerated underwriting refers to the process of using available digital data sources together with algorithmic tools and modeling techniques to offer life insurance products to qualifying applicants without the collection of bodily fluids or paramedical exams. For those who qualify, this means that you are basically taking it from a 2-12 week underwriting process to 48 hours. The question is whether it requires additional regulatory controls and that is what the WG is looking into.

The WG's charge is to consider the use of external data and data analytics in accelerated life underwriting including consideration of the ongoing work of the life actuarial task force on the issue and if appropriate, draft proper guidance for the states. A work plan has been drafted that contemplates moving forward in three different

phases: the gathering of information; the identifying of issues; and drafting a work product for adoption by the A Committee. The WG is currently in the mode of information gathering which was started at the NAIC's Fall meeting. Thus far, presenters have included consultants that have developed accelerated underwriting programs, insurance companies that have developed and used accelerated underwriting, and consumer advocates raising issues. The WG has been meeting via conference almost each week since the start of 2020 with additional calls planned through mid-April. There have been presentations in both open calls and regulator-only calls.

It is important to note that there have been regulator-only calls because of concerns from consultants and insurance companies regarding the distribution of confidential information that they wanted to share in a closed setting. Dir. Rob Muriel from Illinois is Chairing the WG and he has assured everyone that all calls that can be open will be open and only confidential and proprietary issues will cause a call to be regulator-only. The WG is looking forward to completing its information gathering phase and then hopefully in the coming weeks determine what to do next such as the possible development of a white paper.

ADJOURNMENT

There being no further business, the Committee adjourned at 5:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL -NAIC DIALOGUE COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 6, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Friday, March 6, 2020 at 1:15 p.m.

Assemblyman Ken Cooley of California, NCOIL Vice President and Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Martin Carbaugh (IN)	Sen. Jerry Klein (ND)
Rep. Matt Lehman (IN)	Sen. Bob Hackett (OH)
Rep. Michael Webber (MI)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Utke (MN)	

Other legislators present were:

Rep. Joe Cloud (AR)	Asw. Connie Munk (NV)
Rep. Deborah Ferguson (AR)	Asm. Kevin Cahill (NY)
Sen. Paul Wieland (MO)	Sen. Bob Peterson (OH)
Sen. Paul Lowe (NC)	Sen. Roger Picard (RI)
Rep. Garland Pierce (NC)	
Rep. Stephen Ross (NC)	

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a motion made by Rep. Webber and seconded by Rep. Lehman, the Committee approved the minutes of its December 11, 2019 meeting in Austin, TX without objection by way of a voice vote.

UPDATE ON NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) SUITABILITY IN ANNUITY TRANSACTIONS MODEL REGULATION

The Honorable Ray Farmer, Director of the South Carolina Department of Insurance and

NAIC President, stated that it is the job of regulators and legislators to protect consumers and citizens. The NAIC's Suitability in Annuity Transactions Model Regulation (Model) does that. The NAIC first adopted the Model in 2003 and it has been updated a number of times as needed. Last month, the NAIC adopted significant revisions to the Model following extensive deliberations. The NAIC heard from regulators, consumer representatives, industry, and attorneys. The revisions incorporate a best interest standard that requires all recommendations by agents and carriers to be in the best interest of the consumer. The consumer's interest must be put above the agent's or the carriers. That is normally done anyway but the revisions allow for more specific rules to ensure that is being done.

The regulation requires producers and insurers to satisfy the requirements outlined in the care obligation, a disclosure obligation, a conflict of interest obligation, and documentation obligations. The NAIC believes the revisions are in harmony with federal rules as well. The Model codifies as a requirement the good business practice of carefully and clearly explaining to the consumer the basis for a recommendation. The agents are to disclose and answer questions about their role in the transaction, their compensation, and any material conflicts of interest. The revisions are a good piece of consumer protection regulation and from this point forward, you will begin to see states adopt it as part of their regulatory framework as the revisions were just recently finalized.

Asm. Cooley asked if there was any consideration given to the issues this Committee raised when it discussed this Model during its last meeting in December. Dir. Farmer stated that after that meeting, the suitability working group continued to meet primarily by conference call and all of the information that was discussed during both NCOIL's and the NAIC's Austin meeting was combined together and the revisions were adopted by the relevant NAIC committee in late December. The NAIC Executive Committee later adopted the revisions and now it is up to each state to adopt the revisions. NCOIL's input was valuable and part of the NAIC's process.

Asm. Cooley asked how the NAIC envisions the Model being implemented – will states use the Unfair Trade Practices Act (UTPA) as enabling legislation or will states pass a law with specific authority to adopt this regulation? Asm. Cooley noted that California had actually adopted the prior version of the Model as a freestanding statute. Dir. Farmer stated that in his state the Model will be adopted as a regulation, but the process is such that the regulations go through the legislative process as well in terms of hearings, and subcommittees approval. It will be up to each state to do what their statutes and regulations provide for. Dir. Farmer stated that as most Directors, Commissioners, and Superintendents do when interpreting statutes and regulations, a common sense method will prevail. This is not a "gotcha" type of regulation. It is something that protects policyholders and constituents. Everyone did not agree with the revisions in the end but that typically does not happen with anything and it is important to now move forward in the best interest of policyholders and consumers.

Asm. Cooley stated that going back to the adoption of Dodd-Frank, buried in that was a provision that basically said the NAIC in its adoption of a suitability standard establishes a type of regulation that was exempt from Dodd-Frank. So, this was a case with Congress saying that we are regulating a lot of things but insofar as this is concerned and adopted by the NAIC as amended from time to time, that steps out of the Dodd-Frank framework. Accordingly, there is a recognition in the Dodd-Frank Act that the NAIC would be in this general area. An underlying question with any NAIC regulation, is

what is the underlying statutory authority in a state to adopt a regulation as regulations have to be founded upon statutes. Asm. Cooley again noted that the underlying authority could vary from state to state such as the UTPA, or in California's case, the annuity statute itself.

FOLLOW-UP DISCUSSION ON NAIC CASUALTY ACTUARIAL AND STATISTICAL TASK FORCE (CASTF) INITIATIVES

The Honorable Chlora Lindley-Myers, Director of the Missouri Department of Insurance and NAIC Secretary-Treasurer, stated that the CASTF white paper started being developed in 2018. There have been numerous chances for people to offer opinions and at the upcoming NAIC Spring National Meeting and going forward, the paper will be exposed before there is another set of review. The objective of the paper is to identify best practices to serve as guidance to state insurance departments and insurers in their review of complex models underlying the rating claims. The focus this time is on the private passenger and homeowner insurance rate filings. Unlike the suitability model regulation, the paper is not a model regulation; it is a guidance paper that an individual state or territory can decide to use or not. It is totally up to them as to what they use and how they use it. The paper can help them ask questions of those submitting the rate filings that hopefully will help them understand the rate scheme they are looking at, making sure that at least in their minds whatever questions that have come up that they feel the rate is not excessive or discriminatory and meets statutory standards. Unlike the suitability regulation, that is something the states can decide to implement as a regulation or a statute. In Missouri, that is something that would be sent to the general assembly for consideration. That is considerably different from the CASTF white paper. Dir. Lindley-Myers stated that she looks forward to hearing further comments on the white paper as its development is an open and transparent process.

Rep. Lehman stated that just as the white paper is focused on establishing somewhat of a bright line between what is acceptable for rating factors, legislators are concerned with establishing a bright line between what should be done through regulation, a white paper, and legislation. Rep. Lehman stated that he does not necessarily agree with what the white paper is asking but there is a fear on the carrier side and the legislator side as to where this will end. Rep. Lehman asked if a document could be provided to him that clearly outlines the goals and plans of CASTF. Dir. Lindley-Myers stated that in terms of Missouri, she wants to know what's in the rate filings and if she asks a company why they are doing certain things and why certain rating factors are being used and they give a satisfactory answer, then it is over. No additional regulation is needed. It is just an instance of ensuring that the reason or rationale for using the factors is provided satisfactorily and that is no different than what has been done before but now more data may be used.

One of the things to be careful of is to make sure that insurers don't utilize something that is corrupt by putting a bunch of different information and data in there. But, if they are able to differentiate and substantiate the reasons behind a rating factor, then that is fine and that is what the current process is. Dir. Lindley-Myers noted that with the life and health industry, it was found that at one point they were excluding classes of certain people because they carry a particular gene. Accordingly, if a company is submitting rates on that, she wants to be able to ask them certain questions. Dir. Lindley-Myers noted that she has the ability to do that now whether or not she looks at the white paper.

If a satisfactory explanation is provided to the questions from the regulator now, then there is no discrimination and that is the end of it.

Rep. Lehman stated that he has some concerns with predictive modeling but if the models are working and they are not unfairly discriminatory and rates are decreasing, then it is difficult to argue against them. Rep. Lehman stated he looks forward to discussing this issue further. Dir. Lindley-Myers stated that regulators want the models to work as well but not on the backs of certain consumers.

Asm. Cooley stated that he looks at this issue through the lens of the relationship of state legislatures, state regulation of insurance, the adoption of the accreditation system which is actually a form of delegation and the basis of delegation is deferring to someone's expertise in a specific area. So, if you step away from the insurance regulation example, and refer to concussions as they affect high school sports, the legislature might defer some of its policy choices to the American Academy of Pediatrics or another medical group focused on sports medicine. Such examples are commonplace and that is similar to what underscores the mission of the NAIC with the expertise. The delegation to the NAIC was founded upon an expectancy with respect to solvency protection in the larger framework. Accreditation itself was an outgrowth of a concern about solvency. The things that are now running up against each other is that if CASTF changes things that make their way into NAIC handbooks, those changes can be incorporated by reference into state law without anyone ever looking at them. Asm. Cooley stated that he feels this particular process is opening up big questions about the basis of rating and that historically, individual carriers are innovative with rates and the CASTF could be putting the brakes on that. It is also difficult to determine how the work of CASTF would mesh with different state rating laws in terms of some being file and use and some being prior approval. Asm. Cooley asked if there were any comments on that issue.

Dir. Farmer stated that each state is indeed different and South Carolina is a file and use state. Even though SC is a file and use state, if a company has something that is different that they want to be approved, they will come in first to discuss that which is encouraged. Also, even though SC is a file and use state, the department looks at every filing that is made and a concentrated effort is made to turn them around as quick as possible. The SC department has gone from 60 days to 20 days. Accordingly, the company is not held up on the speed to market issues. Dir. Farmer stated that his job at the SC department is to make the company's job easier to help customers. Dir. Farmer noted that when the legislature grants him permission, he is going to implement private flood insurance legislation that will call for use and file as an experiment to see that if the companies that have asked for relaxed standards are serious about it. Therefore, each state has its own rating statute but even those that are file and use like SC can closely and quickly review each filing.

Dir. Lindley-Myers stated that if you have file and use, use and file, or prior approval, it is not the NAIC but rather the people in those individual states that are looking at that and making the determinations and looking at what is going into it. One important issue to consider is that if you let company #1 do something and then company #2 does not really tell the regulator what they are doing and they say they thought they could because company #1 is permitted, there should not be any unevenness in the marketplace where one company can do something but it is so far buried that the regulator does not even know it is there and the other company does not know that they

can do something to lower their rates. Dir Lindley-Myers stated that it is up to each state's determination but noted that if she thought something was particularly helpful she would not hesitate to discuss with the legislature putting certain things in statute. Sen. Hackett stated that he realizes different states have different rating laws but couldn't a scenario be created where you have one company having certain rating models approved in only certain states. Dir. Lindley-Myers stated that possibility already exists as some things are prohibited in some states that are permitted in others. Sen. Hackett stated that he agreed with that but noted that this could make it more uneven that it currently is which inevitably results in more costs to the insurers resulting in higher rates. Dir. Lindley-Myers stated that companies will make a determination as to which states they want to operate in.

Asm. Cooley stated that in his career he has seen instances of individual states and individual regulators and the NAIC feeling under the gun of Congress and Europe on certain things relating to the state based system of insurance regulation. Accordingly, the way to defend the state based system of insurance regulation is to move forward with a common understanding as to what it is and why we support it. There is very much a question on this particular issue as to whether the right process is being followed and whether the material could find its way into handbooks and rating laws. Because the issues go to the rating laws and something as fundamental of how rates get set, the issue of a systematic risk should be discussed. It is one thing to deal with an individual company's filing but another to start injecting a new standard across all rates. If you have a blunder in a big way, the causes risk in a systemic way which is something that no one wants. It would be a sad day if something that came out of the NAIC caused others to re-think the state based system of insurance regulation. Throughout 2008-2010, there were discussions about whether insurance regulation was a problem and it was determined that there was no problem with the state based system. It is important to not lose sight of these fundamental issues. This is a very productive dialogue because the entire system of the NAIC is founded upon delegation from state legislatures and moving forward together is ultimately in defense of said system.

UPDATE ON NCOIL AND NAIC REBATE REFORM INITIATIVES

Rep. Lehman stated that the issue of rebate reform has received significant attention the past several years, particularly with advancements in technology viewed through the risk-mitigation lens. Rep. Lehman noted that the NCOIL Rebate Reform Model, which he is sponsoring, will hopefully be adopted at the end of this meeting. Rep. Lehman also thanked the NAIC for including NCOIL in its rebate reform model drafting working group. Rep. Lehman stated that he hopes to bring the NCOIL rebate reform model law to the NAIC's upcoming Spring Meeting to offer the legislative perspective on this issue in an effort to work together going forward.

Dir. Lindley-Myers thanked NCOIL for participating in its rebate reform model drafting working group as the NAIC wants to hear from a wide array of different voices when drafting models. At the 2019 NAIC Summer meeting, the task force voted to move forward with the development of a model law request (MLR) to open up the UTPA and amend the language in Section 4(h)(1). The MLR was adopted by the task force in October 2019 and subsequently by the Executive Committee in December of 2019 during the NAIC's Fall national meeting. The task force subsequently established a model drafting group which is led by Rhode Island Superintendent Beth Dwyer. The NAIC is thrilled to have Rep. Lehman and NCOIL staff be a part of the drafting group.

The NAIC is working towards developing language and appreciates all of the information given. The task force has received a tremendous amount of input from stakeholders regarding this topic. The draft group has been able to move forward expeditiously in drafting language and is currently taking comments from the drafting group members on the third draft to amend the UTPA. As the NAIC continues to examine different ideas as to what rebates should and should not be, the NAIC hopes to continue to have productive discussions so that something can be developed that is palatable for both NCOIL and NAIC.

Rep. Lehman stated that when discussing this issue, one thing that continues to arise is whether rebate reform should be done in the form of standalone statutes or in the form of amendments to the UTPA. Rep. Lehman stated that is an important issue to consider moving forward and hopes that the NAIC is mindful of that and related issues such as different penalties that can arise when putting something within the scope of the UTPA.

DISCUSSION ON RUTLEDGE V. PCMA AND ERISA PREEMPTION

Asm. Cooley asked if the NAIC representatives had any comments on the ERISA-focused preemption case of *Rutledge v PCMA*, which NCOIL filed an amicus brief in, and/or on ERISA in general and how it impacts regulator's ability to help protect consumers.

The Honorable Glen Mulready, Oklahoma Insurance Commissioner, stated that in January of this year the U.S. Supreme Court decided to take up the *Rutledge* case which dealt with the preemption of Arkansas's pharmacy benefit manager (PBM) regulation statute (Act 900). Cmsr. Mulready stated that to be clear, Act 900 dealt with maximum allowable cost (MAC) pricing which passed in Arkansas in 2015. Arkansas also passed a separate PBM licensing statute in 2018. Act 900 had three main components: require PBMs to promptly update their MAC cost lists when a drug's prevailing wholesale costs increases by 10% or more; required PBMs to grant appeals and increase reimbursements if a pharmacy was reimbursed below acquisition cost and the pharmacy shows that it couldn't have purchased that from the primary wholesaler; and allowed pharmacies to decline to dispense a drug of the PBM's MAC list resulting in pharmacies or pharmacists being paid less than what they pharmacy paid to get the drug.

The federal district court agreed with PCMA that ACT 900 was preempted by ERISA, this resulting in the appeal to the U.S. Supreme Court. The Oklahoma legislature passed PBM legislation last year and Cmsr. Mulready stated he was then sued by PCMA and that was on its way to federal court but it has been put on hold due to the *Rutledge* case. Oral arguments will be heard on April 27 and Arkansas' Attorney General Leslie Rutledge just recently filed her brief basically stating that the state regulation of reimbursement rates for generic drugs is preempted and the Supreme Court has long held that ERISA was not meant to preempt rate regulations. The Supreme Court has previously held that there are two tie-ins to that: one is the mentioning of ERISA and the other is the impermissible connection with ERISA-plans. Cmsr. Mulready stated that 45 states and D.C. all filed amicus briefs, including Oklahoma.

Cmsr. Mulready stated that the NAIC has always been strongly supportive of state regulation of insurance and is therefore generally opposed to ERISA-preemption of state

insurance laws. The NAIC is very aware of the work that NCOIL has done with regulating PBMs and the NAIC looks forward to NCOIL participation in NAIC's process of developing a PBM model act. The NAIC is hopeful that the NCOIL PBM Model will be the foundation of the NAIC's model.

Rep. Martin Carbaugh (IN), Vice Chair of the Committee, asked whether, with the growing size of the ERISA marketplace, state insurance commissioners feel handcuffed in the ability to regulate. Rep. Carbaugh stated that he has felt challenged trying to legislate in the healthcare arena due to the growing size of said marketplace. Cmsr. Mulready agreed and stated that as a regulator, and former legislator, the number of impacted constituents when developing certain types of healthcare reform is dwindling and it is frustrating.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that NCOIL adopted a Resolution last year In Support of Amending ERISA to Enable State Policymakers to Enact More Meaningful State Healthcare Reforms. Asm. Cahill asked if the NAIC would consider supporting such a measure as it is important to come with some type of solution or else there will continue to be constant ERISA-preemption litigation. Cmsr. Mulready stated that he thinks the NAIC would consider that.

UPDATE ON NAIC PET INSURANCE WORKING GROUP

The Honorable James Dodrill, West Virginia Insurance Commissioner, stated that the NAIC Property & Casualty Insurance (C) Committee adopted the regulators guide to pet insurance, a white paper, in March of last year. The white paper includes a history of pet insurance, a market overview, a review of regulatory issues relating to coverages, policy forms, marketing strategies, licensing, rating, and claims practices, as well as a summary of regulatory concerns. The committee then formed the pet insurance working group to review the need for the development of a model law or guidelines to establish appropriate regulatory standards for the pet insurance industry that had been highlighted in the white paper.

That working group at last year's NAIC's Summer National meeting submitted a request for model law development to define a regulatory structure related to pet insurance including issues such as producer licensing, policy terms, coverages, claims handling disclosures, arbitration, and pre-existing conditions. The working group has exposed a draft model and is taking comments from regulators and the industry on the first four sections which include the title, scope and purpose, definitions relevant to pet insurance including chronic conditions, pre-existing condition, and veterinary expenses, and disclosures to be included in the pet insurance policy including exclusions, waiting periods, and premium increases based on claims history. Comments will also be received on the remaining sections of the draft model in the near future which include violations, licensing, pre-existing conditions, and reimbursement benefits. The working group is holding bi-weekly conference calls with the expectation of completing and adopting the model by this year's 2020 Summer national Meeting.

The working group is taking steps to collect pet insurance data, including premiums, losses, policy counts, and claims handling data, through the NAIC's annual financial statement and market conduct annual statement. Among the more debated issues are producer licensing and the definitions generally and weather specific prescribed definitions are needed or if the model should just include language that definitions can

be substantially similar but not less favorable, pre-existing conditions, eligible expenses, free look periods and whether such periods are actuarially sound or fair to other policyholders as they would have to absorb the cost, issues over insurers using a brand name that is not the same as the name of the insurer, an appropriate level of filing with the DOI, how group policies are distributed in the property & casualty line of business, whether they are offered as an employee benefiter and whether they are truly group policies, and the appropriate type and amount of data that is needed to be filed with regulators.

ANY OTHER BUSINESS

Dir. Farmer then provided a brief update on the status of the NAIC's Life and Health Insurance Guaranty Association Model Act (Model) which was updated a couple of years ago. Specifically, provisions were added addressing the long-term care insurance market. The amendments spread assessments for guaranty association coverage to areas where they have not been before, equally among health insurers and life insurers and also bringing in HMOs into the assessment base. Twenty seven states have adopted the amendments. There are four states where the amendments are pending, including South Carolina which should be finalized in a couple of weeks.

Asm. Cooley stated that is a good way to end this session as when you think about consumers and insurance, the worst thing possible for a consumer is an insurance policy that they bought that they cannot pay the claims on. When looking at the insurance marketplace, there are two things out there to protect consumers from that outcome: on the front end is the setting of rates and on the back end is the guaranty funds. The Honorable Mike Causey, North Carolina Insurance Commissioner, thanked everyone for attending this meeting and stated that he looks forward to working with the NAIC and NCOIL on these important issues.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY AND CASUALTY INSURANCE COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 6, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Friday, March 6, 2020 at 11:00 a.m.

Representative Tom Oliverson, M.D. of Texas, Vice Chair of the Committee, presided.

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Vickie Sawyer (NC)
Sen. Jack Tate (CO)	Sen. Jerry Klein (ND)
Rep. Martin Carbaugh (IN)	Sen. Shawn Vedaas (ND)
Rep. Matt Lehman (IN)	Asw. Maggie Carlton (NV)
Rep. Michael Webber (MI)	Asm. Kevin Cahill (NY)
Sen. Paul Utke (MN)	Asm. Andrew Garbarino (NY)
Sen. Paul Wieland (MO)	Asw. Pam Hunter (NY)
Sen. Valerie Foushee (NC)	Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Joe Cloud (AR)	Rep. Wayne Sasser (NC)
Rep. Deborah Ferguson (AR)	Asw. Connie Munk (NV)
Rep. Roger Lynch (AR)	Sen. Robert Ort (NY)
Rep. Brenda Carter (MI)	Sen. Bob Peterson (OH)
Rep. Garland Pierce (NC)	Sen. Roger Picard (RI)
Rep. Stephen Ross (NC)	

Also in attendance were:

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

QUORUM

Upon a motion made by Asm. Ken Cooley (CA), NCOIL Vice President, 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. Lehman (IN), NCOIL President, and seconded by Sen. Paul Utke (MN), the Committee approved the minutes of its December 13, 2019 meeting in Austin, TX without objection by way of a voice vote.

CONTINUED DISCUSSION ON NCOIL E-SCOOTER INSURANCE MODEL ACT

Sen. Klein, Sponsor of the NCOIL E-Scooter Insurance Model Act (Model), stated that he appreciates the work that has gone into developing the Model thus far and noted that interest in the Model is continuing to grow. Sen. Klein stated that he looks forward to further development of the Model in order arrive at the best possible work product. Andrew Kirkner, Regional VP, Ohio Valley/Mid-Atlantic, at the National Association of Mutual Insurance Companies (NAMIC), thanked Sen. Klein and the Committee for the work on the Model thus far and then provided the Committee with an update on the Model's development. NAMIC, its members, and others have been in discussions with e-scooter representatives in an effort to improve the Model keeping in mind the balance between consumer protection and the concern that the startup companies have relating to insurance requirements. Meetings and discussions have thus far been productive and it is hopeful that the insurance industry and the e-scooter companies will be able to come to an agreement on a Model that makes sense for both groups.

Ben LaRocco, Senior Manager of State Policy at Lime, thanked the Committee for its work thus far and echoed Mr. Kirkner's remarks regarding how meetings and discussions have been productive and that both sides are learning more every day. Edward Fu, Senior Regulatory Counsel at Bird, agreed with Mr. Kirkner and Mr. LaRocco and stated that he is happy to answer any questions.

Rep. Lehman asked for an update with regard to what has changed in the Model since the Committee's last meeting in December. Mr. Kirkner stated that the Model as introduced fell into two camps. There was a requirement for scooter riders, scooter companies, or some combination of both, to carry some type of liability insurance. There was also a secondary provision relating to what has been described as a gap in coverage – the scenario being the individuals that work as independent contractors that drive around, pick up scooters, take them to their homes, charge them, and take them back to the streets. The conversation is still ongoing with regard to what provisions the Model will contain but the focus has shifted to the independent contractor issue. The concern is that if you have a policyholder that is driving around engaging in a commercial activity when picking up scooters and charging them, there are so many insurance issues that arise such as homeowner's and renters issues if a fire were to occur when charging a scooter. In lots of policies those activities would be excluded so the goal has been to plug that gap for the people that are driving around thinking they are covered under an auto policy or homeowner's policy.

Mr. LaRocco stated that Lime understands that there is a gap relating to the scooter chargers referenced by Mr. Kirkner. People draw a lot of parallels between this and the transportation network company (TNC) debate of several years ago. While they are similar in that they are both new transportation technologies that have not been contemplated before, that is really where the similarities end. One of the challenges was the livery exemption. Lime understands that the scooters would not be covered under most policies and Lime wants to work on that but it wants to do it in a way that does not single out scooter chargers as compared to other industries and in a way that continues to allow utilizing folks who have a great opportunity to earn money with low barriers to entry, especially in what is a relatively niche market.

Asm. Andrew Garbarino (NY), stated that during the Committee's last meeting in December there was discussion about insurance coverage for people riding on the

sidewalk when they weren't supposed to. Asm. Garbarino asked if the current version of the Model addresses that. Mr. LaRocco stated that is something that is still being discussed. Currently, light electric vehicles such as e-scooters, e-bikes, and Segway's have no state imposed mandatory liability coverage requirements for rider liability. Companies cover their negligence but no state mandates rider liability coverage for those vehicles. Accordingly, that is still under discussion as to how that should be addressed in the Model. Asm. Garbarino asked how the rider knows that the rules are before they start riding. Mr. LaRocco stated that generally, sidewalk riding is illegal in any downtown area. For Lime's scooters, and probably Bird's scooters, a note is printed on the scooter itself telling the rider not to ride on the sidewalk. Also, city ordinance, city law, and state law typically addressed that. Asm. Garbarino stated that if the notice is not on the scooter then it is up for the rider to know, similar to how a renter of a car knows to not drive on the wrong side of the road. Mr. LaRocco stated that he believes there is some shared responsibility for that. The rider has some obligation, cities have some obligation, and the scooter companies have some obligation. Lime is working hand in hand with cities across the country to educate riders and make sure there is good compliance and pedestrian-scooter conflicts are minimal. Asm. Garbarino asked if this applies to where the scooters can be parked as well. Mr. LaRocco replied yes.

Rep. Oliverson thanked the panel for its remarks and stated that the Committee looks forward to hearing another update at the Summer Meeting in July.

PRESENTATION FROM THE INSURANCE INSTITUTE FOR BUSINESS AND HOME SAFETY (IBHS)

Debra Ballen, General Counsel and Chief Risk Officer at IBHS, stated that strategically, IBHS believes the three most important ways to reduce property risk are: lead with the roof – roofs are responsible for the vast majority of insurance claims following a natural catastrophe; solve with research – IBHS is trying to figure out problems that have not been even thought about, much less answered, so that we can help reduce losses by reducing the vulnerability of both homes and businesses; and preventing avoidable damages – talking to public policymakers who can make a lot of what IBHS talks about happen through laws, regulations or promoting good building codes in states.

Ms. Ballen stated the roof is extremely responsible. Looking at the fire at Notre Dame, the roof is what burned. There are many lessons to be learned by keeping up to date with disasters such as that fire. The roof is responsible for not only damage to the roof but more significantly, water penetration that comes inside. Asphalt shingles, which when looked at from the ground seem really secure, are paper thin and blow off in even 60-70 mph winds. So if the roof underneath them does not secure the contents, you are going to magnify the amount of an insurance claim and more significantly the displacement for a family. While IBHS's members think about this in terms of having a healthy property insurance system, public policymakers constituents think about it in terms of staying in their homes or keeping a business operating following a severe hailstorm, windstorm or wildfire.

Ms. Ballen stated that if the research IBHS does is only of value to other building science experts, we really have not prevented avoidable losses by helping policyholders by helping public policymakers. Increasingly, IBHS is trying to turn the research into something that is simple to understand. It is important to help people understand that they can make a decision in terms of making their homes less vulnerable and making

their businesses more able to survive a disaster. Ms. Ballen noted that IBHS's facility has a roof farm where it is aging asphalt roofs. They are doing that because most people do not live in a brand new home that IBHS can put in its test chamber and test the materials. They live in homes that are 5-15 years old and that have roofs that have been on the home for a time period unbeknownst to the buyer. By aging the roofs in a natural environment and then bringing in those materials to test them, IBHS is finding out how vulnerable certain products are. It is important to make people think about their roofs. They are really important and no one understands them and no one understands that they can do better with respect to the materials as well as preventing water damage.

Ms. Ballen stated that wind is an amazing thing and IBHS has learned that at various speeds, different parts of a building can fail. Following Hurricane Michael, which was a small and compact storm, field research was conducted to see how certain building codes would respond to certain wind speeds. From low speed to high speed, damage would occur in this process: roof cover, soffits, fascia lost; wall cover lost; roof sheathing lost; roof structure lost; and total collapse. As a research organization, IBHS likes to develop perfect test conditions inside its research center and then test them to determine what will happen in the real world. If you can predict what happens, and then test that, those are the two critical steps to doing better in the future.

Ms. Ballen stated that before IBHS began its hail research, all research underwriting labs testing on impact resistant shingles was done with steel balls. One thing we know is that steel balls do not fall from the sky. So, IBHS went out in the field and gathered real hail stone and tested their hardness and density. In the IBHS lab, they were re-created so tests could be run against the same asphalt shingles that are available in the marketplace. IBHS saw the types of damage that hail caused, measured it, and came out with the first performance ratings for impact resistant shingles. After that was done, the two manufacturers that had the lowest performance shingles took those products off the market. IBHS verified that and tried to buy them and until you could no longer buy them they were not taken off of the IBHS rating system. The point is that consumers who are buying an impact rated product deserve to know that the product will perform as expected. IBHS is also working very closely with the roofing industry because most people trust their roofers so roofers need to be educated.

With regard to wildfires, Ms. Ballen stated that 90% of wildfire ignitions are ember-caused. There are not walls of flames hitting houses – its embers. The defensible space is critical. IBHS recommends five feet although that is something they are still looking at. All IBHS-recommended products and guidance don't guarantee that a home won't burn but they greatly reduce the risk. In this environment, not only in California but in many other states, this is critical. Defensible space is not pretty. It is not easy to convince people that vegetation next to their house is not attractive and is a fire hazard. With regard to building codes, Ms. Ballen stated that most states have building codes. IBHS strongly supports a strong and mandatory state-wide building code. IBHS conducts a study every three years that looks at hurricane prone states from Texas up to Maine and evaluates building codes. It has resulted in improvements to building codes in a number of states. Some states only have local codes. IBHS is happy to work with state legislators in any state that would like to improve its building codes.

Ms. Ballen stated that "fortified" is an alternative to building codes. IBHS calls it beyond building codes. It is not mandatory and is something that a homeowner or business owner chooses to do. IBHS provides the standard and provides the evaluation process

and provides a designation. That is recognized in a number of states and recognized in the marketplace by individual companies in terms of their underwriting guidelines and the way they assess individual risks. Just like you can shop for a safer car, you can shop for a safer home and that is a fortified home. Ms. Ballen stated that IBHS did some work with the North Carolina Insurance Underwriting Association (NCIUA) which showed that fortified absolutely worked. There were 1,000 homes threatened during Hurricane Dorian and 99.5% kept the water out.

Ms. Ballen stated that IBHS products are available on its website and IBHS is happy to work with policymakers that want to take some of it and make it theirs by working with the state insurance department or other groups so that people understand that the next innovation in resiliency is indeed affordability. There are lots of things that can be suggested and easy for homeowners and business owners to do on their own. IBHS recognizes that do-it-yourself is important, but also, with the right contractors in place you can get this stuff done fairly quickly and maintain it.

Rep. Oliverson stated that with regard to the IBHS aging roofs, he could see obvious implications of perhaps revising guidelines as to when certain building materials like shingles need to be replaced. Rep. Oliverson asked if IBHS is able to make recommendations as far as replacement guidelines. Rep. Oliverson also stated that he sees implications in terms of folks in his communities that are exposed to hail and roof damage tend to opt for less expensive actual cash value policy riders. Rep. Oliverson asked if IBHS data can be taken to more accurately determine what the values should be for those building products years down the road for policyholders. Ms. Ballen stated that she does not believe IBHS is at that point yet. With regard to the roof aging farm and the shingles being taken off, that was at five years. The original research plan for was for 5, 10, 15 and 20 years but what IBHS found at year 5 was that the roofs were a lot more brittle than they thought they would be. There are aging farms at the IBHS South Carolina facility as well in Madison, Wisconsin, Cincinnati, Ohio, Coastal, Alabama, and Kansas so that IBHS can get different climate zones and learn more. Ms. Ballen stated that one thing that is really important is the time when someone experiences a loss is an opportunity to build back better. IBHS wants to encourage the system to provide those options. Some states are putting in endorsements so people can get a fortified roof if they lose their roof. Those are opportunities to be more resilient.

Rep. Brenda Carter (MI) stated that in Michigan there is a lot of damage to roofs because of snow and ice and asked if IBHS has any programs and products for that. Ms. Ballen stated that IBHS has guidance for that and frozen pipes. Since the facility is in South Carolina, IBHS can't really research extreme winter weather because it is not cold enough but there is guidance on the IBHS website for how people can protect themselves better for such conditions.

Asw. Maggie Carlton (NV) stated that she experienced significant wind damage and when she was looking at how to replace it, nothing was really rated for zones – everything was talking about rain, hail, and snow. Her roof has to sit through 130 degrees for two or three months every year. Accordingly, Asw. Carlton asked if IBHS will start thinking about ratings or zones for those who live out west in the desert. Ms. Ballen stated that with regard to the roof farms, member companies had campuses that allowed IBHS to put its roof farms on those campuses. If an appropriate location can be found, IBHS would be happy to set up a roof farm in other locations. Ms. Ballen stated

that you would be amazed at how hot it gets on a roof in South Carolina in the middle of summer. Those temperatures are measured and it is extreme on a lot of roofs. With regard to wildfires, IBHS is working to apply building codes to states other than California so that better products are put on roofs – it is not a guarantee against burning but it helps. For example, cedar shakes look great but they burn.

DISCUSSION ON THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CASUALTY ACTUARIAL AND STATISTICAL TASK FORCE (CASTF) INITIATIVES

Before the panel discussion began, Rep. Oliverson noted that Frank O'Brien of the American Property Casualty Insurance Association (APCIA) was scheduled to be part of the panel but he was unable to attend the meeting due to company-level travel restrictions surrounding the coronavirus. A comment letter from APCIA regarding CASTF has been distributed.

The Honorable Chlora Lindley-Myers, Director of the Missouri Department of Insurance and NAIC Secretary-Treasurer, stated that the NAIC realized that computing power has grown exponentially and has opened up a door for actuarial modeling which is new and sophisticated. Accordingly, the NAIC is reviewing that data within the individual departments of the states and territories which results in insurance companies seeking increasingly predictive or potential losses by employing evermore complex modeling methods and establishing and justifying their premiums since they have to tell regulators why they are going to be charging a rate. What they do through predictive modeling and predictive analytics involves a number of techniques such as data mining, statistical monitoring and machine learning which allows insurers to use big data to more precisely forecast future events. These evolving techniques have made it increasingly challenging for insurance regulators to evaluate filed rating plans that incorporate complex predictive models.

Compounding that issue is the fact that many state insurance departments don't have sufficient resources in house actuarially and nor do they have the expertise to review the filings. While the insurance regulators recognize clearly that there is a great potential of emerging technology to positively affect the insureds and consumers that they serve, the regulators have grown concerned about how the insurers might use the treasure trove of information and new data sources and predictive modeling in the marketplace. That includes the lack of transparency and potential for bias in the algorithms used to synthesize big data; highly individualized rates that lose the effective benefit of risk pooling; cyber threats to stored data; complexity in volume data that may present hurdles for smaller sized insurers; collection of information sensitive to consumer privacy; and the potential for discriminatory practices such as price optimization which is varying the rates based on factors other than the risk of the loss such as the likelihood that a policyholder will renew their policy and the willingness of certain policyholders to pay higher premiums more than other policyholders.

To address this concern, the NAIC at its 2018 Spring Meeting in the Big Data Working Group asked the Property & Casualty (C) Committee to adopt charges to the CASTF to look at changes to the product filing review handbook to include best practices for review of predictive models and the analytics filed by insurers to justify rates; and draft and compose state guidance regarding information and data. It is just state guidance, not anything that regulators have to do but just gives regulators another opportunity to look

at things. CASTF began developing a white paper on regulatory review of predictive models and assembled a drafting group of a variety of regulators and began to work on this initial draft. At the end of 2018 at the NAIC Fall National Meeting, CASTF exposed for comment the first draft. There have since been two additional drafts, the latest one being Oct. 15, 2019. CASTF wants to hear comments and has received presentations from interested parties on the issues, both at NAIC meetings and during various conference calls.

The objective of the white paper is to identify best practices to serve as guidance to state insurance departments and insurers in their review of complex models and underlying rating plans. The focus is on the private passenger auto and homeowners insurance rate filings. These are usually done at the NAIC open meetings and usually done during open conference calls. The NAIC is hoping that with this last bit of review and exposure, CASTF can present at the NAIC Spring National Meeting later this month the results of the last discussion which was on Oct. 16, 2019.

In looking at the particular models, CASTF was looking at best practices which is to provide to state insurance regulators in their essential and authoritative roles over the rating plans in their respective states to identify various elements of a model that may influence the regulatory review as to whether modeled rates are appropriately justified and compliant with all state laws. It aids in the speed to market and competitiveness of the state marketplace and provides a framework for the states to share knowledge and resources to facilitate the technical review of complex predictive models. The best practices which will eventually be included in the NAIC product filing review handbook are being drafted in the form of guidance designed to break down the review of these complex models and to various considerations or information. There are comments on what is important about such considerations and there is insight as to when the consideration will become an issue the regulator needs to be aware of or what they might need to explore further.

CASTF has received a number of written comments from regulators, consumer representatives, and industry. Overall, industry expressed a number of concerns many of which are unjustified and without merit. For example, the white paper is not establishing rate filing requirements. The white paper is collective opinion only. State regulators will decide in their own state what they would want to require based on state law. The white paper is not creating any requirements but promoting regulatory best practices of what to look for based on a collection of current practices in the various states. Another comment is that the white paper documents current practices and therefore there is no need for field testing. A lot of the industry is saying field testing is needed as there is a need to figure out what is going on. Dir. Lindley-Myers stated that this is already going on in the individual states and so the states are looking at that and making a determination as to whatever the model is, whether it is compliant with that specific state's law.

Another issue is that of correlation vs. causation which is the requirement of rating variables that they be reasonable and not unfairly discriminatory. CASTF is looking at three main areas of state law. Generally speaking, state laws state that any rates that are issued shall not be unfairly discriminatory. In almost every state, a rating variable must be related to claim losses or expenses – that's the correlation – and not be unfairly discriminatory. Risk classes must be reasonable – companies have to decide if that state law includes the requirement that risks cannot be classified in an unreasonable

way or that the risk must be reasonably related to the issues that are afforded in that particular policy. The point of that is that reasonableness is usually defined in the law so regulators look at the law and see whether or not the rates might be reasonable based on what the company is saying that they are collecting this data for and utilize it. Regulators will abide by confidentiality of state law as it relates to trade secrets. Regulators are not seeking to change that by coming up with this model. The hope is that if it is already a state secret in a state, they will be able to use it. Some states have tougher laws than others as to what is a trade secret or confidential. The NAIC will abide by those state laws and wants to make sure there is a speed to market. In some states it is file and use and in other states it is prior approval. Utilizing those models that are already in the states, CASTF is looking at what is already there and whether or not it would be advantageous to look at that.

When comments are submitted, there is then a specific answer to that particular comment as to why that is not important in a particular jurisdiction. Each state will make that determination on their own. Dir. Lindley-Myers stated that she has worked in five different states and the laws have varied in five different ways. CASTF is looking at that and trying to see whether or not it is able to utilize that and how they able to utilize it and work with other state regulators as to whether or not something should be approved in a particular state or whether there should be more information. CASTF is gathering that information and in some of the filings the information is already there so there is no need be gathered. So, this is an ongoing process of the NAIC and the process is open and transparent to allow any of the stakeholders to weigh in on what they think should be important when looking at these models.

Erin Collins, VP of State Affairs at NAMIC, stated that Ms. Ballen's presentation really outlines all of the reasons why the industry needs to continue to study risk factors in all area of insurance and how it can measure risk and predict risk through the underwriting and rating process. That is a conversation that NAMIC firmly believes needs to happen in the states. Most recently in Congress earlier this week, NAMIC advocated that these conversations do need to happen in the states and they need to continue to happen in the states as opposed to anywhere else. To that end, NAMIC has concerns that the CASTF white paper goes further than state law and creates hurdles and challenges that very few if any underwriting factors could survive. NAMIC has partnered with The Honorable Nat Shapo, Partner at Katten Muchin Rosenmann LLP and former Director of the Illinois Department of Insurance, for an analysis of this issue by means of developing an issue analysis white paper ("The State Rating Statutes and Constitutional Policymaking: Causation and Disparate Impact Standards in NAIC's Draft White Paper").

Dir. Shapo stated that the white paper is on NAMIC's website and is publicly available. The paper focuses on core questions about the state unfair discrimination statutes and what they require and how they were made. NAMIC has articulated other specific concerns about CASTF's white paper but they are beyond the scope of the NAMIC paper. A lot of the issues discussed today present core questions about insurer risk discrimination practices which is what the NAMIC paper focuses on. Dir. Shapo stated that it is not clear to him from reading the CASTF white paper that we have established that there is a qualitatively different method of classifying risk that would require a substantial change in public policy which NAMIC believes parts of the CASTF white paper do in fact suggest. It is still risk classification – using technology to try and classify risk based on future expected losses. That is what insurers have always done. Clearly, there are quantitative differences every year as there is more and more computer power

every year that can do these things more quickly. With regard to increasingly predictive models, Dir. Shapo stated that is something that the laws have always encouraged. They have always encouraged the best risk classification practices which have two public policy norms: it is fair for people to pay according to their expected losses; and there is a solvency issue that has always been at the heart of risk classification – that the better you can predict risk, the more solvent the insurer will usually be which is in the interest of consumers and society.

Dir. Shapo stated that there are two substantive policy issues in the current draft of the CASTF white paper that insurers have seen in state legislatures and state rating reviews and state market conduct exams and proposed bills in Congress and even in other NAIC committees. They go to the heart of unfair discrimination principles which is part of almost every state's rating law. The first substantive issue is that of causation vs. correlation. In several instances, the CASTF white paper calls for an evaluation of causation. It directs a rate filing reviewer to demand a narrative from each company for each rating factor as to how they believe that the rating factor is causative. Causation is not a standard established by any legal authority. The basic standard is correlation which is an objective standard. The question is not whether a rating factor causes a loss but whether or not it correlates with a loss. A good example would be the American Academy of Actuaries (AAA) when it was asked to do a causality study by the NAIC with respect to credit scoring said "any finding of causality in any context or field of study is a statement of a theory or conjecture based on the observation that there is a strong statistical relationship between the 'cause' and the 'effect.'" Basically, what they are saying is that when you unpack it and when you think that a factor causes losses, it really doesn't. Even driving record is not causative, it is correlative. If you had four accidents last year, those accidents themselves are not going to cause your accident next year. They usually correlate and statistics will show that they correlate. It probably has something to do with your physical reflexed or maturity or personality which are things that have never been and never will be rating factors. Every rating factor is correlative, not causative.

The second substantive issue is that the CASTF white paper asks the regulator to try and identify so-called proxy variables for prohibited variables. This goes to the way the unfair discrimination laws are constructed. The basic, core rule of the unfair discrimination principle is correlation. If you can show a correlation with loss based on actuarial principles then the factor is presumed to be legal. There is a public policy overlay on top of that and legislators, after careful study and review, have identified certain specific, discreet rating factors that are further regulated even if they are correlative such as bans on the use of race, religion and national origin as rating factors. Even if those are correlative and meet the basic unfair discrimination provision, they are seen as being unacceptable from a social perspective so legislators, after considerable review, have said they are prohibited. In some cases, such as with the NCOIL credit scoring model, there is further regulation but not a ban. The model puts certain restrictions on how credit scoring is used but that is a social policy overlay over the core rule of correlation.

With regard to the proxy disparate impact question, that is typically addressed in courts by saying if you have a ban the use of race as a rating factor, the ban would apply to intentional and knowing use of race as a rating factor. A so-called proxy variable that may lead to a disparate impact on a protected class like race, national origin, or religion, the law does not recognize a disparate impact standard unless the statute specifically

has language addressing that. The state unfair discrimination laws do not have such language and in fact that is why the NAIC has previously filed an amicus brief with the U.S. Supreme Court opposing the disparate impact liability being recognized in the state unfair discrimination laws.

Dir. Shapo stated that opinions will differ in terms of whether or not the CASTF white paper is imposing requirements or just best practices, but the main concern that the NAMIC white paper addresses is that there are actual legal standards being imposed in the CASTF white paper. As a matter of policymaking, the way the core unfair discrimination law is made is that the legislatures pass a rating statute that says rates shall not be inadequate, excessive or unfairly discriminatory and then legislatures add a social policy overlay in a considered way rating factor by rating factor. The concern here is that with the causation and disparate impact standards, the CASTF White Paper in its current draft proposes those standards which are things that cannot be done by a white paper or by regulators -they would have to be a statutory decision made by legislators.

Brian Fannin, Research Actuary at the Casualty Actuary Society (CAS), stated that the CAS is not a policy-making body - it educates and credentials actuaries and then continues educating them. CAS does not issue public policy statements. It is an international body. The AAA in the U.S. is body which speaks for the actuarial profession in a public policy context. Nevertheless, CAS does have an active membership that is interested in engaging with these types of discussions and wants to be able to look for opportunities where it can contribute its experience and knowledge to help further discussions. CAS is happy to take part in a process that is open, collaborative and deliberate in an appropriate way.

CAS has engaged volunteers from its memberships on three separate occasions in response to three separate exposure drafts of the CASTF white paper. They were made up entirely from the ratemaking research committee which is the standing research committee that the CAS has. There were about eight or nine members that reviewed the drafts and then convened to share thoughts. CAS eventually developed a draft that was shared with the NAIC. Those comments were shared with CAS leadership but it should not be construed as an official policy statement of the CAS although they are aware of the conversations that have been taking place.

Mr. Fannin stated that CAS has raised a few issues with regard to the CASTF white paper. There is a focus on generalized, linear models (GLMs). There are other models which insurance companies do use but they are discussed with less attention than GLMs. That means that the language and guidance starts to construe itself with regard to that particular class of statistical model. GLMs date from 1972. That greater maturity means there is a larger use of them in the field in insurance and elsewhere. That maturity somewhat penalizes them. For newer models like "deep learning" there may be less awareness as to how one would evaluate such models. GLMs get a little but more attention because they have been part of the conversation for a much longer period of time. There are a few comments in the draft about credibility, in particular a comment which one might read as suggesting credibility techniques are not consistent with the use of GLMs. CAS takes issue with that as it feels that you can apply credibility procedures with GLMs in any number of ways. There are some technical points to discuss in that issue which Mr. Fannin stated that he is happy to discuss afterwards. In terms of model assessment, there were repeated references to analysis of p-values which is a statistical concept that Mr. Fannin stated he is happy to discuss further

afterwards. There is a 5% threshold as to whether a rating factor would or would not be significant. There is a great conversation taking place now within this statistical community. A few years ago, the American Statistical Association issued guidance about the use of p-values and they are not necessarily a one size fits all technique.

They are a diagnostic technique which should be used in light of others such as cross validation or regularization which are other ways to look at how effective a model is at gauging the importance or utility of rating variables. CAS also had some discussion with regard to the definitions in the white paper and it would welcome a little bit more clarity with them. Actuaries are mathematicians who are accustomed to very crisp, clean definitions. For instance, "insurance data" was one of the first speed bumps hit. Insurance data is data used by an insurance company which kind of suggests anything but are there other exogenous types of data that would or would not fall out of the guidance like census data or credit data. Also, "predictive power" was discussed and perhaps there should be further discussion about the technical elements and what is meant by "predictive power." Lastly, "test validation" was discussed but Mr. Fannin noted that is somewhat nitpicky.

Sen. Bob Hackett (OH) stated that those who have been involved with NCOIL for awhile have seen the NAIC often come to a line in the sand in terms of trying to do legislation but they don't step over the line. Sen. Hackett stated that it seems to him that the NAIC is trying to take correlation away and operate on causation. As the world develops, there are constant technological advancements and the current system is setup to protect against discrimination. That system should be tested at different times but it looks like the NAIC is coming in and trying to force individual legislation in different states. The country is become very liberal and some places and very conservative in others. If you are an insurance company, are you going to then create underwriting rules that are drastically different in different states? Sen. Hackett asked if the NAIC believes it is acting in a manner that is trying to push legislators to create certain types of legislation with these issues.

Dir. Lindley-Myers replied no, and stated that she believes that the CASTF white paper is allowing the laws that are on the books right now to be reviewed with what is happening right now, which is that companies are using predictive modeling to make certain determinations. The white paper is asking insurers whether by using predictive modeling, are they trying to discriminate through the back door. Accordingly, regulators want to be able to look at what insurers are looking at. The white paper will be looked at by each individual jurisdiction and they will make the determination as to whether they will even look at the paper or not. They may continue to just operate how they are currently operating. The white paper is not changing any laws but is rather looking at existing laws and determining how regulators can utilize the new materials that are out there to continue to do the job regulators have always been doing.

Sen. Hackett asked Dir. Lindley-Myers if she thinks the current system is already set up for new predictive models to come in and to determine whether or not they are unfairly discriminatory. If they're not, then it is up to legislators to create laws to protect against that. It is almost as if the NAIC is handicapping the insurance industry by coming in and trying to radically change the underlying models. Sen. Hackett asked Dir. Lindley-Myers if she wants consumers to be rated properly. Dir. Lindley-Myers stated that she does and she wants to make sure that if a legislator comes to her and asks why is it that a specific zip code in St. Louis is being charged a particular rate, she is able to tell him that

it is because of, x, y, and z which is not causation, it is a correlation. The white paper is not a change in law, it is basically utilizing the laws that are already on the books and making sure that regulators can explain to legislators and consumers any questions about rating variables.

Sen. Hackett stated that he fully supports the predictive models going through the system to make sure they are not unfairly discriminatory, but at the same time it is important and beneficial for everyone that rates are accurate. Dir. Lindley-Myers stated that insurers are saying that the rates are accurate because they are using certain variables and regulators want to be able to understand what things they are using to say that they are accurate.

Dir. Shapo stated that currently, the CASTF white paper directs the rate reviewers to require a documentation of the insurance companies understanding of causation. Dir. Shapo stated that he reads that as an erosion of the correlation standard. In the insurance context, fair discrimination is a term of art. The Massachusetts Supreme Court has stated that "the statutory pattern which deals with insurance regulation requires the commissioner to treat equally insureds who are of the same risk classification. This may result in 'fair discrimination'" - that is the correlation standard. So, in the context of this industry, that is what the term fair discrimination means and it is supplemented by prohibitions in each state law on explicit discrimination against protected classes. The notion that you can unpack and get into a particular rating factor's impact on a protected class is not recognized by the law and that would be a substantial sea change in the law and would require a legislative determination.

Rep. Lehman stated that is not a big fan of predictive modeling and he remembers this conversation happening in Indiana several years ago regarding magazine subscriptions and which stores people shop at. But, at the same time, that technology has started to in some cases prove to be accurate and we have started to see companies say "look at the data." Rep. Lehman stated that there is a technology clash right now with carriers being innovative in how they rate but also questioned when the law or large numbers was thrown out the window. Today, some rates get down to underwriting each individual such as those who have their rates measured on driving safe. We are on a collision course with individual underwriting and a regulatory body still regulating with the law of large numbers. Legislators needs to be sure that they are doing what is right by the public. Rep. Lehman stated that he understands that certain protections need to be in place but noted that he is concerned that the white paper may be imposing requirements that, if necessary, should come from a legislative body.

Kris DeFrain, Director of Research and Actuarial Services at the NAIC, stated that the white paper does not require causality – it requires a correlation. What the regulators are asking for is some kind of explanation/rationale as to why they think the rating variable is not unfairly discriminatory. Accordingly, the white paper is asking for help with that analysis. There is no commissioner that is going to not approve a rate filing because a rationale was not provided for something that met their standards; it is still going to be correlation. But, what you're finding is that there are thousands of very specific rating variables out there right now and there has to be some sort of finding as to whether they are unfairly discriminatory or not. When things like territory come into play, the correlation there is pretty clear and a rationale explanation is not being pushed for there. The rationale explanation is being asked for the odd and unique variables.

Asm. Cooley stated that when he looks at this he tries to look at it in the larger scheme

of the NAIC. Asm. Cooley stated that he was Chief Counsel for the State Assembly in the late 1980s when the accreditation statute was adopted. The whole object of the accreditation statute is to support the solvency of insurance companies. We got to accreditation because of problems in the 1980s with the solvency of carriers. Asm. Cooley stated that he feels we are going into an area where we are starting to unwind the fundamentals of the insurance business with rate setting and doing it on the basis of a correlation. The NAIC needs to look back and ask "how does this fit into our mission?" With long term care, everyone thought they had the rate right and now we have a heck of a problem. Now, we have a white paper that is starting to ask questions about the basis of how rates are established more generally. Asm. Cooley stated that undermines the rating system and it goes contrary to the purpose of the NAIC.

There was big debate in CA in the 1980s with the accreditation statute – are we going to let a non-elected entity start providing guidance to insurance departments?

Traditionally, insurance companies innovate through their rates. Asm. Cooley stated that he spent 18 years as in-house counsel for State Farm. State Farm was founded in 1922 on a different rating model that defied what people thought of rating. In seven years, they were the largest auto insurance company in the country. They innovated through their rates. Asm. Cooley stated that he feels that there is a product being discussed within the NAIC, which is the bulwark for solvency, that is starting to undermine innovation and rating. This could cause problems and could cause people to ask questions if the NAIC, through a white paper, is introducing systemic risk to the insurance industry because they are trying to force a rethinking of rates. It is very problematic and spells trouble for the delegation to the NAIC that has been made by legislators. Questions may come from the Congressional level as to what is going on with the basic fundamentals of solvency and ratemaking. It is important to always pursue new ideas but you cannot lose track of the real landmarks that are important in insurance regulation.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON NATURAL DISASTER RECOVERY
CHARLOTTE, NORTH CAROLINA
MARCH 6, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Natural Disaster Recovery met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Friday, March 6, 2020 at 2:30 p.m.

Senator Vickie Sawyer of North Carolina, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Matt Lehman (IN)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Asm. Ken Cooley (CA)	Sen. Jerry Klein (ND)
Sen. Jack Tate (CO)	Sen. Shawn Vedaa (ND)
Sen. Angela Williams (CO)	Asw. Connie Munk (NV)
Rep. Martin Carbaugh (IN)	Sen. Robert Ortt (NY)
Sen. Paul Utke (MN)	Sen. Bob Hackett (OH)
Sen. Paul Lowe (NC)	Sen. Bob Peterson (OH)
Rep. Garland Pierce (NC)	
Rep. Stephen Ross (NC)	
Rep. Wayne Sasser (NC)	

Also in attendance were:

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

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Lehman and seconded by Rep. Oliverson, the Committee approved the minutes of its December 11, 2019 meeting in Austin, TX without objection by way of a voice vote.

CONTINUED DISCUSSION ON NCOIL PRIVATE FLOOD INSURANCE MODEL ACT
Sen. Vickie Sawyer (NC), Chair of the Committee, stated that the Committee has been working on the development of the NCOIL Private Flood Insurance Model Act (Model) that would facilitate the expansion of the private flood insurance market. A document

which is the result of discussion and compromise between several interested parties has also been proposed as a strike all amendment to the original Model. Sen. Sawyer noted that the Committee will discuss today the strike-all amendment document and what the main differences are between it and the original Model. The goal is to have a Model ready for a final vote at our Summer Meeting in July in New Jersey.

Dennis Burke, VP of State Relations at the Reinsurance Association of America (RAA), stated that the P&C industry seldom agrees on anything but one thing that it does agree on is that there are not enough customers who are protected against flooding. They don't have enough choices and there is a huge protection gap. The P&C industry wants to see if the private industry can help close that gap. A group was convened that consisted of insurers, agents, reinsurers and lenders: RAA, the American Property Casualty Insurance Association (APCIA), the National Association of Mutual Insurance Companies (NAMIC), the Wholesale Specialty Insurance Association (WSIA), the Independent Insurance Agents & Brokers of America (IIABA), the National Association of Professional Insurance Agents (PIA), and the American Bankers Association (ABA). That group essentially agrees on what is euphemistically being called a strike-all amendment to the Model.

Generally, the most important thing about the document is that the group has come to an agreement on it. The document is recast as the Private Primary Residential Flood Insurance Model Act because the group believes that is the target that is being aimed at and those are the people that need to buy flood insurance to get their mortgages. By aiming it at that particular market segment, all of the other market segments that are actually operating right now in the private market won't have to have caveats included in the document to address them to make sure that they are not interfered with. Mr. Burke stated that the document is not an industry wish list. Rather, it reflects compromise and concerns raised by regulators and legislators through a number of discussions. The document borrows from Florida law, which was the original basis for the Model, and from conversations that led to the South Carolina bill. The group believes that the document is fair and balanced, encourages the Committee to read it, and recommends it for passage. Nevertheless, not everything was agreed upon and at the end of the document there are a couple of points that NAMIC would like to raise to ask for inclusion in the document.

Wes Bissett, Senior Counsel, Gov't Affairs at IIABA, stated that there were some members of the group that do not think there is a need for a model law in this area but the IIABA views it as an opportunity to do things to foster the growth of the private flood insurance market and to remove barriers that might exist in regulation today of that market. There are also some unique and anomalous issues that are specific to private flood insurance that can be addressed. One example that is included in the document relates to the fact that in the National Flood Insurance Program (NFIP) there is a continuous coverage requirement – if you qualify for a subsidy in the NFIP you must maintain continuous coverage or you will lose that subsidy. So, there is a unique question as it relates to private flood insurance: what happens if I leave the NFIP, buy a private flood insurance policy, and then seek to go back to the NFIP. The reality is that under current federal law, you would lose that subsidy.

Accordingly, one thing built into the document is a disclosure requirement that agents would be obligated to disclose as long as this situation exists to bring this fact to the attention of a person who is interested in a private flood insurance policy. As you can

imagine, the typical person may not be aware of this fact and it is very significant. That is a disclosure requirement in the document that agents would have to address if they were selling a private flood insurance policy. Mr. Bissett also noted that the document also contains a provision which states that if federal law were to change and the subsidy issue was not the case anymore, then the disclosure obligation would essentially evaporate.

Mr. Bissett stated that another issue that is unique to private flood insurance is that to get into the NFIP today, in most instances there is a 30 day waiting period. If you want to buy an NFIP policy, you can't do it and have that coverage take effect tomorrow – there is a 30 day waiting period. The question becomes: what happens if I leave the NFIP, buy a private flood insurance policy, and then that is cancelled? If you are in a state where there is only a 30 day cancellation requirement you would have no opportunity to get back into the NFIP as there would be a gap in coverage. Accordingly, the document contains a provision which states that in states that have a 30 day cancellation notice requirement, that would be raised exclusively for private flood insurance policies to 45 days so that you would at least have a little gap in time if you did get cancelled and you could try and get back into the NFIP. Mr. Bissett urged the Committee to consider the document going forward.

Erin Collins, VP of State Affairs at NAMIC, thanked the group for working on the document and agreed with Mr. Burke's statement that the document is fair and balanced and indicative of the needs of policyholders as well as meeting the objective to foster a private flood insurance market, especially when considering the challenges that are faced by policyholders and the community with the challenges of the NFIP. The document is a good piece of legislation and NAMIC encourages the Committee to adopt it. Ms. Collins then referenced the drafting note proposed by NAMIC in the document which NAMIC also encourages the Committee to include. The drafting note simply asks that policyholders should consider a provision for insurers to look at prior loss history including weather-related losses. NAMIC believes that is an important component of looking at these issues. NAMIC is supportive of the document, supportive of the process that led to its drafting, and encourages the Committee to adopt it as soon as possible.

PRESENTATION ON NATURAL DISASTER MITIGATION EFFORTS

Lynne Grinsell, Asst. VP of Gov't and Industry Affairs at Zurich North America, stated that even as many leaders work to address climate change and reduce its impacts, severe weather and wildfires are not going away. Hazards may be natural, but disasters are not always inevitable. This is why Zurich strives to be at the leading edge of understanding risk, by applying lessons learned from studying disasters and helping customers and communities reduce the devastation from these events and build back better. Zurich uses Post Event Review Capability (PERC) which provides an overview post-event and provides findings and learnings for those who need to build in more resiliency back into their communities.

Zurich's latest report is titled California Fires: Building Resiliency from the Ashes which focuses on lessons learned and opportunities to build resilience following the historic 2017 and 2018 wildfire seasons, the most destructive in the state's recorded history. The report was written in collaboration with Zurich, DuPont and the nonprofit Institute for Social and Environmental Transition (ISET-International). The Zurich/DuPont/ISET research team spent approximately six months studying the impact of wildfires in

California, entailing interviews with more than 50 community members, public officials and other stakeholders on the ground in California as well as a review of other research and secondary sources. Ms. Grinsell stated that many people are recognizing that climate-related risks are a problem yet have no idea how they can help build resilience through their own actions. With this report Zurich is helping them navigate that chasm.

This PERC methodology was collaboratively developed in 2013 with research partners involved in Zurich's Flood Resilience Alliance, an innovative program funded by Zurich's foundation. It links academic insights, humanitarian sector capabilities and Zurich's own skills and knowledge in risk mitigation to help create resilient communities. As an aside, the PERC methodology is an open source and available to anyone who would like to conduct a post-event review. Zurich leveraged the PERC framework to study the growing peril of wildfires. This was Zurich's first wildfire report in the U.S. and Zurich found that many of the lessons learned from doing post-event flood reports applied to wildfires as well. Zurich focused its initial post-event reviews on floods because floods affect more people globally than any other natural hazard.

Ms. Grinsell stated that wildfires present a number of complexities that make it difficult to assess their risk. Weather, fuels, topography, and exposure all play a role in how weather influences a fire's intensity, severity, and scale. Addressing future wildfire risk will require thinking critically about which risk factors we can effectively and meaningfully address. Living in the Wildland Urban Interface means a number of actions need to be taken into consideration such as maintaining forest health and defensible space. For example, decades of fire suppression have led to a buildup of fuel. In recent decades, controlled burns have taken place. Even so, there is a lot of acreage to treat, and we must mitigate strategically to reduce wildfire intensity in critical areas and also create defensible space around structures and assets. The 2017 wildfires in California burned at record catastrophic rates. At the time, 2017 was the most destructive wildfire season on record in California. The following year became the deadliest and most destructive wildfire season ever recorded in the state, with 8,054 fires burning over 1.8 million acres.

Ms. Grinsell then discussed some key findings from the report. Most broadly, communities must reduce risk and increase resilience. There are multiple components that contribute to communities' exposure to wildfire risk. These include: Sparks from power lines; Continued development in the wildland-urban interface (WUI); Insufficient action to "harden" homes and other structures against wildfires; Gaps in insurance coverage; and Shared management/maintenance of land in the WUI. The first key finding related to building codes. Luckily, California has already taken a leadership role in the U.S. on wildfire hazard and risk, in part through statewide fire hazard mapping and Chapter 7A building codes which prescribe fire-resistant building standards in certain areas designated as high fire hazard severity zones. The codes regulate how structures are constructed and what materials to use to reduce the risk of ignition. Zurich believes that codes should be applied and enforced in more areas: In many blazes, wind-driven embers have ignited structures well beyond the boundaries of high fire hazard severity zones. Zurich understands that such measures can increase fire resistance, they do not on their own eliminate the risk of loss. For example, of 350 homes built to the Chapter 7A codes in Paradise, 51% survived the Camp Fire. That compares with 18% survival of the 12,100 homes built prior to 2008 when the codes were enacted. Further, a 2018 study by Headwaters Economics found that constructing a new home to comply with fire-resistant standards costs approximately the same amount as constructing a similar "typical" home. The city of Paradise is actually in a unique position right now because

they are going to have to rebuild a lot and it's all new constructions so they can actually rebuild the homes to these fire resistant standards Chapter 7A codes.

Ms. Grinsell stated that one of the biggest problems is urban sprawl which is moving into the wildland areas. It is really tough to control but local laws and ordinances are needed to ensure that everyone is being as proactive as possible to reduce some of these risks of losses in areas that are vulnerable to things like wildfires (and hurricanes, for that matter). Incentives can include using public lands, parks and playing fields to create buffer zones that slow the spread of fire and prohibiting building in areas that are too steep, prone to dangerous winds. But a lot of it is building additional resiliency into the communities situated in wildland areas. If you are building into an area that is very dry you should take down more vegetation than you would normally.

Planning for recovery and promoting preparedness is also important – having the “what if” discussion is vital. Residents, governments, businesses and organizations need to consider fire behavior beyond the worst-case scenario. The Camp Fire, for example, led to the contamination of Paradise’s water system with benzene. Utilities should broaden their thinking about potential vulnerabilities as part of their planning. When building resiliency, special attention should also be made to infrastructure which includes power, wastewater removal, communications, and transportation. Attention should be paid to what can fail and what actions can be taken in advance of disaster and in reconstruction to increase robustness and redundancy.

Community actions are also important. Wildfire-prone areas need to develop a culture of wildfire mitigation to reduce collective fire risk. Maintaining defensible space may be obvious but that can help an ember from sparking shrub or getting into an attic and sparking homes. Regulatory activity helps. Because if as a homeowner I do my work, build as resistant a home as possible, maintain defensible space and stay aware of my risk, but my neighbor or my community doesn't, they increase my risk and everybody loses. This is different than flooding because in a flood situation, if I maintain my house in a flood to be flood resilient and my neighbor does not, that won't affect me – but in a wildfire, all bets are off. The community needs to do this together.

Ms. Grinsell stated that planning at the regional level is also important. In addition to California, states including Montana, Colorado and New Mexico have an above-average percentage of households at high or extreme fire risk. It would be great for everyone to learn together. California has mapped wildfire hazard across the state, they've instituted the Chapter 7A building codes for the highest risk zones — things no other state has done and in spite of being disparaged for having so many regulations. Other states can learn from what California has done and what it is trying to do.

Ms. Grinsell then discussed utilities. Everyone read the articles about utilities and the part they played in the wildfires. Power lines running through highly flammable vegetation in environments prone to high winds is fundamentally a problem. At the same time, we want and need power. Some solutions are: Upgrading to coated conductor for power lines and moving power lines underground can reduce the risk of power lines sparking a fire; and Moving to smaller, localized grids utilizing a much higher percentage of wind and solar energy. Those investments can be expensive and disruptive. That doesn't mean they aren't good investments, but there needs to be a lot of communication with the public about the pros and cons. And other options need to be considered. This takes innovative thinking. Also, solutions need to be tailored to local

needs and conditions. With regard to resiliency measures, shifting the mindset from response after a fire to resilience measures before can save money in the long run. Research indicates that \$1 invested in wildland-urban interface fire hazard mitigation measures can save from \$3 to \$4 in future costs. That is huge. Resiliency is the key.

Ms. Grinsell stated that responses should not be limited to specific communities as these types of risks are interconnected. For example, in terms of a business, climate related climate-related changes can cause a cascade of business interruption risks. If I'm a restaurant owner or CEO of a restaurant chain, my supply chain can be affected, causing delays, shortages, price hikes and more. Those are just some of the interconnected nodes to climate-related changes. Having said that, more work needs to be done to help individuals and communities embrace their role in adapting to a new normal of hotter, drier, windier conditions that intensify wildfires. Ms. Grinsell noted that the report is available at www.zurichna.com/CalWildfires.

Gina Schwitzgebel Hardy, CEO/General Manager of the North Carolina Joint Underwriting Association (NCJUA) and North Carolina Insurance Underwriting Association (NCIUA), stated that the NCJUA and NCIUA are two associations that were created by the NC General Assembly but they do not operate as part of the state government, rather, they operate as independent insurance companies serving around 400,000 customers in the state and writing about \$95 billion worth of property in the state. Ms. Hardy stated that she will be discussing today the work that NCJUA and NCIUA are doing in NC to create more resilient communities, in addition to the work that other organizations are doing across the country to make the work that the Insurance Institute for Business & Home Safety (IBHS) is doing prevalent in more communities.

For Hurricane Florence, the winds pounded NC for four days. Ms. Hardy stated that for someone who writes the majority of the exposure in the Outer Banks, the Barrier Islands, and a significant majority in the coastal areas of the state, you can imagine the concern she had. Another Hurricane happened a few years earlier: Hurricane Arthur, a CAT 2 Hurricane in July 2014. Even though NCJUA/NCIUA writes seven out of every ten homes in the Outer Banks and Barrier Islands, it only cost \$10 million worth of damage. Hurricane Florence was very different – NCJUA/NCIUA paid out 100,000 claims and losses exceeded \$1.7 billion. There were very positive results and a lot of credit goes to the partnership both with the General Assembly and the Insurance Commissioner. The Insurance Commissioner spoke to Ms. Hardy's staff who had to work very long hours about how they were first responders and what they could do to serve the citizens of NC.

They even came up with a phrase "It's a mission not a position." 90% of claims were settled within 60 days. After that 60 days, NCJUA/NCIUA even assisted the California FAIR plan with some of the fire losses that were in California because the partnership among all the residual markets across the country is important. Ms. Hardy stated that she is proud to report that they (NC) only have five litigated claims within 100,000 claims filed in the state. That says a lot about the legal and regulatory environment that the General Assembly has put forth in NC.

Ms. Hardy stated that the experience NC had with hurricanes is not unique. If you look at the top ten hurricanes that have occurred, a lot of them have occurred since 2000 with large loss numbers. And it is not just hurricanes but also floods, wildfires, earthquakes, tornadoes, ice/snow, and hail. The IBHS has done a lot of tremendous research and work with these issues. NAMIC conducted a study that said for those that have the best

building codes, for every dollar spent in pre-disaster, it actually saves \$11. When talking about the impact of resilient construction, there are many benefits such as: less community damage; reduced costs of emergency management and disaster recovery resources (for everyone in the country, not just those in high risk areas); maintain tourism and tax base; lower insurance losses; increased availability of insurance; increased affordability of insurance; and stable insurance companies. Perhaps more important than that is the minimization of disruption to the homeowner's lives. There are some things which dollars can't replace.

Ms. Hardy stated that NCIUA looked internally in 2016 and looked at the incredible research that IBHS was doing. NCIUA looked at how many of its 400,000 policyholders had actually taken up getting a fortified roof or fortified their home in some way. Essentially, none did. In December of 2016, there were four that had a fortified roof. So, doing mitigation credits, which typically is how insurance companies go about incentivizing people, was not working. At that point, thought had to be put into how to incentivize consumers. Consumers want granite countertops but yet why were they not wanting a fortified roof that could keep their family safe? A change in approach was needed. The first thing done was building infrastructure because when talking to the building and roofing community, they were unfamiliar with a fortified roof and what it took to get one. When starting in 2016, there was one inspector in the state that could actually inspect to certify that someone had a fortified roof. Now, there are over 300 inspectors in the state and there had been a lot of training conducted for inspectors and contractors. There has been an incredible response from the local and national homebuilder's associations because it gives the builders something else to sell. If you think about a car, they don't just sell low-end cars; they sell luxury cars as well. Roofers should be able to sell a normal roof and a fortified roof but the roofing community needs to be explained what that means.

Ms. Hardy stated that NCIUA then looked at what it could do as an insurance company. NCIUA can't use all of the benefits to cost-justify for itself because it is not a state agency so they looked at how they justify it from the standpoint of "why could our company invest money?" The two ways they looked at it was "what was our loss savings over a 10 or 20 year period" which is the period over which a new roof would last; and "what would be our reinsurance cost savings?" It was discovered that in the most exposed areas, the Barrier Islands and Outer Banks, the cost savings per house per roof was about \$6,000 over that period of time. First, there was an enhancement endorsement created which said to the policyholder that if they had a loss and the roof needed to be replaced, the insurer will upgrade the roof to a fortified roof at the insurer's expense. That was about a \$3,200 enhancement endorsement that was offered that was put on every single policy free of charge. Ms. Hardy stated that in order to build a fortified roof, you take the existing roof down, seal the roof deck between it so there is not water intrusion, use proper nail spacing, use ring shank nails, and use roof mounted vents. It is also important to make sure there is not an overhang that can easily be taken away because if the roof comes off, the house essentially becomes a bucket. Ms. Hardy stated that the first pilot program IBHS customer was very excited because the insurance company was paying for his roof, settling his claim quickly, paying for an upgraded roof, and giving him a 7% discount on his insurance going forward.

With regard to the results of the pilot program, which was done in the Outer Banks and Barrier Islands, Ms. Hardy stated that after having about 100,000 losses, a lot of which were roof losses, there was some disappointment that only 274 customers that had roof

losses took the offer for an upgraded roof. It was found that roofers were coming in from all over the country and most of them had not gone through the training to know what a fortified roof was, so they were telling the consumer that if they needed a new roof, a regular roof could be put on quickly but a fortified roof would take very long.

Accordingly, a lot of people didn't take the offer of the free endorsement. That led to further thinking as to how to innovate to help customers utilize fortified structures. The next thing done was a "strengthen your roof" grant program. There was skepticism at first because it was sent out to 20,000 policyholders and the message was that the board of directors is willing to give \$10 million out to the first people that apply and they can get a grant of \$6,000 – they did not have to have an insurance loss; the grant would be given to replace the roof with a fortified roof. A lot of people thought they were being scammed, but a significant number of people took the offer and there was a lot of positive feedback and peace of mind on behalf of those people. From 2016 to now, there has been a snowball effect with both the endorsement and grant programs.

Ms. Hardy stated that two studies were conducted by NCIUA, one after Hurricane Florence to compare the losses of fortified roofs with those with regular roofs within a mile radius. The results were staggering in how well the fortified roofs held up compared to regular roofs. Further, of all NCIUA properties (400+) with fortified roofs in place when Hurricane Dorian struck North Carolina, only 7 losses reported roof damage. Of those, 3 reported minor interior water damage and only 1 suffered significant water intrusion, and that 1 was due to the roof being put on the day before and it did not have time to cure and seal before the Hurricane hit. Comments received from those policyholders were very positive and they urged another pilot program to be started.

Ms. Hardy then discussed other mitigation programs across the country. The California Earthquake Authority (CEA) is a non-profit residential earthquake insurer. After the Northridge earthquake struck in 1994 and caused \$20 billion in residential damage and left 22,000 people homeless, the CEA formed. North California is home to two-thirds of the nation's earthquake risk. CEA started doing something beneath the homes which is called the brace and bolt program. They give away grants of \$3,000. California's residual market, the CEA (which is quasi-governmental), is getting a lot of federal grants along with some state grants. They are also seeing a snowball effect as they started in 2014 with just 9 homes. In 2019, they were able to get FEMA grants consisting of \$23 million. They are scheduled this year to apply for five other grants and they anticipate retrofitting over 10,000 homes.

Ms. Hardy noted that the Strengthen Alabama Homes program, run through the Alabama Insurance Department, gives grants of up to \$10,000. This year, the Alabama legislature has allocated \$10 million for the program to do grants. Alabama actually has the largest number of IBHS fortified roofs in the country. The South Carolina Safe Home Program is run by the South Carolina Insurance Department. The South Carolina General Assembly gives grants of up to \$5,000 for fortified roofing. It is indicated that this year there will be \$2.2 million of funding.

Ms. Hardy stated that the NCIUA board of directors has approved \$10 million of its own money to do another grant program. NCIUA has not sought, federal, state, local or private funding. Accordingly, the board stated that it would put up another \$10 million for matching funds if it can get such funds from other Federal, State, Local or Private Sources. The brace and Bolt program is expected to complete about 2,600 homes and has applied for four FEMA grants. They are extremely fortunate in that they hired

someone from a government agency that wrote grants. NCIUA is still trying to figure out the federal grant program and policies. It is very complicated and the regulations are very thick. Strengthen Alabama Homes' funding comes from the state legislature and current amount of funding available for 2020 is \$10,000,000. The South Carolina program will have \$2.2 million of funding from the General Assembly of South Carolina. Ms. Hardy stated that everyone is working together because believe it or not, if the federal government gives grants, those grants are not subject to federal taxation. However, the grants that the state organizations give are subject to federal taxation.

Accordingly, Congressman Mike Thompson of California has introduced federal legislation – H.R. 5494, The Catastrophe Loss Mitigation and Tax Parity Act - which establishes tax exempt status for state-funded residential mitigation programs for earthquake, windstorm and wildfire. There are several co-sponsors and the National Association of Insurance Commissioners (NAIC) has endorsed it, along with the Chamber of Commerce, and other organizations. Ms. Hardy stated that having NCOIL joint as a supporter would be tremendous.

Ms. Hardy then offered the following advice for anyone looking to help NCIUA in its journey: Assist with Securing State and Federal Funding; Encourage more legislators to co-sponsor federal legislation H.R. 5494 exempting grants from Federal Taxation; Encourage other residual plans and private market insurers to educate policyholders and provide enhancement coverage; and Engage with the Building Community. Ms. Hardy stated that together we can build resilient communities and thanked the Committee for the opportunity to present.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
CHARLOTTE, NORTH CAROLINA
MARCH 7, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Charlotte Marriott City Center Hotel in Charlotte, North Carolina on Saturday, March 7, 2020 at 2:15 p.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)	Sen. Paul Wieland (MO)
Rep. Matt Lehman (IN)	Sen. Jerry Klein (ND)
Rep. Joe Fischer (KY)	Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Utke (MN)	

Other legislators present were:

Rep. Kevin Coleman (MI)	Sen. Shawn Vedaa (ND)
Rep. Stephen Ross (NC)	Sen. Robert Ortt (NY)
Sen. Vickie Sawyer (NC)	Sen. Bob Hackett (OH)

Also in attendance were:

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

QUORUM

Upon a motion made by Sen. Jerry Klein (ND) and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Klein and seconded by Sen. Paul Utke (MN), Vice Chair of the Committee, the Committee approved the minutes of its December 12, 2019 meeting in Austin, TX without objection by way of a voice vote.

INNOVATION IN THE WORKERS' COMPENSATION INSURANCE MARKETPLACE: A PRESENTATION FROM PIE INSURANCE

Teri Leon, General Counsel at Pie Insurance (Pie), stated that Pie was originally formed in 2017 and it wrote its first policy on March 23, 2018. Pie is operating in 35 states and the District of Columbia. Pie writes on Sirius America Insurance Company as Pie is a program manager for them. Pie is a big fan of its name as it celebrated national Pie Day

on January 23 and will celebrate the mathematical pie day on March 14. For any celebration, Pie has various flavors of pie.

Ms. Leon stated that Pie also uses a lot of pie-isms as it has pie-r-side chats; pie-oneers are its team members; and it has pie-awards. However, Pie is following a very proven path from other companies. Progressive used credit-based insurance scores, driver point matrixes and vehicle symbols to rate. Capitol One started using FICO-based scores to determine interest rates and credit limits. Those companies all married market data and risk selection and pricing. Pie is doing the same thing. It is using algorithms to help schedule rate its policies. Ms. Leon stated that Pie writes small business workers' compensation. Currently, the annual premium for all of its policies would be less than \$75,000. Generally, Pie's insureds are between 3 to 8 non-owner employees. Pie wanted to support small businesses because it saw that 80% of them were being overcharged.

Ms. Leon stated that the current process to get a workers' compensation policy is time consuming and completing an application is difficult. There are approximately 20 steps to get through a normal, traditional insurance policy application as there is a lot of emailing, scanning, and phone calls back and forth between the insurance company and agents before you can even get a quote. Pie has changed that and has made insurance as easy as pie since you can complete the online application form in less than three minutes. Pie helps determine the in-person's class code by free form search so they can put in the word "florist" and different class codes for florist will come up such as retail florist and wholesale florist that the person can choose themselves.

Ms. Leon stated that Pie asks questions regarding the person's prior work comp experience. Pie also pulls demographic information from third-party websites such as their address, and how long they have been in business. The person can then review and confirm that information on their own. Pie is continuing to leverage emerging technologies and third party sources to make the online application as effortless as possible.

Ms. Leon then provided an example of who Pie generally writes for. Jim Pelletier of JP Construction; 26 years in business; concrete installer; \$75,000 in (non owner) payroll; found Pie through Facebook; non-renewed by Auto-Owners (for being too small); purchased a \$6,594 Pie policy. Pie focuses on small businesses that are considered too small for other carriers or too new because they have not been in business long enough. Pie meets businesses where they are: 75% of Pie's businesses are finding Pie through their mobile devices; 67% of them are doing searches and doing Pie's online application after outside business hours; and 80% found Pie on social media. Pie is here to solve the small business and will serve them in the traditional route. Pie will use agents and brokers who can use the online application process as well or they can go through Pie's direct line.

Ms. Leon stated that there are, however, some regulatory and statutory obstacles for online transactions. First, insurance was not developed with online transactions in mind. In 3100 BC, Chinese traders put all of their goods on different boats so that if one boat went down they only lost some of their goods. In 2100 BC, the Code of Hammurabi contained an early insurance type protecting traders who took out loans. They could pay an additional sum to a bank for loan forgiveness for lost shipments. The Code also included compensation for workers who were injured on the job. In 1667 AD, after the

Great Fire in London, the first insurance company was created called The Insurance Office. The first fire brigades were also created which were previously owned by insurance companies which was also problematic when a brigade owned by Company A did not put out a fire of Company B. Accordingly, the brigades were transferred to the municipalities. More and more insurance companies continued to be formed and in the 1990s, insurance companies in the U.S. started going online.

Ms. Leon stated that the laws were created when paper-based commerce was the only option and everything went through U.S. mail. Pie's insureds are finding Pie online and they generally expect a completely online, electronic transaction. But in several states, Pie is still forced to print out and mail the policy to the insured. Any notices of nonrenewal or cancellation cannot be delivered by e-mail but must be delivered by certified mail, return receipt requested. In the states that do allow for electronic transactions, it is a rather expansive terms and conditions that they have to agree to on an opt-in basis.

Ms. Leon further stated that a lot of the documentation that insurance companies and insurance agents have to provide is not electronic friendly. E-signatures are not widely accepted in Departments of Insurance even though e-signatures laws have been passed in all 50 states. Yellow books that are financial statements for companies have to be wet-signature. The applications to become a licensed insurance agent are also sometimes paper-based. Applications for certificates of authority vary. Although submitted electronically, they are basically paper applications that are uploaded and submitted. Some states allow at least partially electronic expansion applications, but some require portions be mailed in. Others require paper applications mailed to multiple locations. The ACORD 130, which is the application for work comp, is required by many departments of insurance. Getting another online application is difficult if not impossible in some states. So even online applications that Pie has can be problematic; Pie has to backfill its ACORD 130 so that it sits in their records and they have it even though they are collecting the exact same information in its electronic application.

Pie understands that change takes time and changes to statutes and regulations require thinking about the long term consequences to all parties. Pie hopes the process will continue and that the departments of insurance will move towards electronic processes that are easier for all involved and that policyholders will be met where they are: online, like other transactions. Ms. Leon further stated that one of Pie's values is fun and it wonders whether it is time to re-brand work comp. Companies rarely call their workers employees anymore. There are team members, partners, and talent. Should it really be called compensation when it provides so much more? It provides reimbursement, support, and re-training for those individuals who have been injured. Pie has not come up with a new name for work comp yet, but asks that legislators and regulators keep that in mind.

Rep. Bart Rowland (KY), Chair of the Committee, asked if Pie's determination that many were being overcharged for work comp was due to rates in general, misclassifications, or inaccurate audits. Ms. Leon stated that Pie believes there are a number of different reasons for being overcharged. When an agent is looking at a very small business with a very small premium, they may only go and get a quote from one insurance company because having to plug in all of the information to all of the different insurance companies to get multiple quotes may be too much. Pie also believes that a lot of

insurance companies will not schedule rate for a policy that is less than \$10,000 on an annual basis but Pie will. Pie schedule rates all policies no matter what the premium.

Rep. Rowland asked if Pie has a minimum premium. Ms. Leon stated Pie does not. Rep. Rowland further asked if Pie does business with independent agents and brokers such that they can be licensed with Pie and sell Pie's products. Ms. Leon stated that Pie currently has over 400 agents and brokers who are licensed with Pie and they have an online application process as well. With regard to regulatory obstacles, Rep. Rowland noted that Kentucky recently implemented a regulatory sandbox and asked if Pie has looked at any of the states with such sandboxes and looked for ways to get around certain regulatory obstacles such as the ACORD 130 issue. Ms. Leon stated that Pie has looked into that in certain states and some states will allow Pie to get out of the ACORD 130 but some states will not. Each state is different as some states are very friendly towards electronic transactions but other states require everything to be paper-based.

Rep. Matt Lehman (IN), NCOIL President, stated that there is often a lengthy process to get a work comp policy for a contractor. Rep. Lehman asked what Pie is doing different such that a contractor is able to get a policy so quickly. Rep. Lehman also asked if it matters to Pie that contractors may be doing work in different states such as being based in Indiana but doing some work in Ohio. Ms. Leon stated that if the contractor is doing any work in Ohio, they must get an Ohio policy and Ohio is monopolistic so Pie cannot write for Ohio. Pie is still using traditional methods such as loss costs, class codes and experience mods. Pie's algorithms are helping to ensure that the scheduled rating is right. Pie is still looking at things like safety records, what kind of health insurance is being provided, and how long they have been in business. The algorithms help ensure that Pie is looking at those things more accurately than perhaps some of the traditional insurance companies.

Rep. Lehman further asked if Pie is required to file any rate deviations with the state. Ms. Leon stated that for each state Pie does file its own scheduled rating plans which addresses debits and credits depending on what the range is for the state.

Rep. Lehman asked what the biggest hurdle is for Pie with regard to the e-commerce issues discussed earlier. Ms. Leon stated that for policyholders, they often complain when they are mailed policies despite them having opted-in to electronic delivery which forces Pie to explain the differences in state electronic delivery laws. On the claims side, there is a lot of electronic claims filing which is a big issue. There is room for improvement with claims handling so that people are getting things taken care of more quickly especially for medical only claims. Rep. Lehman asked if Pie has its own claims adjusters or if Pie uses independent adjusters since independent adjusters in certain states can pose regulatory issues. Ms. Leon stated that Pie currently uses CorVel as a third party administrator and they are a nationwide, public company. Pie will be building out its own claims group in the future.

Rep. Rowland stated that he assumes Pie does payroll audits with its customers at the end of the policy term and reports that data with the National Council on Compensation Insurance (NCCI) like others. Ms. Leon replied yes.

Sen. Paul Utke (MN), Vice Chair of the Committee, asked if Pie plans to build out to more states or are there challenges in the states that Pie is not in yet. Ms. Leon stated

that Pie's goal is to be in all 50 states except the four that are monopolistic by the end of 2020. Sen. Utke asked if applicants typically always give Pie all the information and data they need or if sometimes it is like pulling teeth to get all of that information. Ms. Leon stated that there are certain instances where it is like pulling teeth but Pie has inside licensed agents who will contact the applicants if they need additional information and they will help the applicants find that information. Other applicants know their business very well and are able to provide all of the necessary information which results in a quote being delivered more quickly.

ADJOURNMENT

There being no further business, the Committee adjourned at 3:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
SPECIAL COMMITTEE ON NATURAL DISASTER RECOVERY
INTERIM COMMITTEE CONFERENCE CALL
MAY 1, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Special Committee on Natural Disaster Recovery held an interim meeting via conference call on Friday, May 1, 2020 at 1:00 p.m.

Senator Vickie Sawyer of North Carolina, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Matt Lehman (IN)
Rep. Edmond Jordan (LA)

Rep. George Keiser (ND)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Bob Hackett (OH)
Sen. Bob Peterson (OH)

Rep. Robin Smith (TN)

Also in attendance were:

Commissioner Tom Considine, NCOL CEO
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 President, the Committee waived the quorum requirement without objection by way of a voice vote.

DISCUSSION ON NCOIL PRIVATE FLOOD INSURANCE MODEL ACT AND PROPOSED STRIKE-ALL AMENDMENT NCOIL PRIVATE PRIMARY RESIDENTIAL FLOOD INSURANCE MODEL ACT

Sen. Vickie Sawyer (NC), Chair of the Committee, thanked everyone for joining particularly given how busy everyone is dealing with the global health crisis. Sen. Sawyer thanked everyone for their work thus far on the development of model legislation that would facilitate the expansion of the private flood insurance market. Sen. Sawyer also noted that since the Committee's last meeting in March in Charlotte she signed on to the NCOIL Private Flood Insurance Model Act (Model) as a primary sponsor.

Sen. Sawyer stated that at the Committee's last meeting in March in Charlotte, the Committee briefly discussed a document that was submitted by a group of interested parties as a proposed strike-all amendment to the Model – titled the Private Primary Residential Flood Insurance Model Act. Sen. Sawyer stated that in terms of process for this call, she would like to go through certain Sections of the strike-all amendment document and first ask for feedback from interested parties that submitted the strike-all

document. Then the call will open up for discussion among both legislators and interested parties on the call.

Sen. Sawyer stated that the goal today is to make as much progress on the Model as possible so that when the Committee meets next it can vote on the Model. However, Sen. Sawyer noted that if the Committee does not get through all Sections today, that is fine as the Committee can hold an additional Interim Committee Meeting to do so. Sen. Sawyer also noted that the NCOIL Summer Meeting which was scheduled for the end of July in New Jersey has been postponed, and will not be in Jersey City. NCOIL Officers and staff are currently working through whether the Meeting will be held virtually or in-person at another location in August or September.

Before beginning review of the Model, Sen. Sawyer offered Wes Bissett, Senior Counsel, Gov't Affairs at the Independent Insurance Agents & Brokers of America (IIABA/The Big I), and Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), the opportunity to make brief comments on behalf of the industry group that submitted the strike-all document.

Mr. Bissett thanked the Committee for their work thus far in its efforts to create additional consumer choice in the form of private flood insurance. The Big I and every industry constituency organization agrees on the importance of promoting private flood insurance alternatives and for some it has been a goal for a long time. From the Big I's perspective, its members are independent agents so the more markets and options they have the better. Much of the conversation about private flood insurance over the last decade has occurred at the federal level but the proposal submitted by Rep. David Santiago (FL) two years ago jumpstarted the conversation at NCOIL and it posed an important question: are there things that state legislators can do to facilitate the growth of the private flood insurance market?

Given the collective interest in these issues and strong support for private flood insurance among industry, various trade groups convened a few months back and over the course of hours of conversations they talked very seriously about these issues. The group focused on three main topics: if there is going to be a private flood insurance-specific Model, how might it foster and encourage the growth of the private flood insurance market?; are there barriers that exist in existing codes that can be addressed in such a Model?; and are there unique public policy issues that arise in the context of private flood insurance? Mr. Bissett stated that the group started with Rep. Santiago's proposal and ended up sticking pretty close to it. The group also looked at the statute that Rep. Santiago enacted as a legislator in Florida and the strike-all amendment, in some ways, is even closer to that statute. The group also looked at some other proposals including a South Carolina bill that was unanimously passed by the state Senate.

Mr. Bissett stated that the Big I was also having conversations with Rep. Santiago and some of the provisions in the strike-all amendment are the product of those conversations and reflect things that he supported. Mr. Bissett noted that the industry group that submitted the strike all document had a broad array of support and the proposal was developed and supported by the primary insurer community: the American Property Casualty Insurance Association (APCIA) and NAMIC; the reinsurance industry: the Reinsurance Association of America (RAA); the banking industry; the American

Bankers Association (ABA); the surplus lines industry: the Wholesale and Specialty Insurance Association (WSIA); and the agent-broker community: the National Association of Professional Insurance Agents (PIA) and the Big I.

That is something of a rarity as the industry typically doesn't agree in such a broad manner. The group respectfully urges the Committee to consider the proposal and to perhaps use it as a starting point for further discussions. The group does not suggest that it is perfect and as evidence of that there are a couple of associations that intend to propose some amendments to the proposal. However, the group does believe it has come up with a document that advances the objective of growing the private flood insurance market and the document does have broad support. Mr. Bissett thanked the Committee for its consideration.

Ms. Collins thanked the Committee and stated that the proposal represents a long and deliberative collaboration among industry with the objective of agreeing upon what could be a methodology to foster a private flood insurance market. The National Flood Insurance Program (NFIP) has some significant challenges and some of those are such that there are barriers within the Program to having actuarial data recognized and reflected within the rates of the NFIP. Ms. Collins stated that in order to foster a private flood insurance market, the insurance company industry believes strongly that in order to do that, companies starting from a competitive position behind the NFIP because of that actuarial data need some additional rate and form freedom and some additional consideration to make sure that a private flood insurance market can be fostered.

Accordingly, the group believes that it has joined together to create a proposal that is measured and fair and has some sensible provisions on how rates have to be filed and must be based on actuarial data, how forms have to be filed and that the coverage of those forms has to at least meet that of the NFIP, and also some provisions regarding notice to consumers. Ms. Collins thanked the Committee and urged it to consider the proposal.

Sen. Sawyer then began a review of the strike-all document. Sen. Sawyer started with Section 4 which deals with rates and noted that the drafting note at the end of that Section states that "a 'use and file' rate filing is used in this section. A State may choose to apply a 'file and use' standard instead." However, subsection (a) of Section 4 states that "rates for flood insurance coverage established pursuant to this paragraph are not subject to approval by the [State entity for regulation of insurance]." Sen. Sawyer stated that stating that rates are not subject to approval while also stating that a "use and file" or "file and use" standard may be used seems to conflict since both of those standards do involve some type of approval, just not prior approval, by the state entity for regulation of insurance. Under either a "file & use" or a "use & file" system the state can come back and direct the insurer to cease using those rates. Sen. Sawyer stated that the draft NCOIL Model states that rates are not subject to prior approval and is therefore curious as to why there is a need to alter that language. Sen. Sawyer asked if someone could speak to the reasoning for the proposed change and the apparent conflict.

Lisa Miller, President of Lisa Miller & Associates, thanked Sen. Sawyer for bringing that issue up and stated that in Florida, the companies file essentially an informational filing and they have an open dialogue with the regulator and there is no formal approval. Ms. Miller stated that the point raised by Sen. Sawyer is an important one and agreed that there does seem to be an apparent conflict and the drafting note is not needed.

Ms. Collins stated that the objective of that Section is to make a distinction between the different filing systems used in the states. The objective is to create a system in which the rates are not subject to prior approval. The Section states that rates are not subject to approval based on the drafting group's interpretation of how the rate filing systems are articulated in state statutes. Ms. Collins stated that she believes nothing in the Section would preclude or override the existing authority of the Insurance Commissioner to ensure that they always have the ability to go back and declare that something is not meeting the standards that are outlined in the Section. The drafting note is simply meant to be educational in making sure that everyone understands the differences between the different rate filing regimes.

Sen. Sawyer then noted that Section 4(a) of the draft NCOIL Model requires an insurer to "attest that rates are based on actuarial data, methodologies, standards and guidelines relating to flood that are not excessive, inadequate, or unfairly discriminatory" but the strike-all document removes the attestation requirement and simply states that an insurer's rates must meet those standards. Sen. Sawyer asked if someone could speak to the reasoning for the change.

Dennis Burke, VP of State Relations at RAA, stated that he believes the group removed the attestation language because the law already requires that the rates be based upon the actuarial data, methodologies, standards and guidelines. So, the attestation language was really just a form of belts and suspenders and it was thought to be unnecessary. The language didn't add anything because insurers are already required by the law to base their rates on such factors.

Ms. Miller stated that she is thrilled to see that the rate framework that is used in Florida has been working so well. This is all about helping consumers and consumers can always go back to the NFIP if the rates are too expensive. That is the beauty of allowing for no rate regulation other than a light oversight by regulators. It is hard for regulators to grasp that but once you tell them that the consumer can always go back to the NFIP if the rates are too expensive the regulator usually then understands. Ms. Miller stated that she believes the Section looks good as-drafted and the drafting note is not needed.

Rep. George Keiser (ND) stated that it is not surprising that there is broad industry support for Section 4. If all other lines of insurance were included in that Section, there would undoubtedly be broad industry support. With regard to the statement made about the consumer always having the option to go back to the NFIP, that is true but not the reason why there is concern about the rate being charged for any line of insurance. Rather, the concern relates to the solvency of the insurer. An insurer can have a very low premium, much lower than the NFIP, but it does have to be actuarially sound based on a specific business model so if that company goes insolvent there at least was due diligence.

Rep. Keiser stated that he has grave concerns with Section 4 as currently drafted. The McCarran-Ferguson Act set up the position that the states have authority to regulate insurance. Rep. Keiser stated that when we get to things like use and file, file and use, and prior approval, he does not know any area of policy related to insurance at the state level that has been discussed more than what strategy a state will use to regulate rates. If there are other areas where states have had more activity, Rep. Keiser stated that he would like to know what they are. Rep. Keiser stated that states are able to look to other states and agree and disagree on certain ways of doing things. Rep. Keiser stated that

he respects Florida and its experience but he also respects the fact that states have made a decision on this issue and NCOIL as an organization that supports McCarran-Ferguson at its heart, should not be saying “however, there is an exception...” Rep. Keiser stated that is wrong and he would be happy to hear industry comment.

Frank O’Brien, VP of State Gov’t Relations for APCIA stated that in many respects, he believes that many in the industry would believe that Rep. Keiser’s are on-point. One of the things that the industry tried to do when developing the proposal was to apply the appropriate amount of regulatory oversight to the private flood insurance product as it is a relatively new product. One of the other things that the industry tried to do, as reflected in the drafting note, is to recognize that different states have made different policy decisions in terms of what rate filing processes they want to use. The group tried to be respectful of the state-based system of insurance regulation in that regard.

John Ashenfelter, Associate General Counsel at State Farm Insurance Company, stated that Rep. Keiser’s comments are well noted particularly with regard to how NCOIL has spoken favorably on behalf of the McCarran-Ferguson Act many times. One of the things that NCOIL has taken action on as well is the general area of protecting competitive rating which is illustrated by the adoption and re-adoption of the Property/Casualty Insurance Modernization Model Act. The Model was recently re-adopted in July of 2018. Many of the principles in that Model carry over into what is being discussed today with regard to Section 4.

Sen. Sawyer then moved onto Section 5 which deals with forms. Sen. Sawyer noted that in the drafting note of that Section, the second sentence states: “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.” Sen. Sawyer stated that she understands the concept of that sentence but questions whether it is necessary for inclusion in the Model as it seems more like an editorial comment than statutory language. Sen. Sawyer asked if someone could speak to the reasoning for that language.

Ms. Collins stated that like most drafting notes, she believes the intent of the language was to offer further context and impress upon potential sponsors that while the Section does have a good framework, there are some states that may wish to further streamline the requirements, perhaps to even more so foster a private flood insurance market that would provide more choices. Ms. Collins stated that the language may be a bit editorial but believes that it is useful in that legislators can look at the Model in its entirety as a way to try to grow the ability of their consumers and constituents to have choices in the private flood insurance market. Accordingly, the language is meant to be contextual in nature.

Mr. Burke agreed with Ms. Collins but also noted that the way the group postured the proposal’s definition of “primary residential flood insurance” was to ensure that the focus was on the consumer element and not inadvertently imposing on the commercial flood insurance market. As part of the drafting note, a consideration for legislators is whether or not the streamlining of filing for residential flood insurance is easier than that of commercial flood insurance and if it is, should they consider making commercial flood insurance as easy to apply due to the somewhat reduced issues of consumer impact.

Sen. Sawyer then moved the discussion on to Section 7. Sen. Sawyer stated that in the draft NCOIL Model this Section is titled "Duties of Producer" and it sets forth certain disclosures the producer must make to an applicant. The Section also states that it shall be a best practice for producers to maintain in their records, written or electronic evidence, to be signed by the applicant, acknowledging the disclosures were made. This Section has received significant pushback from the producer community despite efforts to scale back the requirements from what were in the original version of the Model. Sen. Sawyer stated that she understands the concerns and appreciates the effort made in submitting new language regarding the requirement to disclose to the applicant that if he or she leaves the NFIP and then returns, they may lose subsidies.

However, Sen. Sawyer stated that she is hopeful that some type of compromise can be arrived at with this Section such that some of the disclosures in the draft Model are included in the final version since the strike-all document deleted the Section in its entirety. Looking at the strike-all document, Sen. Sawyer offered for discussion that Section 7(a) be changed to: "If a consumer currently has NO coverage under the NFIP, before placing the consumer applicant with private flood insurance, the consumer must be informed of the existence of the NFIP."

Section 7(b) would then begin with: "All consumers covered by subsection 7(a) as well as consumers who currently have coverage under the NFIP must be informed" and then the language regarding the requirement to disclose the possible loss of subsidies would be included. Current Section 7(b) would then become Section 7(c). Sen. Sawyer stated that her proposal seems like a logical extension because if a producer is already explaining about the possible loss of NFIP subsidies to someone without NFIP coverage, a discussion surrounding the NFIP in general is likely to occur.

Whether or not the Model should also include the requirements to inform - and maintain written or electronic evidence of - an applicant that a homeowner's property insurance policy, unless endorsed for flood insurance coverage, does not include coverage for the peril of flood, and that unless flood insurance is purchased, the applicant has declined flood coverage is also up for discussion. Sen. Sawyer asked if anyone, particularly Mr. Bissett, wanted to comment on these issues.

Mr. Bissett asked Sen. Sawyer to repeat the proposed language. After Sen. Sawyer repeated it, Mr. Bissett stated that after seeing it in writing the Big I would be happy to review and return with comments.

Before taking further comments on Section 7, Sen. Sawyer raised two more issues. First, the last sentence of Section 7(a) states that "The insurance producer, surplus lines broker, or the insurer upon its election or if there is no producer or broker must provide such notice." Sen. Sawyer stated that she wonders about the potential for this language to result in some policyholders slipping through the cracks, and there being resultant finger pointing. The insurer makes the notification whenever it elects to do so, but must do so in every instance where no producer is involved; only in instances where a producer is involved and the insurer does not elect does the duty pass to the producer – that seems cumbersome. Also, Section 7(b) states that "This Section only applies if the applicant lives in a Special Flood Hazard Area." Sen. Sawyer questioned whether that should be changed to apply to all applicants. Sen. Sawyer asked if anyone had any comments on Section 7.

Mr. Bissett stated that with regard to the last point raised by Sen. Sawyer, for any disclosure regarding the potential loss of a subsidy it makes sense to limit that disclosure to anyone who lives in a Special Flood Hazard Area because they are the only people that fall into that universe. Also, in many cases, it might be helpful to draw the attention of the NFIP to someone who does not have flood insurance but at the same time there are a lot of homeowners where flood insurance just is not something that is a necessary consideration.

In response to Mr. Bissett's last comment, Ms. Miller stated that she thought that part of the goal in addressing the coverage gap with flood insurance is that we want more consumers to have flood insurance whether it is necessary or not. The more chances you have to spread the risk the better. Ms. Miller stated that she has had conversations with individual agents in the industry who stated that they always have the conversation with the consumer applicant regarding flood insurance and the fact that homeowners property insurance, unless endorsed for flood insurance coverage, does not include coverage for flood. Ms. Miller stated that she hopes consumers will continue to be put first and that agents do their due diligence and carry out their responsibility to inform and disclose to their customers what the realities of what life can be without flood insurance.

Mr. Bissett stated that he agrees with a lot, but not all, of what Ms. Miller stated. If we were to talk about an all-perils policy or solutions that truly spread the risk, that can be done but disclosing the NFIP to people who really don't need flood insurance as the system exists today is not necessarily meaningful. Mr. Bissett also stated that agents are having these conversations all the time as they want to make sure their clients are taken care of and they have an incentive to sell insurance as that is how they are compensated. Accordingly, any suggestions that agents are trying to "hide the ball" in any manner are off the mark. There is also a difference between what is a good agent practice and whether it needs to be mandated into law. There are lots of things that agents do that occur every day that do not need to be requirements. There are lots of things that citizens as human beings do every day that do not need to be requirements. Just because the Big I is not supporting something to be in statutory law does not mean that it is not a good idea to do in practice.

The Hon. Tom Considine, NCOIL CEO, then provided clarification to Sen. Sawyer's proposal in Section 7(a). The proposal is not meant to apply to any consumer that walks in looking for some kind of property coverage. Rather, it would only apply to a consumer who is in the market for private flood insurance coverage; although it is still somewhat unclear as to who would provide the notice as noted by Sen. Sawyer previously pointing to the language "the insurance producer, surplus lines broker, or the insurer upon its election or if there is no producer or broker must provide such notice." Mr. Bissett stated that he appreciated that clarification.

Lauren Pachman, Counsel and Director of Regulatory Affairs at PIA, stated that she is not certain as to PIA's position on Sen. Sawyer's proposal in Section 7 as it was not previously circulated but as a general matter, PIA supports the idea of requiring agents to provide information about the NFIP to potential policyholders that are looking for flood coverage. Ms. Pachman stated that PIA believes that its members generally do that anyway so PIA does not believe that it would be burdensome for them to have in writing something that they are supposed to be doing and by and large are already doing.

The Hon. Ted Nickel, former Wisconsin Insurance Commissioner and National Association of Insurance Commissioners (NAIC) President, thanked Sen. Sawyer and the Committee for the work it has done thus far and stated that he agreed with Cmsr. Considine's clarification of Sen. Sawyer's proposed language. Cmsr. Nickel stated that he believes the clarification solves some of the issues raised by Mr. Bissett and goes to Ms. Miller's points about increasing the market for flood insurance. Cmsr. Nickel stated that he looks forward to reviewing the language when released as it sounds like the Section is headed in the right direction. Cmsr. Nickel further stated that the strike-all document contains a recognition of the need of consumers to have flood insurance coverage and information about it. Cmsr. Nickel stated that he therefore thinks that the Committee is getting closer to a good compromise and that it is important to keep the consumer front and center in all discussions going forward.

Sen. Sawyer thanked Cmsr. Nickel and noted that the proposed language for Section 7 will be distributed and posted on the NCOIL website after the call.

Sen. Sawyer then moved onto Section 8 regarding cancellation and nonrenewal notices and stated that she does not have any problems with it. However, Sen. Sawyer stated that she is curious as to why the provisions in Section 8 of the draft NCOIL Model were deleted. Specifically, Section 8(a) states that "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." Sen. Sawyer asked if someone could speak to that issue and also the other provisions of Section 8 that are proposed to be deleted.

Ms. Collins stated that, generally speaking, that language was removed to avoid confusion. There was federal activity in 2019 that recently became effective so during the group's discussions it was felt that the language was unnecessary as the federal action provided sufficient protection and also outlined how the protections would be perceived and handled in lending institutions. The deletion of the language was not meant to represent opposition but was rather meant to avoid any confusion and conflict. Sen. Sawyer stated that the language in Section 8(a) just seemed to be beneficial to insurers since it would prevent a regulator from taking requirements – likely more burdensome requirements - that are attributable to the property & casualty insurance industry generally and applying those requirements to private flood insurance.

Sen. Sawyer asked Ms. Collins if she had any comments to that point. Ms. Collins stated that NAMIC favors things that would enable property & casualty carriers to effectively deliver products so NAMIC believes that the removal of that language is not detrimental to that sentiment and it really is meant to avoid any future confusion between federal and state standards and how they interact.

Sen. Sawyer then moved on to Section 9 of the strike-all document regarding surplus lines placements. Sen. Sawyer stated that she does not see any issue with waiving the diligent search requirement, but offered for discussion whether the requirement should only be waived unless and until the Insurance Commissioner certifies in a bulletin or order that the admitted private flood insurance market is adequate. Sen. Sawyer asked if anyone like to speak to that proposal.

John Meetz, State Relations Manager at WSIA, stated that he would have to see the proposal in writing but does not believe that WSIA would have a problem with it. The

intent behind Section 9 is to give the state and the Commissioner the flexibility to determine when an admitted market is available so in principle the proposal sounds like something WSIA would be ok with. Ms. Miller stated that she has had long conversations with colleagues in the surplus lines industry and the “Chinese wall” between the industry and the admitted market should always be alive and well and respected. The surplus lines market always paves the way for new and innovative products and the admitted market always has a strong role in protecting consumers under regulatory control. Ms. Miller stated that it is good to hear that WSIA agrees with the Commissioner overseeing both markets and seeing which ones are going where.

Mr. Meetz then discussed an amendment to the strike all document submitted by WSIA. Mr. Meetz stated that WSIA is supportive of the strike-all document but upon review, it was discovered that some language in Sections 4 and 5 could potentially be confusing as potentially applying to surplus lines placements. Accordingly, WSIA has proposed an amendment to Section 9 that would make it clear that Sections 4 and 5 do not apply to surplus lines. That does not represent a change in public policy in the U.S. with regards to flood insurance or any other line of insurance for that matter. It is just a clarification that the forms and rates are not applicable to surplus lines and that is a longstanding principle that allows the surplus lines industry to do its job. It is WSIA’s understanding that the industry group that submitted the strike-all document has no issues with this proposed amendment.

Sen. Sawyer then moved on to Section 10 and raised two issues. First, Section 10(b) states that “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).” In order to guard against an insurer simply marking every page confidential, Sen. Sawyer offered for comment whether language should be included stating that the Commissioner must accept the information as confidential in order for it to be protected from public inspection.

Next, with regard to the NAMIC requested drafting note at the end of the Section, Sen. Sawyer stated that she understands the intent but does not see anything in the Model that would prevent an insurer from doing what is being asked for in the drafting note. Accordingly, Sen. Sawyer offered for discussion whether the drafting note is necessary. Also, Sen. Sawyer asked whether the fact that it is marked as specific to NAMIC means there is no consensus around the benefit of the note. Sen. Sawyer asked if someone could speak to those issues.

Ms. Collins stated that the drafting note is labeled as “NAMIC requested” because there was not consensus about the inclusion of it. Ms. Collins stated that she does not believe anyone in the industry group opposed the substance of the drafting note but rather some questioned whether it was necessary. NAMIC believes that the peril of flood is unique and it is therefore even more important for insurance companies to have underwriting freedom and to be able to examine claims history and loss experience particular to this peril. Ms. Collins stated that while she agrees with Sen. Sawyer’s statement that there is nothing in the Model to preclude that, there may be something in existing state law to preclude it. Therefore, the suggested drafting note is meant to be a declaratory statement that legislators may wish to take account for in encouraging a flood insurance market.

Mr. Burke confirmed Ms. Collins' statement that there was not opposition to the idea of the drafting note. The intent was to try and draft a fair and impartial proposal and the group wanted to reduce the amount of conflict with the original Model as much as possible.

With regard to the issue of confidentiality raised by Sen. Sawyer, Mr. Ashenfelter stated that when insurers assert confidentiality, trade secret, or proprietary, they have to make sure that they meet the qualifications and prerequisites for those protections or else they will lose such protections. Insurers are therefore cautious about how they mark things in that regard.

Jeff Klein of McIntyre-Lemon stated that McIntyre-Lemon represents the ABA and its subsidiary the Office of Insurance Advocacy (OIA) and noted that they have submitted an amendment which could be inserted in either Section 5 or 10 of the strike-all document. The amendment deals with the fact that the federal banking agencies impose a good degree of due diligence on financial institutions to determine whether a policy meets or does not meet the federal flood requirements. The contours of what is an acceptable private flood program are outlined in the rules that have been implemented pursuant to Biggert-Waters. Banks do not have the underwriting expertise that insurance carriers do and it would substantially improve bank's client's exposure if a provision could be inserted in the Model that states "An insurer may certify that the insurance policy meets the definition of 'private flood insurance,' as specified in 42 U.S.C. § 4012a(b)(7) and applicable federal regulations." To the extent that a lender would have to do whatever due diligence it did around this process by relying on the carrier's own expertise, this language would substantially lessen the compliance burden on the banks.

Mr. Klein thanked the Committee for its consideration. Mr. Burke stated that the industry drafting group does not have any objection to the amendment referenced by Mr. Klein.

Rep. Matt Lehman (IN), NCOIL President, thanked Sen. Sawyer for setting this meeting up and stated that he likes some of the changes to the Model that have been suggested. Rep. Lehman stated that he looks forward to the Committee's next meeting during which the Model can be further discussed.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL MEETING
MAY 29, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee held an interim meeting via conference call on Friday, May 29, 2020 at 1:00 p.m.

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

Other members of the Committees present were:

Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Joe Fischer (KY)
Rep. Edmond Jordan (LA)

Asw. Ellen Spiegel (NV)
Rep. Ryan Mackenzie (PA)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Sen. Matt Lesser (CT)
Sen. Andy Zay (IN)
Rep. Deanna Frazier (KY)
Rep. Chris Humphrey (NC)

Sen. Bob Hackett (OH)
Rep. Mark Willadsen (SD)
Del. Kaye Kory (VA)
Rep. Bill Henderson (WY)

Also in attendance were:

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

QUORUM

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

INTRODUCTORY REMARKS

Rep. Bart Rowland (KY), Chair of the Committee, stated that he knows that everyone is very busy dealing with the global health crisis and thanked everyone for their participation. COVID-19 has had a significant impact on the insurance industry with some lines of insurance being impacted more than others. The impact of COVID-19 on the workers' compensation insurance marketplace has been an issue that has garnered significant national attention. In addition to the overall health and viability of the workers' compensation insurance marketplace going forward, one issue that has been subject to intense discussions has been the actions several states have taken to expand access to

workers' compensation coverage for COVID-19 to include certain categories of employees with some states expanding access to all workers deemed "essential."

Rep. Rowland stated that the panel gathered here today will discuss this in more detail, but this type of legislation, and executive order, creates a rebuttable presumption for certain categories of workers who contracted COVID-19 during statewide shutdowns. Put more simply, the burden of proof is flipped, so that employee workers' compensation claims within these classes of employees and related to COVID-19 are presumed to be covered. Employers can typically rebut claims under certain conditions, including if they can demonstrate the workplace was following current public health guidelines prior to when the employee claims they contracted the virus; and if they can provide proof that the employee was exposed by another source outside of the workplace.

There has also been action on this issue at the federal level. Legislation was recently introduced titled the "Pandemic Heroes Compensation Act" which is modeled after the September 11th Victim Compensation Fund (VCF). The new fund would provide compensation for injuries to any individual, or their families, who are deemed an essential worker and required to leave their home to perform services and who have become ill or died as a result of COVID-19.

Rep. Rowland stated that the impact of this type of legislation on the workers' compensation marketplace has the potential to be extremely significant, with some arguing it to be unwarranted and misguided. As NCOIL is the national insurance legislative policymaking and educational forum, he requested that this hearing be scheduled today so that legislators and interested parties have an opportunity to discuss these issues as they continue to arise in the form of legislation and executive orders.

Rep. Rowland noted that in his home state of Kentucky, Governor Andrew Beshear issued an executive order in April that created a COVID-19 presumption for workers in grocery stores, child-care centers, domestic violence shelters and rape crisis centers, in addition to first responders and healthcare workers. Accordingly, Rep. Rowland stated that he is interested in learning more about these issues and how other states are dealing with them and will deal with them going forward.

DISCUSSION ON IMPACT OF COVID-19 ON THE WORKERS' COMPENSATION INSURANCE MARKETPLACE

Jeff Eddinger, Senior Division Executive at the National Council on Compensation Insurance (NCCI), stated that in early March of this year, NCCI posted its first article on COVID-19 talking about the issues with compensability and the fact that compensability is administered by individual state statutes and most of them require that injuries must arise out of the course of employment and injuries that the general public can be exposed to are generally not covered. However, NCCI did say that there are occupational groups that arguably would have a higher probability for exposure such as healthcare workers. Mr. Eddinger stated that COVID-19 claims are only one issue that the workers' compensation industry is facing. Other issues include mass telecommuting, furloughed workers, extremely high unemployment, and a recession. All of those issues impact the workers' compensation insurance market.

NCCI had to address a couple of different situations. First, NCCI had to make a filing to exclude payroll for furloughed workers that were continuing to be paid even though they

weren't working – those payrolls were then excluded from premium calculations. Second, NCCI made a filing to exclude COVID-19 claims from experience rating and merit rating. Even though there is no claim data that will be seen until the fourth quarter of this year, we all know that claims are occurring but we don't know at this point how many claims are being accepted and denied. States have been attempting to address coverage in a variety of different ways. NCCI is tracking more than 20 states that have put forth bills or Executive Orders that are generally categorized as presumption bills which range anywhere from presumptive coverage for only healthcare workers, only frontline workers, to all workers. NCCI has been tracking all of this on its COVID-19 resource page on its website.

Mr. Eddinger stated that to assist in quantifying the potential impact on the workers' compensation system in NCCI's 38 states, NCCI developed an interactive tool for everyone to use on its website. The tool basically marries NCCI's claim costs data with frequency assumptions related to infection rates, hospitalization rates, death rates, and compensability rates. The tool results in a wide range of potential impacts on the workers' compensation insurance system. At the low end of the range, the tool shows somewhere around \$3 billion and at the high end of the range, around \$80 billion. The good news is that the industry is facing this pandemic from a position of strength. However, there are still many unanswered questions and as Summer arrives, NCCI will have to make decisions if and/or how to reflect COVID-19 in its rate filings. In the meantime, NCCI continues to track and update information on its COVID-19 resource page on its website available to everyone.

Mitch Steiger, Legislative Advocate at the California Labor Federation (CLF) stated that he would be speaking to the Executive Order (EO) recently issued in California which CLF viewed as some rare good news in the ocean of bad news that has surrounded everyone the past few months. CLF views the EO as a big win and is something that CLF supported. Mr. Steiger stated that it is helpful to discuss how things existed in CA before the EO was issued. In CA's workers' compensation system, the burden is on the employee to show that something did happen at work and with an occupational disease claim that is something that can be very difficult to do. The workers' compensation system has always struggled with that and for a lot of workers that do come down with an occupational disease or illness, depending on the employer and who is administering the claims, they find themselves in the middle of it and they find the claims difficult if not impossible to win.

Mr. Steiger stated that like most states, CA has a Governor that approved stay-at-home orders that required workers to stay-at-home. It is not known exactly how many workers in CA were counted as essential – somewhere probably between one-third and half – and still had to go to work at their typical place of employment. Some employers had already started fighting claims. CA had severe personal protective equipment (PPE) shortages at a lot of places of employment and a lot of employers were struggling in trying to figure out how to best protect their workers. Frankly, there were some actors in the system that weren't even trying and were pretty hard on their workers so it was a cauldron of a lot of forces really putting workers in a very dangerous situation. A lot of employees did contract COVID-19 and did file claims which struggled to get through the system. In the middle of that, the Governor signed an EO on May 6 that applied to all essential workers that started from the date of the stay at home order that was in mid-March and ended 60 days from enactment of the EO – July 5. The EO is rebuttable so if employers do believe that they have strong evidence to rebut the claim that contraction

of COVID-19 is work-related, they do have an opportunity to present that. Employers have 30 days to approve or reject the claim and after that if new evidence comes to light they can still rebut the claim but it has to be something that came to light after that 30 day period has expired. The EO also only applies to workers for 14 days from the last day that they worked.

Mr. Steiger stated that CLF believes that the measures implemented by the EO are important things to do not just in an effort to take care of those workers but also to take care of their co-workers and the public. It is a very scary situation right now for a lot of workers and there is only so much that can be done to keep them safe. While everything that can be done to protect them is being explored, at a minimum it needs to be certain that when those workers get sick or God forbid die from COVID-19, they and their families are taken care of. CLF believes that the EO was a great start and a great way to do that. CLF wishes that some of the EO's provisions were stronger and accordingly CLF is in discussions regarding developing legislation that would shore up certain things in the EO while its in place and after it ends.

CA's history with rebuttable presumptions is that it represents somewhat of a thumb on the scale that does usually mean that the worker is able to get coverage for their illness but it does open the door to some delays and gamesmanship from some actors in the system. Given the time sensitive nature of COVID-19, those opportunities should be minimized and therefore CLF is pushing for a conclusive presumption in statute. Everyone is also aware that COVID-19 is not going to go away on July 5 and there are going to still be healthcare workers and grocery workers exposed to some pretty severe hazards so CLF would like to see something that continues to cover more people. One thing that CLF would like to see to strengthen the EO is that there are a lot of workers that didn't fall into the general category of essential but are still at a very high risk of exposure to COVID-19. CLF would therefore like to have a deeper conversation about who the EO covers.

Mr. Steiger then touched upon cost-estimate issues. Before the EO was signed, the CA workers' compensation rating bureau released a cost-estimate that put the range at somewhere between \$2 billion and \$34 billion for a presumption that lasted until the end of the calendar year and presumed that 100% of workers with compensable claims would file them. CLF believes that range highlights the difficulty in guessing what the cost of these are going to be. The bureau released an updated study following the EO's release that brought the mid-range estimate down to around \$1.2 billion which is about 7% of the overall cost of the workers' compensation system. The more specific a presumption statute or EO is, the easier it will be to estimate costs but it is a very difficult thing to do as there is a lot we don't know about COVID-19, how the system will respond to it, who will come to work, and who won't. Despite that difficulty, CLF believes that in the context of stay at home orders, the vast majority of COVID-19 illnesses are going to be work related so a presumption makes sense.

Mr. Steiger stated that the bureau passed a few regulatory changes to respond to the EO. The biggest change is that the bureau chose not to experience rate COVID-19 claims which CLF believes works well with the workers' compensation presumption to make sure that employers that just happen to be in an industry where COVID-19 is a major concern, it helps minimize the impact to them and their work comp costs to say while there is a lot of things employers can do with PPE and social distancing to reduce worker exposure to COVID-19 there is only so much that can be done and certain

employers are going to be hit harder than others. In the interest of fairness CLF stated that it made more sense to spread the costs out across the entire system.

Richard Marcolus, Chair of the New Jersey Council on Safety & Health (COSH) stated that in addition to his position at COSH he is also a plaintiff's lawyer in NJ, a carpenter by trade and a member of the carpenter's union in Essex County, NJ. One of the things that he has found fascinating in NJ is that despite having the second highest rate of COVID-19 infections and deaths in the country, NJ has a wealth of different types of industry. In addition to being called "the garden state", NJ has fishing, wildlife, beaches, all types of tourism, and a lot of travel. Accordingly, NJ has been working on trying to figure out in a fair manner how to get people who have been sick and injured by COVID-19 the proper medical treatment. Mr. Marcolus stated that on April 3, a worker in NJ went into the warehouse where he worked about 25-30 hours per week. Because of his part-time status he was not offered health insurance, and he did not have health insurance. He noticed that some of his co-workers wore masks while others did not and a few days later he got sick. He went to his employer and said he did not feel well and did not want to get anyone else sick and asked what he should do. He was directed to the HR office where he was given a form to fill out for unemployment benefits and was told good luck.

Since he had no health insurance and was not even sure if he was entitled to unemployment benefits, the gentlemen – who ended up having COVID-19 – continued to work and invariably infected other people at the facility. The man ended up being ok but the problem that the NJ legislature has tried to address is how to get people who we believe were infected with COVID-19 while working fair compensation when there really is no avenue for them at this point. Most people when dealing with their employer end up being whisked into some type of program that the employer wants them to go through and it's generally not workers' compensation. Fortunately, NJ already has a law called the Canzanella Act which deals with workers' compensation benefits for first responders following 9/11. The Act was just recently signed into law and it basically says that for any first responder that contracted cancer as a result of their work there is a presumption that the cancer was work-related. Mr. Marcolus stated that someone had inserted "pandemic" into the bill so those first responders now have the presumption applied to them if they contract COVID-19.

However, the law leaves out all the other essential employees in NJ that were categorized as such by an EO issued by the Governor. That basically included anyone who was required to go to work such as gas station attendants, food delivery employees, and grocery store staff. A bill is currently pending in NJ that would give those employees a presumption which essentially says that if you contract COVID-19 during the time period we are in a state of emergency it is presumed that said contraction is work-related. It is intended that the bill gets the insurance companies involved – NJ has a private insurance industry that handles workers' compensation – to come to the table to be able to at least pick up the claims rather than litigating them and arguing over where the contraction took place. Without the bill, very few claims have been picked up by insurance carriers and unless you are a first responder there is really no avenue. Courts are open but only remotely and this is causing a hardship.

Mr. Marcolus stated that the bill is important and should be signed into law. It is also important to note that the presumption is rebuttable so employers can present evidence that the employee contracted the virus elsewhere. If the presumption is overcome, then

you go back to a level playing field with the burden back on the employee. Mr. Marcolus stated that he is hopeful that the bill will be signed into law and it is good to hear that other states have enacted similar legislation and EO's. So many employees are ignorant when dealing with this and they are looking to their employer for help. Mr. Marcolus stated that several people have come into his office asking for help who are on unemployment and that is a drain on another system and that is not where the risk should be considering that the likelihood that the people who are going to work every day and dealing with the public contracted COVID-19 while working is very high.

Dr. Robert Hartwig, Clinical Associate Professor, Finance Department and Director, Center for Risk and Uncertainty Management at the Darla Moore School of Business University of South Carolina, stated that in his current academic role he looks at the workers' compensation situation in the context of the impact on the overall property & casualty insurance marketplace. The impact on workers' compensation is potentially very large but so are the potential impacts on business interruption claims and other potential claims that are out there. In terms of magnitude, workers' compensation is either the largest or the second largest impact for insurers depending on which scenario you subscribe to – some say business interruption is the largest. It all depends on the severity of the event and the recovery and those things remain largely unknown at this point.

In terms of potential losses, Willis Towers Watson has released a comprehensive analysis of global impacts and they have asserted that potential impacts for losses for workers' compensation in the U.S. range anywhere from about \$2 billion to \$23 billion. Within that are ranges. The \$2 billion range is relatively optimistic with the virus being relatively contained and a strong recovery occurring. \$2 to \$7.5 billion is a range forecasting a moderate type of COVID-19 event. For a particularly severe event the range is \$7.5-\$23 billion. When you start talking about those sums, and couple them with sums that are much larger than that for potential business interruption losses what concerns insurers is the fact that this ultimately becomes a systemic risk for the property & casualty insurance industry. If you accumulate all of these losses across all lines of insurance it becomes potentially destabilizing if you wind up in a situation where the presumption in workers' compensation goes uniformly against the insurance industry across the country. If you couple that with a situation where, for instance, the virus exclusions for business interruption claims are overridden it becomes a systemic issue of the overall insurance industry. Accordingly, when thinking about these issues it is important to remember that the workers' compensation insurance industry does not live in a vacuum and is a large and important line within a large and important industry.

Beyond the presumption issue, there is also the issue of the revenue of workers' compensation. This will certainly be the largest and fastest drop in premiums that this industry has ever seen, at least on this side of the Great Depression, as we see payrolls plummet and we know what types of industries that will most likely occur in such as service sectors. We're looking at several billions of dollars potentially exiting the workers' compensation market. On the revenue side of things, there is a concern obviously as insurers rely on revenue for a variety of different reasons such as paying claims and investing premiums to generate investment income. Dr. Hartwig stated that there has been some discussion as well as to whether or not the COVID-19 experience should be experience rated: should the experience employers are seeing today in 2020 with respect to COVID-related claims be in some way shape or form or at all reflected in rates going forward. Given that we are not looking at a vaccine for the virus being widely

available at least until the middle of 2021 the reality is that the virus will be with us at least for a year and probably beyond that. Accordingly, those realities could lead one to believe that it makes sense to include the experience of COVID somewhere in the rating structure. Insurers would absolutely need to reflect the fact that the flip in presumption could have a very material impact and that may be idiosyncratic by state.

Dr. Hartwig further stated that it is important to keep in mind that with workers' compensation, many employers have very large deductible programs and there are employers that are largely self-insured for this particular exposure as well. That is important to keep in mind when thinking about flipping the presumption. There is also a lot of interaction that is likely to occur in the months ahead associated with The Occupational Safety and Health Administration's (OSHA) role – and state equivalents of OSHA – and other regulatory agencies that are charged with regulating workplace safety. We are only at the tip of the iceberg with those issues. For instance, OSHA just recently issued guidance essentially asking employers to investigate the genesis/origin of COVID-19 claims among employees. There have been several accusations against OSHA as to whether they are doing enough and being proactive enough with these issues. There is a huge role for federal and state occupational and safety and health administrations out there to help establish guidance in this area.

Erin Collins, Vice President of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that the workers' compensation system has been in place for over 100 years in this country working to provide compensation to employees directly impacted by injuries on the job. One of the hallmarks of the concept of the workers' compensation system is that workplace injury and disease have to be specific and peculiar to a particular job. A communicable disease like COVID-19 is a worldwide pandemic that everyone is subjected to. None of this means that U.S. citizens impacted by COVID-19 either financially or by virtue of contracting the illness itself cannot get help. It does not follow though that such help comes from a specific business sector that isn't meant to contemplate these types of events like pandemics. In fact, some of the prior panelists were talking about the impact of COVID-19 on the public at large and hoping to get the insurance sector involved in that impact which is not what the workers' compensation system is designed for.

Ms. Collins stated that some states have taken steps to force workers' compensation for COVID-19 to a broad array of people. The challenge in that, apart from what has been discussed in terms of the nature of the pandemic, is that some of the actions seen have been so broad that they can be construed to contemplate people working remotely or off of work when the virus is contracted or even presumed to have the illness without any confirmation. Additionally, some of the actions taken are tied to states of emergency as opposed to the length of stay at home orders and in the insurance industry it is known through experience and prior crises that states of emergency can stay in place for extremely long periods of time – sometimes years after a crisis.

The retroactive nature of actions like this are also concerning not just from a constitutional perspective of impeding contracts but also on the basis of solvency as Dr. Hartwig noted. Insurers have reserves for their existing claims based on preexisting actuarial calculations of exposure. Paying these retroactive and uncovered claims restricts their ability to pay claims for their existing contracted risk. That is something that neither the workers' compensation system nor the broader insurance industry is built to contemplate. In terms of what the answers are, NAMIC is in favor of anything the

federal government can do to assist the economy and certainly COVID-19 victims through the crisis. NAMIC believes that the federal government is the only entity large enough and broad enough to assist in times of pandemic and NAMIC is in favor of any activity in that regard, but the workers' compensation system is not the right answer to a pandemic crisis.

Rep. Bart Rowland (KY), Chair of the Committee, stated that Ms. Collins' last point brought up an issue that he is curious of regarding federal government activity. Rep. Rowland asked if something similar to the Terrorism Risk Insurance Act (TRIA) enacted following 9/11 should be enacted by Congress to deal with these types of workers' compensation claims. Ms. Collins stated that she is aware of the federal bill titled the Pandemic Heroes Compensation Act but has yet to see the language of the bill. However, certainly the outline of it in creating federal assistance for citizens impacted by COVID-19 is certainly something that would fall in line with what NAMIC is discussing in terms of federal government assistance.

Rep. Matt Lehman (IN), NCOIL President, stated that he is curious if by creating conclusive presumptions in this area the workers' compensation system is being turned on its ear especially regarding diseases. If this box is opened up with COVID-19, what will happen to future cases of catching a really bad case of the flu? Mr. Marcolus stated that NJ's Canzanella Act only lists specific cancers and the presumption in the pending legislation is strictly limited to COVID-19 – it will not include the flu or anything else. The state legislature or the federal government can always decide what it wants to cover and not cover.

This is really not a case of turning the workers' compensation system on its ear but rather putting another nail in the coffin. The workers' compensation system was designed to deliver benefits in a fast, efficient manner without any controversy. It was designed such that the injured worker cannot sue their employer but if they get injured while working benefits must be paid and the worker should not have to go through two years of litigation to get those benefits. The pending NJ legislation is an effort to say to the industry "time to pick up the ball on this." Even though the legislation calls for a presumption the case still has to be proved and without the presumption you can still win the case but it just makes it more difficult. If the insurers are not going to come to the table and pay for the medical and time out of work under a presumption they certainly are not going to pay if there is no presumption so you might as well stop all the cases and have a law that says COVID-19 is not work-related as a matter of law because you cannot prove it. Mr. Marcolus again stressed that NJ's pending legislation is limited to only COVID-19.

Mr. Steiger stated that in California there was a bill introduced a few weeks ago in the Senate Labor Committee that contained a rebuttable presumption for COVID-19 for healthcare workers. The bill also included a few other conditions such as muscular and skeletal conditions. The bill did not get a single "yes" vote in Committee which is fairly typical of CA's experience with workers' compensation presumptions where even if there is fairly overwhelming evidence in favor of one the CA legislature is fairly hostile towards them. Accordingly, when CLF believes it has a pretty strong case for a presumption it almost never passes. Mr. Steiger stated that the presumptions that currently exist in CA pre-date his time in CA. In his experience, CA legislators start from a place of skepticism with these presumptions and the only real reason the current bill is being considered is because of the extreme situation we find ourselves in. Accordingly, Mr.

Steiger stated that he does not believe the concern of opening up “pandoras box” is one that is much to worry about going forward.

Ms. Collins stated that she believes Rep. Lehman made an excellent point and agreed with him in that establishing presumptions for diseases turns the workers’ compensation system on its head. What we’re talking about is going from a system that is based on the fact pattern of particular cases to presumptions that deal with burdens of proof. When you talk about rebuttable presumptions you are talking about having to create a higher burden – clear and convincing proof – to overcome a rebuttable presumption which in the case of a disease like COVID-19 is almost impossible. Also, if it is a conclusive presumption that cannot be overridden. Ms. Collins stated that going down the road reconsiders in a dangerous way what the purpose of workers’ compensation is and would endanger the system itself.

Dr. Hartwig stated that as a follow-up to Ms. Collins’ remarks, presumptions will establish precedent maybe not for COVID-19 but for COVID-20 and any other diseases down the road and the reality is that there is no way that insurers at this point or that point are going to be able to assess doing anything other than pricing this in to the base rate for workers’ compensation. They will then have to have the expectation permanently that a presumption could potentially occur for a disease like this or with precedent the bar could even be lowered in time. This directly results in higher costs for businesses; it would be passed on dollar for dollar to businesses large and small all across America. There has been a lot of discussions about the Walmarks and Amazons of the world but the reality is that the burden will fall on small and medium sized businesses all across the country.

Sen. Matt Lesser (CT) stated that he understands that there may be a moral hazard associated with these issues and that he heard earlier that NJ does not allow for experience rating for this. Clearly there are some categories of employers that are inherently risky such as hospitals and nursing homes and within those categories there are employers taking aggressive measures to mitigate risk and invest in PPE and to employ CDC guidelines in office settings and it seems unfair that if you don’t want to allow for rating of an experience then you are basically asking irresponsible employers to be subsidized by responsible employers. Sen. Lesser asked if any of the panelists had any thoughts on that and whether that would affect employers decisions to re-open or invest in PPE.

Mr. Steiger stated that he is not sure if they disallowed experience rating in NJ but they did such in CA and CFA had the same concern noted by Sen. Lesser. CFA didn’t necessarily agree with all of the arguments in support of that proposal that sort of treated it as an inevitability that workers were going to contract COVID-19 and nothing could be done to prevent that. The reality is that there are a lot of things employers can do to limit exposure and in some ways prevent it and CLF believes that there is still plenty of incentive for employers to treat these illnesses. From a pure cost perspective, high deductible plans are very common so even though it is not going to affect their x-mod there are still definitely going to be costs for a lot of those employers and for a lot of self-insureds.

Also, there is the fact that these are people that they care about and don’t want to see get hurt and will do what they can to help keep them safe. There has also been a lot of guidance released by the California Department of Public Health that CLF believes does

have the force of law and can be enforced under CA's safety regulations. So, if an employer decided to flout those standards there will likely be some sort of citation action against them. Finally, there is the argument that a lot of employers, especially those heavily populated by the public like grocery stores and hospitals, that have other liability concerns besides workers' compensation where other people are coming into their place of business where they may be some sort of risk of being sued if you are especially egregious in not keeping people safe. All of those things will help encourage employers to help do what they can to help stop illnesses.

Mr. Eddinger stated that NCCI filed to exclude COVID-19 from its experience rating in all of its 38 states. NCCI's feeling in doing so was that even though there are some things that employers can do to mitigate exposure, it was not necessarily predictive and there were way too many other types of variables which wouldn't necessarily mean that hospitals or employers that are hit harder that it was necessarily due to a lack of controls. There could be other random factors involved.

Asw. Ellen Spiegel (NV) stated that she has been thinking about all of the employers that do not enforce social distancing for either their employees or customers and asked if someone could speak to the impact that said lack of enforcement would have on the presumption. Mr. Marcolus stated that in NJ that would not matter. The statute, and most workers' compensation statutes are no-fault statutes, which means that it does not matter if the employer took precautions and in NJ the statute states that unless it is an intentional act it does not matter. And the intent must be clear as in NJ there have been cases where somebody takes the shoring out of a ditch and the ditch caves in and the person gets killed but it was ruled to not be intentional but only negligent. In this instance, unless it was shown that there was an intent for someone to get the virus then it would not affect the case at all. It would be evidential but without the presumption there are still other issues with those types of cases which is going to make it very difficult. Everyone is not socially distancing so you could certainly bring that in as evidence but quite frankly you don't need that.

The problem with COVID-19 is that there are so many different ways to get it and the fact that you wear a mask may not even prevent you from getting it – it may only reduce your risk. Mr. Marcolus stated that he does not believe that type of evidence is going to win or lose a case. Without a presumption you have a very difficult burden of proof but you are not going to have a separate cause of action in NJ if the employer was not social distancing; a worker will be stuck with the same type of case as with an employer that does have social distancing and uses masks and uses PPE.

Mr. Eddinger stated that the conversation has been about a presumption for any worker that reports to work and there may be a more measured way to look at "out of or arising in the course of employment." In other words, there are a class of workers whose job it is to deal directly with sick people and even within the healthcare industry there are people whose job it is to deal with COVID-19 patients. On the other end of the spectrum there are people whose job as a grocery worker is not necessarily to deal with sick people but we all know now that they come in contact with sick people. Measures are being taken in grocery stores and other places to minimize or stop that direct contact. Accordingly, there is a class of workers where you can say it is recognized to be part of their job and it is presumed that if they catch this disease it is because they deal with and treat people with the disease. That is perhaps a more measured way to look at this.

Asm. Ken Cooley (CA), NCOIL Vice President, stated that these are very important issues and the problem with the fact pattern is that there are so many variables. We've seen the collapse of the economy and so many businesses are closed and you have units of government saying for safety purposes people should be quarantined. But certain businesses are not put in quarantine because there is a public good associated with them; these are businesses where the worker is employed and doesn't have access to workers' compensation so they need to take care of themselves by going to work in an environment where even though we are now in June we are still asking questions about how the virus spreads and things of that nature. This is an extraordinarily complicated and unusual fact pattern and therefore what is being done on COVID-19 will not spill over to more run-of-the-mill diseases/ailments. There are a lot of factors that make this very unique and you end up trying to figure out how best to help people in the context of how the system works.

Asm. Cooley stated that he thinks a lot of people are at these jobs but afraid of being there and there is such little known about the virus. However, they are still going to work by reasons of public policy as in many states certain jobs are deemed "essential." Those workers are therefore bearing a risk for some public policy good in an environment where the precise details of how you get the virus are unclear. With regard to PPE and safety protocols, people are not really sure of what assures them of protection. There is somewhat of a level of magic thinking that if you do "x" then "y" will occur. Asm. Cooley reiterated that this is a good conversation to have and that it is unlikely that the COVID-19 measures will spill over to other diseases as this is a unique fact pattern and it is complicated by the fact that we all don't want the whole economy to collapse and we want businesses opening with their employees who are then interacting with the public. Balancing the equities is very difficult and important. It is very constructive to have a conversation at this point. It is hard to believe that in February there were no deaths and now we are over 100,000.

Sen. Bob Hackett (OH) stated that a lot of states are also trying to develop some type of liability protection for businesses. Ohio is trying to incentivize its businesses to come back and operate. It is important to be very careful in how this subject is addressed and to make sure we don't really hurt the economy resulting in businesses not coming back. That is why Ohio is trying to develop liability protection legislation at the same time of developing other measures.

ANY OTHER BUSINESS

Rep. Rowland apologized to the interested parties on the call since all of the time dedicated to questions was taken up by legislators. Accordingly, Rep. Rowland stated that if interested parties have any comments or questions they would like addressed or feel that it would be a good idea to have a follow-up conference call to please let NCOIL staff know. The Hon. Tom Considine, NCOIL CEO, reiterated Rep. Rowland's statement and noted that if interested parties would like to have a follow-up call it could be scheduled soon.

ADJOURNMENT

There being no further business, the Committee adjourned at 2:05 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
INTERIM COMMITTEE CONFERENCE CALL MEETING
JUNE 11, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee held an interim meeting via conference call on Thursday, June 11, 2020 at 12:00 p.m.

Senator David Livingston of Arizona, Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Martin Carbaugh (IN)	Asw. Ellen Spiegel (NV)
Rep. Matt Lehman (IN)	Asm. Kevin Cahill (NY)
Rep. Joe Fischer (KY)	

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
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), Vice Chair of the Committee, and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee waived the quorum requirement without objection by way of a voice vote.

INTRODUCTORY REMARKS

Sen. David Livingston (AZ), Chair of the Committee, stated that because of concerns of being disconnected from the call due to bad cellular service and a lack of internet connection, Vice Chair Spiegel will handle some of the discussion and review of the proposed amendments to the NCOIL Articles of Organization (Articles) and Bylaws. Sen. Livingston noted that he and Vice Chair Spiegel have been working on those proposed amendments with NCOIL staff the past several weeks and the purpose of the call today is to discuss, review, and vote on them. Sen. Livingston also noted that he has some sponsor's amendments to offer during the call in addition to the proposed amendments that were distributed prior to the call.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL ARTICLES OF ORGANIZATION & BYLAWS

Vice Chair Spiegel stated that the first amendment is one of the sponsor's amendments just referenced by Chair Livingston – on page 1. After the proposed amendments were sent out, differences were noted in the Preamble and Section 3(A) of the Articles regarding membership. Section 3A states that "General Membership shall be afforded to all States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico."

However, the Preamble does not mention territories, the District of Columbia, or Puerto Rico. Accordingly, in an effort to simply reconcile those provisions it is proposed that the first sentence of the Preamble read “We, duly elected representatives of the People to the Legislatures of the 50 sovereign States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico...” and the rest of the provision would remain as-is.

No questions or comments from either legislators or interested parties were offered regarding the proposed amendment.

Vice Chair Spiegel stated that the next amendment is on page 4 and is again one of the sponsor’s amendments just referenced. In Section 7 of the Articles the citation to the 30-day rule needs to be changed from Section 4G to Section 3G. The same change also needs to be made in the corresponding Amendments Section of the Bylaws on page 9.

No questions or comments from either legislators or interested parties were offered regarding the proposed amendment.

Vice Chair Spiegel stated that the next amendment is on page 4 - a new section is proposed to be added to the Articles as Section 8 titled “Reasonable Departure from the Articles of Organization.” The reasoning behind this proposed amendment is fairly straightforward. Vice Chair Spiegel stated that she believes it is proper to allow for reasonable departure from the Articles and Bylaws in the event of an emergency such as the one in which we currently find ourselves. A large, national organization such as NCOIL should not be constrained when trying to operate during an emergency. Vice Chair Spiegel also noted that the same language is proposed to be included as an amendment to the Bylaws as new Section 7 on page 9.

Chair Livingston noted that this amendment is essentially the heart of why this interim meeting was called as NCOIL needs to be able to function no matter what is going on in the world and in each of the respective states. Therefore, it is critical and appropriate to do this at this time.

Wes Bissett, Senior Counsel, Gov’t Affairs at the Independent Insurance Agents & Brokers of America (IIABA), stated that he appreciates that the proposed amendment has limits and triggers applied to it but noted that he and his colleagues have scratched their heads as to the openness and subjective nature of it. Mr. Bissett stated that as he reads the Articles and Bylaws he sees a significant amount of flexibility and asked if some examples could be provided where there would be a need for invoking the reasonable departure authority.

Chair Livingston stated that generally, the Articles and Bylaws are somewhat open-ended so as to account for how the respective states each operate differently. Chair Livingston asked the Hon. Tom Considine, NCOIL CEO, and Will Melofchik, NCOIL General Counsel, to offer examples in response to Mr. Bissett’s question. Cmsr. Considine stated that there are specific things in the Bylaws such as the requirement for officers to be elected at the Annual Meeting and noted that, unfortunately we may be looking at a year where there is no Annual Meeting. There is also a requirement that there be three NCOIL conferences annually. In the next week or so we may find ourselves down to two and there could be a chance where we could end up with one

meeting in 2020. Cmsr. Considine further stated that in discussions with Chair Livingston, Vice Chair Spiegel and Mr. Melofchik leading up to this call, it did not make sense to specifically edit the Articles and Bylaws to account for every possible contingency. Chair Livingston stated that is correct.

Mr. Melofchik stated that there are also provisions in the Articles and Bylaws that relate to the adoption of budgets and audits of the organization within certain timeframes. Those are examples of how this proposed amendment would allow reasonable departure from those requirements.

Paul Martin, VP of State Relations at the Reinsurance Association of America (RAA), stated that RAA, the American Property Casualty Insurance Association (APCIA) and the National Association of Mutual Insurance Companies (NAMIC) submitted a comment letter yesterday regarding the proposed amendments. There is certainly no objection to the idea that NCOIL needs flexibility given what we have seen the past few months and it can be appreciated that there may be times where there needs to be meetings held on an expedited basis. However, the language that is in the current proposed amendment permits for a fair amount of flexibility that RAA, NAMIC and APCIA would like to see some more details as to what would be a better trigger perhaps for when the flexibility is authorized.

One of the specific concerns focuses on notice to interested parties especially since it is noted in the Preamble that part of the purpose of NCOIL is to share information and a lot of that information is from the industry. When discussions start regarding reasonable diversions away from the Articles and Bylaws, that raises a lot of questions as to how interested parties can provide information in a timely fashion and have meaningful conversation. It is encouraged that the Committee reviews the comment letter submitted and the associations are more than happy to work with Committee. It is understood that interested parties do not get a vote on matters that are before NCOIL but at the same time the value that interested parties see in NCOIL in part is the ability to share information in a timely manner and it is believed that throughout the pandemic industry has shown its ability to be flexible and gather in order to answer questions and provide feedback on certain issues and industry welcomes the opportunity to do that with NCOIL going forward.

Chair Livingston stated that he also values the presence of interested parties at NCOIL greatly and believes that transparency and a collaborative working effort are critical for NCOIL to be successful on an ongoing basis. That has been a key to success in the past. Chair Livingston stated that he and Vice Chair Spiegel did receive a copy of the comment letter noted by Mr. Martin and asked Mr. Melofchik if it was sent out to the other Committee members. Mr. Melofchik stated that the letter was sent to the other Committee members as well as everyone else who registered for this call. Chair Livingston stated that on an ongoing basis NCOIL of course wants to hear from legislators and also interested parties. Together, that is what makes NCOIL successful.

Lauren Pachman, Counsel and Director of Regulatory Affairs at the National Association of Professional Insurance Agents (PIA), stated that in response to the comments made by Cmsr. Considine and Mr. Melofchik regarding officer appointments, budgets, and audits, all of those provisions seem to be in the Bylaws – none seem to be in the Articles. Accordingly, Ms. Pachman stated that she is still unclear as to why the Articles need the amendment to allow for reasonable departure. Ms. Pachman further stated

that she agreed with the previous comments made by previous commenters regarding vagueness, broadness, and necessity.

Cmsr. Considine stated that as noted earlier, it did not seem necessary to edit for every potential circumstance. Further, the Articles do require each Executive Committee member to attend in person at least one Executive Committee meeting annually, or else they would be removed from said Committee. Ms. Pachman stated that she was going to bring that provision up and recommended that in the spirit of making these adjustments the words "in person" be struck from that provision in the Articles (Section 5.1.).

Cmsr. Considine stated that even if "in person" was deleted, the provision still requires three meetings of the Executive Committee and if circumstances such as those we are in are such that there are not full Executive Committee meetings, there would need to be a reasonable departure under the circumstances limited declared by both the Executive Committee and officers. Accordingly, this is not meant to allow for a President of NCOIL to simply throw out the Articles and Bylaws to allow she or he to do whatever they want. Chair Livingston stated that he is not worried about that. Ms. Pachman stated that is not a concern under the current circumstances but the Articles are meant to live beyond the current administration. It is much easier to remove the words "in person" and the Articles do not need the reasonable departure amendment.

Karen Melchert, Regional VP of State Relations at the American Council of Life Insurers (ACLI) stated that she agreed with the comments made by other interested parties regarding the broadness of the reasonable departure amendment and noted that the Committee may want to consider narrowly tailoring the reasons and scope to which Articles may be departed from. The word "reasonable" is an interesting word that can be interpreted in many ways. For something as dramatic as departing from the Articles, it may be prudent to list specific circumstances which can trigger a departure such as procedural measures other than the adoption of Models and Resolutions.

Chair Livingston stated that there is a fine line between how specific the amendment should be and how broad it should be and noted that the current language strikes a good balance. Cmsr. Considine stated that NCOIL has been around for 50 years and in his experience with NCOIL for close to 20 years prior to becoming NCOIL CEO there have always been different people leading NCOIL but they are people of good faith. Cmsr. Considine stated that he is scratching his head as to some of the concerns raised because even if there was an NCOIL President who wanted to depart from the Articles or Bylaws, it is hard to imagine that the rest of the officers would allow that to happen. Chair Livingston stated that he agreed with Cmsr. Considine and stated that he believes the Executive Committee members would not allow for that either.

Andrew Kirkner, Regional VP of State Affairs at NAMIC, stated that he believes there are some suggestions in the comment letter referenced earlier that may address some of the concerns raised during this call and also align with the comments made by Cmsr. Considine. One of the suggestions in the letter is to require a unanimous Executive Committee vote for a reasonable departure. That speaks to what Cmsr. Considine just said regarding the members of NCOIL keeping checks and balances in place. Another suggestion is to tighten the language regarding states of emergency by replacing it with nationwide states of emergency as opposed to a single state of emergency. Chair Livingston stated that Mr. Kirkner's last point was previously discussed prior to this call.

but it was ultimately decided that it was important to have flexibility and the hope and intent is obviously that the provision would not be used very often.

Vice Chair Spiegel stated that the next amendment is on page 4 and deals with Section 2 of the Bylaws - Voting. The section is proposed to be split into subsections A and B, with subsection A dealing with the procedure regarding voice votes. The current section states that all voting shall be by voice vote except that a roll call vote shall be taken at the direction of the Chair or upon the request of two members of that Committee. The thought is that given the possibility of NCOIL Committees meeting and voting on measures via conference call or Zoom more often in the future, it makes sense to lower the threshold needed for a roll call vote. So, the section is proposed to now read that a roll call vote shall be taken at the direction of the Chair or upon the request of "a member of that committee in instances where there are dissenting votes."

No questions or comments from either legislators or interested parties were offered regarding the proposed amendment.

Vice Char Spiegel stated that the next amendment is the proposed new subsection B titled "Written Consent in Lieu of Meeting." The language is proposed to deal with situations like that which occurred with the Rebate Reform Model Law at the Spring Meeting in Charlotte this past March. During the meeting of the Financial Services & Multi-Lines Issues Committee in Charlotte, the Committee voted to adopt the Model as amended by the Committee. Staff then made those changes to the Model upon arriving home and then sent the Model via e-mail to the members of the Executive Committee saying "the version of the Model, which we attach to this e-mail, is the approved version with the changes incorporated. Unless we hear to the contrary, we will post the Model as final by ____".

It is here that an additional Sponsor's Amendment referenced earlier is offered which would clarify that "Written Consent in Lieu of A Meeting" can be used only for matters on which there has been previous discussion and an opportunity for public comment. So, subsection 1 would now read "A decision on any matter previously discussed with an opportunity for public comment and evidenced by..." and the rest of the subsection remains as-is. Similar language would also be added to subsection 2 so it would now read "Unanimous consent on a matter previously discussed with an opportunity for public comment as achieved..." and the rest of the subsection remains as-is. Chair Livingston thanked the interested parties that reached out with suggestions regarding this amendment.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), stated that AHIP did not join the comment letter referenced earlier, but supports many of the issues raised in it. AHIP did not submit formal comments but did reach out to NCOIL staff to raise concerns about this amendment which the sponsor's amendment is intended to address. The sponsor's amendment largely addresses AHIP's concerns but Mr. Peppard suggested that given the direction this is headed and its intent, it would be helpful for transparency purposes that if this action was taken, then at the next meeting it would need to be confirmed and ratified so that publicly everyone sees that has happened. Understanding that there are many discussions at meetings and changes to certain things are written afterwards, it is still important for interested parties to actually see what has been agreed upon.

Mr. Martin stated that he believes the sponsor's amendment helps but noted that it appears that this amendment to the bylaws is not supported by the Articles as outlined in the comment letter referenced earlier. Mr. Martin stated that even with the sponsor's amendment he is still scratching his head as to how it would function since it was disclosed. The sponsor's amendment helps with transparency, but he stated that he is not sure it gets RAA to where it wants to be.

Cmsr. Considine stated that he was surprised to hear any comments that the sponsor's amendment was just disclosed today because anyone that had reached out about this amendment, including the RAA, was reached out to by Mr. Melofchik to explain the sponsor's amendment. With regard to the suggestion from Mr. Peppard, it is not uncommon, although infrequent, in situations where the officers have meetings to take certain action in between the national meetings where there was no executive committee meeting – this may have happened twice in the past five years – the executive committee at its next meeting has ratified those actions. Accordingly, that is a matter of NCOIL practice, but that may not be something that needs to be detailed in Articles or bylaws – that is up to the members of the Committee, but nowhere in the Articles or Bylaws is it said that if the officers take action in between meetings then it needs to be ratified by the executive committee. As a matter of practice, and policy, that is the way NCOIL operates.

Dennis Burke, VP of State Relations at RAA, stated that he spoke to Mr. Melofchik about this proposed amendment but had not seen it in writing. Mr. Burke stated that the comment letter referenced earlier can be distilled to say that interested parties are interested in as much transparency and as much opportunity to inject views before a vote is taken. The word "notice" is used more in the letter besides "a" and "the." There have been instances in the past, before Cmsr. Considine's arrival as CEO, where just as it happens in state legislatures, there is a committee vote and then you want to have a challenge on the floor and the executive committee is essentially that.

So, when there is a written consent in lieu of a meeting, even if it is ratification of something that was passed by a committee in the absence of notice to all legislators and interested parties in some way, that level of interaction is important because the executive committee is comprised of different people and perhaps different views than the policy committee. Interested parties look for some opportunity in the rare circumstances where they would attempt to educate non-committee members on some of the issues to avoid unintended consequences. Those are the issues that the comment letter seeks to address. Clearly, interested parties do not need the notice to be part of the governing documents. They would like to see it be a formal practice of NCOIL that has been adopted and if there is a recommendation for that to be part of the amendments to the Bylaws it would be very much appreciated. Chair Livingston stated that transparency and making sure that objections are heard has always been critical and it is important that such practice continues.

Mr. Bissett stated that the sponsor's amendment improves upon the language and offered a way to further improve it. The example made by Mr. Burke entailed a substantive committee taking action on a matter and then the executive committee taking action on it without ever having discussed it before so perhaps language should be included to make clear that the discussion/comment requirements apply to the committee that is taking the measure up so that there would not be new issues

addressed by a committee that never discussed them before that had been previously discussed by another committee.

Mr. Bissett further suggested that the ability to do this be restricted to cases where there is unanimous consent. There is quite a bit of statutory law that relates to the ability of organizations to take action without a formal meeting, both for private corporations and non-profit entities. Many state laws restrict the ability of organizations to do that and many of those laws require that there be unanimous consent. Given NCOIL's nature, there is a heightened interest in having transparency and openness and you wouldn't want a situation where there is action taken outside of meetings and that having the effect of stifling debate and opposition. At the same time, if there are issues where all members agree upon, it is conceded that there is no need to go through the formality of having an in-person or telephonic meeting. Accordingly, the best spot to land on this to balance everything is to limit this to cases, as many state laws do and as the National Association of Insurance Commissioners (NAIC) does, to cases where only there is unanimous consent.

Mr. Melofchik stated that with regard to Mr. Bissett's first point, that suggestion was previously discussed in conversations leading up to this call and it was thought that could be addressed by adding the words "by the Committee voting" so section 1 would now read: "A decision on any matter previously discussed by the Committee voting, with an opportunity for public comment, and...." The same language would also be added to section 2.

Chair Livingston stated that he is comfortable with that language since it strikes a good balance between ensuring transparency and not restricting the ability to function. Hearing no further questions or comments, Chair Livingston moved on to the next amendment.

Vice Chair Spiegel stated that the next amendments are to Section 3 of the bylaws on page 5. These amendments are simply technical in nature and are proposed for clarity. Instead of having the title of the Section read as "Executive Meetings" it is proposed to be changed to "Committees." Also, in subsection A, language is proposed to be added to the first sentence so it reads "There shall be an Executive Committee which shall meet..." and the rest of the subsection remains as-is.

No questions or comments from either legislators or interested parties were offered regarding the proposed amendment.

Vice Chair Spiegel stated that the last amendment is again technical in nature. A re-numbering of the sections of the bylaws is proposed - starting with now Section 4, Finances, at the bottom of page 7, and ending with the new Section 7 on page 9, Reasonable Departure from Bylaws.

No questions or comments from either legislators or interested parties were offered regarding the proposed amendment.

Rep. Matt Lehman (IN), NCOIL President, stated that he appreciates all of the comments made today and noted that we are currently in the middle of unprecedented times. When the NCOIL Articles and Bylaws were established, it is hard to believe that anyone anticipated not meeting in-person. There could be weather issues and other

things that require moving meetings, but the issue of a national shutdown most likely never came to light. Accordingly, while these amendments are probably not perfect – just like anything else – it is important for NCOIL to be in a position where it can function appropriately if these events occur again. NCOIL has always been focused on transparency and hearing from all interested parties and there are checks and balances within NCOIL's own members that act as safeguards. These amendments do not serve to solve all possible problems but are appropriate to have in place. Rep. Lehman thanked everyone for their work on the amendments.

Upon a Motion made by Rep. Lehman and seconded by Rep. Martin Carbaugh (IN), the Committee voted without opposition to adopt the amendments by way of a voice vote.

Cmsr. Considine noted that despite the Committee waiving the quorum requirement at the beginning of the call, there was in fact a quorum present.

ADJOURNMENT

There being no further business, the Committee adjourned at 12:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE INTERIM CONFERENCE CALL MEETING
JULY 1, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee held an interim meeting via conference call on Wednesday, July 1, 2020 at 11:30 a.m.

Representative Matt Lehman of Indiana, NCOIL President and Chair of the Committee, presided.

Other members of the Committees present were:

Rep. Deborah Ferguson (AR)
Sen. Jason Rapert (AR)
Sen. David Livingston (AZ)
Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Martin Carbaugh (IN)
Sen. Travis Holdman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Sen. Paul Wieland (MO)

Sen. Vickie Sawyer (NC)
Rep. George Keiser (ND)
Asw. Ellen Spiegel (NV)
Sen. Neil Breslin (NY)
Asm. Kevin Cahill (NY)
Asm. Andrew Garbarino (NY)
Asw. Pam Hunter (NY)
Sen. Jim Seward (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Deanna Frazier (KY)
Rep. Michael Webber (MI)
Rep. Rick Gundrum (WI)

Also in attendance were:

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

INTRODUCTORY REMARKS

Rep. Matt Lehman (IN), NCOIL President and Chair of the Committee, thanked everyone for joining the call and noted that there are a lot of issues to discuss during the call's 90-minute schedule. Rep. Lehman noted that because of that reality, if necessary, he will need to stop some speakers short if they take up too much time so that everyone can be heard. Rep. Lehman noted that the format for all issues discussed during the call will be such that legislators will be provided the opportunity to comment or ask questions, followed by interested parties. Rep. Lehman then asked The Hon. Tom Considine, NCOIL CEO, to explain the details on the recently re-scheduled NCOIL Summer Meeting.

DISCUSSION ON 2020 NCOIL SUMMER MEETING (SEPTEMBER 24-26; HILTON ALEXANDRIA OLD TOWN; ALEXANDRIA, VA)

Cmsr. Considine thanked everyone for participating today and thanked the NCOIL Officers for all of their time the past several weeks discussing NCOIL's Summer Meeting. The Officers first determined that they did not want to do a three-day virtual meeting. There was some discussion about doing a legislator-only in-person meeting and having everyone else participate remotely, but that was ultimately decided against. Cmsr. Considine stated that it was ultimately decided to have an in-person meeting in Alexandria, VA, but with a streaming option via Zoom for those who cannot attend or feel uncomfortable doing so. Full participation will be available via the Zoom option. Cmsr. Considine noted that the Zoom option will be available only for this meeting and for any other meetings that would be similarly impacted by a national emergency. NCOIL is not going to go down the road of having virtual attendance as an option as that is a disincentive to in-person attendance and participation.

Cmsr. Considine stated that the Summer Meeting will run in conjunction with the fifth Annual D.C. Educational Fly-in (Sep. 22-23) so that saves those legislators participating in the fly-in from making two trips. The Summer Meeting will be somewhat shorter than typical meetings as it will begin on Thursday, Sep. 24 around 3:00 p.m. and end around 2:00 p.m. on Saturday, Sep. 26. The room will be large enough such that everyone will be socially distant. It is not finalized as to whether masks will be required but the feedback from the hotel thus far has been that they will be required. Registration for legislators will open this upcoming Monday, July 6.

The Meeting will be subject to capacity constraints so the first week of registration will be open only to legislators so there will be a sense of how many legislators will attend. One week later, registration will open for everyone. The room will be limited to about 150 total attendees consisting of legislators at the "U" and others in the general audience. There will be overflow rooms if necessary where there will be screens set up so that people can watch the meetings if there are capacity issues. Those rooms will also be set up to meet social distancing requirements. There will also be a lounge room available for meetings to foster interaction between legislators and interested parties. There will not be an organized micro-meetings session, although staff would be happy to facilitate a specific meeting with a legislator if requested.

Rep. Lehman thanked Cmsr. Considine and stated that if anyone has any comments or suggestions regarding the Summer Meeting to please reach out to NCOIL staff.

Rep. George Keiser (ND) asked if there is an idea as to how many states are not funding out-of-state travel. Rep. Lehman stated that he does not know but noted that in Indiana, travel funding restrictions have been implemented until August 1. Rep. Keiser stated that is something that should be monitored particularly given what is going on in the country right now. Rep. Keiser stated that North Dakota will not fund travel to the meeting so there will need to be another option available for participation, at least at this point in time. Rep. Lehman thanked Rep. Keiser for raising that issue and stated to NCOIL staff that it would be good to research that issue.

DISCUSSION AND CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL ARTICLES OF ORGANIZATION & BYLAWS

Rep. Lehman stated that the NCOIL Articles of Organization & Bylaws Revision Committee (Committee) met last month via conference call to discuss proposed amendments to the NCOIL Articles of Organization and Bylaws. The amendments were adopted unanimously among those voting and accordingly await review and affirmation by the Executive Committee. In conversations leading up to that call with Senator Livingston and Assemblywoman Spiegel - Chair and Vice Chair of the Committee - Commissioner Considine, and NCOIL staff, everyone agreed that it was wise for NCOIL to take some time to reflect on whether any changes to its normal method of conducting business should be altered to allow NCOIL to continue to conduct business now as well as to account for any future emergencies.

Accordingly, after several discussions, amendments were crafted, the main purpose of which are to ensure that a large, national organization such as NCOIL is not unnecessarily constrained when operating during current and future emergencies. Other amendments concern clerical changes and formalizing certain practices which NCOIL Committees have been operating under for years but did not have express authorization in the governing documents. Rep. Lehman then reviewed the amendments as a reminder of what they are and their intent.

On page 1, the Preamble was amended to align it with Membership provisions which recognizes the territories of the United States, the District of Columbia, and Commonwealth of Puerto Rico as members of NCOIL.

On page 4, a new Section was added titled "Reasonable Departure from the Articles of Organization" – the same language was also added to the Bylaws on page 9: "In the event of any emergency resulting from a military or terrorist attack, widespread pandemic, or similar disaster resulting in the declaration of a state of emergency (or similar declaration) by Federal or State officials, reasonable departure from these Articles of Organization shall be permitted upon the Officers and Executive Committee declaring that such action is warranted." The amendment is intended to ensure that NCOIL can continue to operate as needed during an emergency. Importantly, the decision to reasonably depart from the Articles or Bylaws cannot be made by just the President – there is a strong level of checks and balances as Declarations of an Emergency are required by the federal or state government as well as the Officers and the Executive Committee.

Rep. Lehman noted that there were some concerns raised regarding this amendment as to how it might allow an NCOIL President or staff to operate without transparency, but Rep. Lehman stated he strongly disagrees with those concerns and noted the checks and balances built into the amendment. The amendment was crafted because there was nothing in the NCOIL Articles or Bylaws that allowed the organization to pivot.

On page 4, Section 2 was split into subsections A and B, with the language in subsection A explicitly allowing for votes via conference call and lowering the threshold needed for a roll call vote. Subsection B titled "Written Consent in Lieu of Meeting" is proposed to deal with situations like that which occurred with the Rebate Reform Model Law at the Spring Meeting in Charlotte this past March during which the Financial Services & Multi-Lines Issues Committee voted to adopt the Model with amendments that were extensively discussed by the Committee and interested parties. In those type of scenarios, staff makes those changes upon arriving home and sends the Model via e-

mail to the members of the Committee. In such instances, there is no need for the committee to meet formally again because the committee was so clear in its direction.

Rep. Lehman stated that the remainder of the amendments were technical in nature such as fixing some internal citations, re-numbering sections, and improving readability. Rep. Lehman further stated that he has been involved with NCOIL since 2009 and the things that he tells people as to what he really likes about NCOIL is that it is not a political organization; it is transparent; and all views on issues will be heard. Rep. Lehman stated that the amendments discussed will not in any way, shape or form, impact the way that NCOIL has conducted its business in terms of providing ample notice and opportunity for everyone to be heard. If NCOIL wants to remain active and vibrant long into the future, these changes are necessary to operate virtually in an open and transparent manner.

Sen. Livingston thanked Rep. Lehman for his remarks and stated that he did a great job summarizing everything. Asw. Spiegel agreed with Sen. Livingston and thanked everyone for all their work throughout this process.

Asm. Ken Cooley (CA), NCOIL Vice President and Vice Chair of the Committee, stated that it is the nature of NCOIL that it is an organization that seeks to serve as a clearinghouse of information to advance important insurance dialogue across the country. The amendments are not a way to step away from that organizational characteristic, which some might worry about. Rather, the amendments enhance NCOIL's ability to act in that manner despite unforeseeable circumstances. NCOIL also has a practice of getting a record of votes out and that is something that NCOIL will continue to do whether there is a virtual or in-person meeting as NCOIL will continue to operate in a transparent manner. The amendments support NCOIL's clearinghouse function which in turn support state legislature efforts. Sen. Livingston stated that he fully agreed with Asm. Cooley's comments.

Hearing no other comments or questions from legislators or interested persons, upon a Motion made by Sen. Jason Rapert (AR), NCOIL Immediate Past President, and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee voted to adopt the amendments via voice vote without any opposition among those voting.

RATIFICATION OF PRIOR NCOIL ACTIONS

Rep. Lehman stated that now that the amendments to the Articles and Bylaws have been officially adopted and they explicitly allow for telephonic votes, in an abundance of caution, he discussed with staff the need to ratify all prior NCOIL actions – notably those that have taken place without the express authorization of the prior versions of the governing documents, typically via interim committee meeting conference calls.

Hearing no comments or questions from legislators or interested persons, upon a Motion made by Sen. Travis Holdman (IN), NCOIL Immediate Past President, and seconded by Asm. Cahill, the Committee voted to ratify all prior NCOIL actions via voice vote without any opposition among those voting.

DISCUSSION AND CONSIDERATION OF NCOIL RESOLUTION URGING THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS TO REFRAIN FROM INTRUDING ON THE CONSTITUTIONAL ROLE OF STATE LEGISLATORS

Asm. Cooley, sponsor of the NCOIL Resolution Urging the National Association of Insurance Commissioners (NAIC) to Refrain from Intruding on the Constitutional Role of State Legislators (Resolution), thanked everyone for participating and noted that many present today attended NCOIL's Spring Meeting this past March, during which the Property & Casualty Insurance Committee had an initial discussion on the work of the NAIC's Casualty Actuarial and Statistical Task Force (CASTF). That is a part of the NAIC that routinely provides analysis of issues to the NAIC and collaborates with industry. Specifically, the discussion in March was on CASTF's work towards developing a white paper to identify best practices for the regulatory review of predictive models and analytics filed by insurers to justify rates, and provide state guidance for review of rate filings based on predictive models.

Asm. Cooley stated that, on its face, the white paper sounds harmless and perhaps beneficial as support to regulators but when you dig deeper, it starts getting into the role of law as guiding the business of insurance. Asm. Cooley stated that prior to becoming a legislator he was counsel to the California State Assembly's Insurance and Banking Committee which is during the time when NAIC accreditation arose – the idea that the NAIC would promulgate model laws that states should adopt and then they would rate and evaluate insurance departments based on the accreditation system. When you get to that initiative, it highlights a couple of things such as the fact that the NAIC only operates on a delegation of legislative authority. They do not have inherent authority as they are not a government entity and they conduct their work in express reliance on the legislature to enact authorizing statutes and thereby enable their work.

Asm. Cooley stated that he feels that some of the work contained in the white paper has actually gone beyond that approach as to how policy is enacted, acting as if the NAIC is able to grant authority and methodologies for rating evaluations that regulators can then run with, with no reference whatsoever to the underlying law. We are a nation of laws and the regulator has no authority besides what is in the state statutes. So, the white paper is veering into an area of independent authority which is a problem. Those issues were raised at the March meeting during a panel discussion which included Missouri Insurance Director and NAIC Secretary-Treasurer, Chlora Lindley-Myers, NAIC staff, and former Illinois Director of Insurance Nat Shapo who had collaborated with the National Association of Mutual Insurance Companies (NAMIC) to write an issue analysis paper that highlights the perceived problems with the white paper. The topic was also discussed again during the NCOIL-NAIC Dialogue.

Despite those conversations, changes were not made to the white paper to address those concerns and in some cases, it has become worse. The main problems with the white paper, and which are addressed in the Resolution, are that it starts telling regulators how to regulate rates without reference to the underlying law. It starts introducing a mode of analysis that is not necessarily called for in the underlying statutes. Asm. Cooley stated that at that point, he feels that the NAIC is veering towards a different direction than the accreditation model which involved them going to the legislature when they wanted to break new ground. Here, they are breaking new ground but not going to the legislature and presuming that the regulator can do it unilaterally which is not the system of laws we have. That can be viewed on how they presume to vary the basis of rating to get into requiring regulated insurers to go beyond demonstrating correlation and submit a rational explanation of how a rating variable connects to the risk of insurance loss.

The definition of rational explanation in the white paper is problematic and is essentially a causation requirement disguised in other words and phrases. By including the qualifier that a rational explanation does not require strict proof of causality in the definition of rational explanation, the white paper inherently imposes some level of a causality requirement in rate filings, which is a departure from settled law. That opens up a lot of ground for argument which is not to say that you cannot benefit and gain clarity from argument, but if a state wants to get into those arguments, they should do so by statute. In California, one of the oldest insurance statutes dates to the 1870s which states that the insurance commissioner has the obligation to enforce all the laws regulating the business of insurance in the code and other codes. So, basically, the regulator is tasked with being an administrator under the statutes of the state. That is the job and he or she cannot expand that unilaterally by introducing a new idea unless it is anchored in the law.

The white paper's causality requirement is also linked to instructions for the regulator to ensure that the variable in question is not obscure, irrelevant, or arbitrary. Each of those words attracts a high level of subjectivity for the reviewing regulator to apply. Asm. Cooley queried as to if it is not in the underlying law, how do you conjure it up and use it as a guide for regulators? We are a system of laws and one cannot pull things out of thin air. No one is a king. Asm. Cooley noted that some may argue over whether there should be a movement away from correlation towards causation, but the conversations need to be anchored in law. Arguments may be encountered which state that the misuse of rating creates fairness issues, but in all states, issues of fairness and rating and non-discrimination are well anchored in statutory systems.

It is not as if there is a "blank" in state codes regarding discrimination in insurance. It is a long-established concept in the law and has long been a topic of legislative conversation and NAIC-conversation over decades. So, it is not as if there is a hole in the law. The basic principles are pretty clear, and it is always right to look at how we can improve justice in our system of law. Still, there is a conversation needed between the NAIC and lawmakers to make sure we have it right and then bring any changes to the legislature. It is not something for a white paper to do to break new ground.

Asm. Cooley stated that the Resolution is meant to stand up for the prerogative of lawmakers under their state constitutions to superintend the evolution of law in their states to ensure that members of the executive branch act in accordance with law and that their conduct is guided by the constitution and statutes of their own state. In that sense, it harkens back to the evolution of accreditation whereby the NAIC acquired some specific new authority because they partnered with the legislature. It is a reminder that is how things should proceed when an organization operates not with their own power, but with a delegation of legislative power.

Asm. Cahill stated that in this particular instance, some concerns have been raised about a multitude of issues that were perceived in the way that the Resolution was drafted and how certain terminology is used in the Resolution. Part of those concerns are derived from the complexity of the Resolution. Asm. Cahill stated that he identified two or three issues that are identified in the Resolution and each one deserves its own distinct consideration. Whether we should adhere to national as opposed to federal standards is an ongoing discussion. New York was one of the last states to sign on to principle-based reserving (PBR) and the state has still not signed on to the interstate compact. New York understands the primacy of the state regulatory scheme when it

comes to insurance. That being said, there are places where it is important to be informed by a national standard, not a federal standard.

Asm. Cahill stated that another issue is the substantive issue that underlies the white paper and that is whether a correlative methodology or an algorithmic explanation is more appropriate to determine risk and premium levels. Another issue relates to ensuring that legislatures, not the executive branch, make the rules when it comes to insurance. The powers that insurance departments have are derived from legislative mandates. Those three issues warrant three discussions. There is relative unanimity regarding legislative primacy and a high level of support for the concept that while we accept national standards we do not want the insurance industry to be federalized.

But the underlying actuarial issues are subject to further examination for a couple of reasons. One is that we have become a more aware society and the implications of our actions, whether they are intended are not. The other is that we have access to massive amounts of data that we never have before and you can essentially make a statistic say whatever you want it to say because there is that kind of computing power out there.

Asm. Cahill noted that he had commented to a colleague earlier that 100% of the time when he washes his car it rains within 24 hours but that does not mean that washing the car caused it to rain. Accordingly, Asm. Cahill stated that he believes we need to step back and asked for consideration that the Resolution move forward as separate components so that the goal and purpose is clear without succumbing to criticism which has already been levied, some of which is extremely unjust, but nonetheless warrants taking a pause.

Asm. Cooley stated that he believes NCOIL is up against the clock due to the NAIC's timeline with the white paper. The Resolution is appropriate and the gravamen of it is the focus upon that the NAIC cannot operate independently of the legislature and cannot give guidance to regulators without reference to that. Asm. Cooley stated that he is not a technical expert in the field of actuarial science or the use of big data but noted that he does not feel he needs to be as the main point is that on behalf of lawmakers generally who oversee the insurance industry, the white paper is a canary in a coal mine. The NAIC is poised to adopt something which runs afoul of legislative authority and they want to bring it through their adoption process to start providing guidance to regulators which is the wrong way the NAIC should proceed.

As a practical matter, we know the NAIC is reliant upon legislatures. The NAIC exists entirely on the grant of legislative authority and it was much clearer earlier in the organization's history that they knew they needed to work with legislatures. The Resolution is an important message to send and it will hopefully lead to conversations at the NAIC. Asm. Cooley stated that he believes it is important to move forward but with a posture of saying that NCOIL is making a statement but wants to talk about the relationship the NAIC has with legislatures. Asm. Cooley stated that he hesitates to pull back and send a signal to the NAIC that is wholly incompatible with his view of the legislature.

Rep. Lehman stated that there is a time factor involved with this. NCOIL goes through an ebb and flow with the NAIC in terms of each organization pushing back on the other. The Resolution is not so much as a shot at the NAIC but rather a call to continue a discussion because the people Rep. Lehman has spoken to at the NAIC have been very receptive to NCOIL engaging. At the same time, the NAIC will move forward whether

NCOIL wants to be involved or not. Accordingly, the Resolution simply says that when the NAIC goes down the path of potentially making serious changes to rate review law, those changes must be done by the legislature. The Resolution is well-written and precise as to what the white paper itself addresses and NCOIL's concerns with it. Rep. Lehman stated that he understands Asm. Cahill's concerns and stated that the Resolution keeps the conversation moving forward.

Sen. Rapert stated that upon reviewing all the material, including comment letters, and listening to the concerns, he supports the Resolution as it sends the right message at the right time.

Sen. Holdman stated that he agrees with Sen. Rapert and noted that the issue of incorporation by reference (IBR) is always hanging over everyone's head as a reminder of the NAIC's developments that seek to move forward without legislative approval. The Resolution is well-written and he agreed with the comments said thus far in support of it.

Asm. Cooley stated that one of the difficulties here as lawmakers is that they are very talented but are generalists and it works better that way as law is not that technical. It has been said that the white paper is very technical and involves technicians which Asm. Cooley agrees with. The business of insurance does rely upon careful analysis and those types of things, but it is not a free floating entity and it must be anchored in the law. Asm. Cooley stated that he feels that going back several years, NCOIL has been trying to re-frame what the relationship is between state legislators and the NAIC, what the NAIC's source of authority is, and how they work with NCOIL. The white paper is a moment where attention as to what is the source of their authority starts to veer away.

Legislators do not need to presume to be the technical experts, but they are the defenders of the people's power inherent in the constitution to set the law and set the boundaries on what the technicians do. That is what the Resolution is really focused on and represents a necessary dialogue. There is also nothing in an NCOIL Resolution that will alter how individual state laws operate with respect to rating, fairness, and justice in the marketplace. All of those things are fair topics for legislation but an NCOIL Resolution cannot vary the state law, just as an NAIC white paper cannot. Accordingly, the Resolution is sticking up for the people of the various states operating through their legislature and those who support it are not compromising themselves on other issues because they are not touching law.

Rep. Lehman stated that at the March meeting it was stated that the white paper would be further discussed but then the NAIC stated that its intent is to adopt it at its Summer Meeting later this month so that moved the timeline such that the Resolution was drafted and this conference call meeting was scheduled. Asm. Cooley agreed.

Asm. Cahill stated that he continues to urge that the Committee not confuse this matter because there are parts of the Resolution he wholeheartedly supports and parts which he believes warrant further consideration. While it is important NCOIL continue to assert the primacy of the legislative authority over insurance regulation in the various states, Asm. Cahill stated that he does not see how the white paper threatens that, and noted that there is still a third branch of government – the judicial branch. If it is determined that insurance commissioners have overstepped their boundaries, that would be a ripe subject for judicial intervention and consideration. Asm. Cahill stated that he does not see the urgency in advising another agency of state officials of opposition to their

substantive argument when in fact the central purpose is to discuss the relative power and authority of the branches of government.

Rep. Edmond Jordan (LA) agreed with Asm. Cahill and stated that he understands that NCOIL is supposed to operate as an exchange of information but it seems as if the Resolution makes NCOIL an arbiter of what the NAIC says. Rep. Jordan noted the last provision of the Resolution which states that “a copy of this Resolution shall be sent to state legislative leaders and members of the committees with jurisdiction over insurance public policy, as well as to all state insurance regulators and the NAIC.” Rep. Jordan stated that if the Resolution was only being sent to the NAIC that might be ok, but when sending it to the other people listed, that is different. Rep. Jordan noted that like Asm. Cahill, there are parts of the Resolution that he agrees with, and parts that he has serious concerns with.

Birny Birnbaum, Executive Director of the Center for Economic Justice (CEJ), thanked the Committee for the opportunity to comment on these issues and noted that CEJ submitted written comments beforehand. Mr. Birnbaum stated that NCOIL has before it a resolution, which would be sent to every state legislature, every commissioner and the NAIC denouncing the NAIC for usurping state legislative authority. NCOIL has rolled out the nuclear option to get rid of an ant. The NAIC CASTF is a technical working group of actuaries whose work is reviewed by at least two parent committees. Had NCOIL simply sent a letter to CASTF noting concern with the term “rational explanation” and asked how this phrase fits into the regulatory framework, NCOIL would have gotten a dialogue and the ability to educate and be educated by regulators. NCOIL would have learned that the farthest thing from the actuaries’ intent is to usurp legislative authority.

In terms of time – the CASTF is taking comments for another 30 days. Then CASTF has to adopt it and pass it up the Property Casualty Committee for their consideration and then up to the Plenary. So, NCOIL has months for discussion on the white paper. Instead, NCOIL has this nuclear option containing demonstrably wrong information that undermines the message. More important, the real action on this issue is with other groups at the NAIC. These issues were discussed on yesterday’s NAIC Artificial Intelligence WG Call when the regulators – the commissioners, not actuaries – voted some 15-0 with 1 abstention to include a principle for insurers’ use of AI to proactively avoid proxy discrimination against protected classes – and it was adopted despite the very same arguments industry has made to NCOIL for this resolution. If nothing else, that action under the direction of NAIC leadership should prompt NCOIL discussion with the regulators over these issues instead of issuing this Resolution.

The fatal flaw in the NAMIC analysis and the Resolution is the second paragraph, “WHEREAS, established rate filing review is based on correlation, which demonstrates that rating variables are valid so long as they correlate with a loss.” The NAMIC paper, which is sort of the foundation of the Resolution, argues that causation is not required, which is true. But, the absence of a requirement to prove causation does not equal a requirement only for a simple correlation. Mr. Birnbaum stated that he has been reviewing rate filings for 30 years as a regulator and as an expert, and a simple correlation has never been the sole requirement or a sufficient justification for a rating factor.

In fact, the term “correlation” does not appear in either of the NCOIL rating models cited in the Resolution. Nor does “correlation” appear in any of the NAIC property casualty

rating models. Nor does “correlation” appear in the Casualty Actuarial Society’s “Statement of Principles Regarding Property and Casualty Insurance Ratemaking.” Nor does it appear in the American Academy of Actuaries (AAA) “Risk Classification Statement of Principles.” These risk classification principles identify a variety of considerations in developing risk classifications that go way beyond simple correlation. In fact, a simple “correlation” is not the basis for fair discrimination. NAIC models define unfair discrimination to exist if “after allowing for practical limitations, price differentials fail to reflect equitably the differences in expected losses and expenses.” Further, if simple correlation was the basis for assessing fair discrimination, consider this. The NCOIL models don’t define unfair discrimination other than discrimination “on the basis of race, color, creed, or national origin.” Well, what does “on the basis of” mean? If, as claimed in the Resolution that “rate filing review is based on correlation,” then the appropriate test for discriminating “on the basis of race, color, creed, or national origin” would also be a simple correlation between the rating factor and the prohibited classifications. CEJ doubts that is NCOIL’s intent.

Mr. Birnbaum stated that the reason that a simple correlation is not the justification is because there can be correlations between factors for a variety of reasons unrelated to whether one is predicted of the other. The term for that is a “spurious correlation.” For example, there was a 99.3% correlation between the divorce rate in Maine and per capita consumption of margarine from 2000 to 2009. As an example, the Indiana Department of Insurance disapproved a rate filing in which the insurer sought to use per-capita margarine consumption as a risk classification. In the 30 years that he has been reviewing rate filings and risk classifications and the regulatory activity in this arena, Mr. Birnbaum stated that a simple correlation has never been a sufficient justification for a rating factor.

The Resolution’s references to “correlation” seem like a quaint reference to a long-gone – by 50 years – era. The same NAIC CASTF holds monthly “book clubs” in which insurers and experts make presentations on current ratemaking practices. Mr. Birnbaum has been one of the presenters. This past week was an example in which Allstate subsidiary Arity made a presentation on the development of their telematics pricing models for auto insurance. The presentation reviewed the parts of a scoring (pricing) model, including ordinary least squares regression, generalized linear models, generalized linear models with log link functions, decision tree models, neural nets, gradient descent, hyperparameters and extreme gradient boosting. Needless to say, that when a regulator is presented with rating factors based on such a model, it is meaningless to try to look for a simple correlation.

It is this new and massive complexity – actuarial science merged with data science merged with astrophysics – that presents the challenge for regulators to enforce current statutes. CEJ suggests that instead of a Resolution, NCOIL’s efforts would be better spent working with regulators to modernize regulatory authorities and capabilities to deal with the reality of complex models in insurance while remaining true to bedrock cost-based pricing principles. A challenge for insurers and regulators that has always existed and continues to exist is whether a particular relationship – correlation – is real or spurious. The repeated references to “correlation” in the Resolution are an endorsement of proxy discrimination. By declaring that any correlation is sufficient justification – even if that correlation is a proxy for discrimination against a protected class and defending such proxy discrimination on the basis of states’ rights – ignores the

commitment and efforts by industry and regulators to address systemic racism in insurance.

By the standard espoused in the Resolution, a rating factor that was a proxy for being a Black American is legitimate as long as there is a correlation to losses. Never mind that the factor is a proxy for a prohibited class or that that the factor has the effect of discriminating on the basis of a prohibited factor. Again, we gave an actual example in our letter. One is that some data vendors offer a criminal history score that purports to score homeowners insurance on the basis of complaints filed with courts. Based on the Resolution, as long as there was a “correlation,” that would not only be okay, but regulators are prohibited from further inquiry. What would the use of a criminal history score look like in the case of George Floyd, if he lived?

Asm. Cooley stated that legislators are subject to the same laws that the regulators are subject to, so for Mr. Birnbaum to assert that anything in the Resolution opens the door to marketplace conduct is incorrect because it is constrained by the laws of the 50 states. The issue is that both legislators and regulators are subject to the law but the place where the conversation veered off is the NAIC acting as if they can unilaterally guide regulators into developing new rating approaches without confronting the underlying law. Saying that the Resolution opens the door to conduct is incorrect because the law exists in the 50 states. The issue is what is the fundamental methodology if indeed the NAIC at any level wants to engage in conversations which can lead to groundbreaking innovative approaches. Those discussions must run through the 50 state capitals and it cannot be short-circuited by going through regulators.

Mr. Birnbaum stated that he agrees with Asm. Cooley but disagrees with the assertion that the white paper is in fact doing that. Asm. Cooley stated that the charge of CASTF is to give guidance to regulators, without referencing underlying statutes. Asm. Cooley noted that if the NAIC was not seeking to adopt the white paper at its Summer Meeting that would provide the opportunity to discuss the issues with the NAIC and not be forced by the calendar.

Mr. Birnbaum stated that, respectfully, if NCOIL really wants to get at this issue – and it is an issue as when you look at things like the valuation manual and actuarial guidelines that are adopted by the life actuarial task force that immediately have the force of law. There are some real issues there about the delegation of authority – there is no question about that. But on this particular issue, the concern about usurpation of legislative authority by a technical task force and mis-using the term “rational explanation” is just not there. That term is being used in an attempt to identify a spurious correlation. If someone comes in and says I want to use eye color as a predictor of homeowner’s claims, the regulators will ask what is the basis for that. The company can say they have a correlation but there is no regulator that would ever accept that and they would ask for data for proof that there is a relationship that exists and that there is not a spurious correlation.

Rep. Lehman stated that he believes the issue of timing is important in this instance as the NAIC’s summer meeting is later this month, and asked if other interested parties had any comments.

Erin Collins, VP of State Affairs at NAMIC, stated that in addition to the written comments previously sent to the Committee, she believes that Asm. Cooley is correct in

that the main issue the Resolution addresses is the ability to create new law and policy. The issues described in the white paper are not based in current statute. At the NCOIL meeting in March, and today, it has been asserted that the white paper is a best practices document and not policy, but it is instructing regulators how to regulate and creating new forms of regulation that have not been passed into law so it becomes law in that sense. From NAMIC's perspective, NCOIL is wise to consider the Resolution because changing the law is for legislators and the full legislative process. NAMIC encourages NCOIL to move forward with the Resolution and concurrently agree that discussions should continue with the NAIC on this and other issues.

Dir. Shapo stated that he knows time is running short on this call so there is not enough time to go into a deep dive on the substance of all of these issues. However, the word correlation is used in many actuarial authorities that are cited in the paper he wrote as well as many other legal authorities. It is also important to note that other terms referenced in actuarial authorities are often used interchangeably with correlation such as predictive accuracy and expected outcomes. Those are grounded in correlation and if you went and talked to an actuary, they will tell you that they often use those terms interchangeably and that they would never use the word causation interchangeably with those terms. Dir. Shapo noted that the letter submitted by CEJ did not make an attempt to defend causation and that is the main problem with the white paper – the erosion of the correlation standard and the movement towards a causation standard.

Further, earlier drafts of the white paper addressed insurer practices of grabbing at things that represent true correlation. That is an overstatement of insurer practices as there is a level of professional diligence applied. With regard to the anecdotal examples provided by CEJ noting that the regulator would ask follow-up questions regarding what the data is to support the rating factors, such a scenario is a correlation focused discussion. There is no data on causation. The AAA flatly rejected even a discussion of causation in this context in the past as speculative and stated that no rating factors demonstrate causality.

Mr. Birnbaum stated that he is not sure why Dir. Shapo is harping on the causation issue because nobody, including CEJ, has said that causation should be a requirement. The problem with Dir. Shapo's analysis is that he equates a lack of requirements for causation with all that is required is a simple correlation. That is nowhere to be found in any statutory language, actuarial principle, or the actual practice that insurance regulators have conducted for decades. The problem with the Resolution is that it puts forward a concept that regulators are going to say "what are you talking about?" NCOIL will not help itself with discussions with the NAIC. Rather, NCOIL will undermine its own position. Dir. Shapo stated that he relies on his previous statements in response to Mr. Birnbaum's remarks.

Asm. Cooley stated that as a practical matter, it is the case that part of the timeliness of moving the Resolution today is the NAIC's timing of its meeting. It would be productive to talk to NAIC leadership on the issue of timing and if there is an alteration to timing that would provide an opportunity to make adjustments to the Resolution. Asm. Cooley stated that he would like to move forward today while also reaching out to the NAIC on process and the issues discussed today to see if either their schedule could be changed or the actual language of the white paper. Thus, if adopted, the Resolution would be held pending discussions with the NAIC and if no adjustments were made by the NAIC then the Resolution would be forwarded to the recipients stated in the Resolution.

Rep. Lehman asked Asm. Cooley if he means to pass the Resolution and then hold it pending discussions with the NAIC. If the NAIC moves forward, then the Resolution stands but if they make adjustments or pause then that would provide NCOIL the opportunity to either make adjustments to the Resolution or reverse it. Asm. Cooley replied yes and stated that is a constructive way to proceed. Rep. Lehman agreed and stated that conversations with the NAIC will indeed occur as he feels that at this point in time NCOIL has a very good relationship with NAIC. Rep. Lehman then asked for a Motion to move forward with that course of action. Asm. Cooley made the Motion which was seconded by Sen. Holdman. The Committee then voted to adopt the Resolution by voice vote. Rep. Jordan, Asw. Spiegel, Asm. Cahill, Asm. Andrew Garbarino (NY), and Asw. Pam Hunter (NY) all voted "no."

ANY OTHER BUSINESS

Rep. Lehman stated that the last piece of business is a reminder that NCOIL has started its new dues structure. The dues have increased for the first time since 2002 from \$10,000 to \$20,000. The introduction of legislator stipends into the financial model was made to help underwrite the cost of attending and participating in NCOIL meetings. Of the \$10,000 in additional dues paid by Contributing States, \$6,000 will be allocated to the legislator stipend program. This amount is split between each of the three national meetings for two legislators, one per chamber, to be reimbursed up to \$1,000 for the meeting they attend. There is a formal set of stipend guidelines which can be found on the website and by reaching out to NCOIL staff.

Rep. Lehman stated that for those of on this call whose state has paid its dues or has reached out to NCOIL staff to indicate that they will be paid, we sincerely thank you. For those from states that have not paid yet, by this time in the year your state should have received both initial and reminder invoices. As a reminder, if a state does not pay contributing membership dues, the legislators from that state will not be able to serve on the Executive Committee, run for an Officer position, or serve as Chair or Vice Chair of NCOIL policy committees. Additionally, NCOIL has heard from some states that their fiscal personnel were not aware of the increase, despite the letters NCOIL sent in 2018 and 2019. For this year only, NCOIL is working with those states to allow a lesser dues payment and forfeiture of participation in the stipend program.

Rep. Lehman stated that he knows that during this global health emergency in which we find ourselves, state budgets have been adversely impacted. However, during times like these, the value in being an NCOIL Contributing Member State is tremendously strong. Opportunities to be involved in a national forum to help educate legislators from different states with similar goals by having conversations on how to improve the quality of public policy are more important than ever before. Rep. Lehman thanked everyone again and stated that if there are any questions on this please reach out to NCOIL staff and they will be happy to talk to you.

Cmsr. Considine stated that for those legislators on the call not from NH, OH, OK, KY, ME, MI, MO, NC, PA, or VT, those remaining states have not paid their dues. Cmsr. Considine asked legislators from the remaining states to please reach out to the appropriate person in their state to get NCOIL dues processed. Staff is happy to send another invoice or any other information needed.

Rep. Jim Dunnigan (UT) asked if there is an option for states that only want to send one person to NCOIL meetings. Rep. Lehman stated that as of now, the dues structure does not allow for that but that is a conversation that can be had going forward particularly due to the budget constraints many states are facing. Cmsr. Considine stated that due to the tough economic times and some states that have informed staff that they were not aware of the new financial model, the response has been that paying \$10,000 for this year is fine but participation in the stipend program will not be permitted. The budget committee, executive committee, and officers would then need to have a conversation as to whether that practice should be permanent. Rep. Dunnigan requested that conversation be held, particularly for those states that only want to send one person to NCOIL meetings. Utah has severely restricted state agency travel

ADJOURNMENT

There being no further business, the Committee adjourned at 1:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING
JULY 24, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, July 24, 2020 at 1:00 P.M. (EST)

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

Other members of the Committee present were:

Asm. Ken Cooley (CA)
Rep. Richard Smith (GA)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Rep. Joe Fischer (KY)
Rep. Michael Webber (MI)

Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Sen. Bob Hackett (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deanna Frazier (KY)
Rep. Edmond Jordan (LA)
Sen. Pamela Beidle (MD)
Rep. Forrest Bennett (OK)

Rep. Mark Willadsen (SD)
Rep. Robin Smith (TN)
Rep. Amy Walen (WA)

Also in attendance were:

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

QUORUM

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

INTRODUCTORY REMARKS

Rep. Bart Rowland (KY), Chair of the Committee, stated that he is honored to preside over NCOIL's first ever Zoom meeting and also noted that as the new Chair of the Committee, he has huge shoes to fill. The former Chair was Georgia Representative Richard Smith, whom everyone knows and respects greatly, and has been a longtime supporter and active member of NCOIL. Rep. Smith recently became the Rules Chair in the Georgia House, which is a deservedly prestigious position but comes with enormous responsibility and demands on his time. Rep. Smith wanted to make sure that neither NCOIL nor this Committee had any hiccups due to these additional demands in GA and

selflessly stepped aside as Chair. He has committed to remaining an active NCOIL member and indeed registered for this call.

Rep. Rowland stated that since he was Chair of the Worker's Compensation Insurance Committee, a couple of other adjustments to the roster of NCOIL Chairs and Vice Chairs needed to be made. The new Chair of the Work Comp Committee will be Texas Representative Tom Oliverson, M.D.; Minnesota Senator Paul Utke will remain as Vice Chair.

Rep. Rowland noted that he knows that everyone is very busy as we all continue to deal with the realities of facing the global health crisis in which we find ourselves, and stated that that he really appreciates everyone's participation today. Rep. Rowland further stated that, as the agenda shows, this Committee has a lot of work to do over the next several months, and in the next now 80 minutes. Accordingly, he asked to call this interim meeting of this Committee because he wanted to make sure that when the Committee meets at the "Summer" Meeting in September, the Committee is not so pressed for time such that people feel unduly rushed.

Rep. Rowland stated that the Committee will get started today with an update on the work of the National Association of Insurance Commissioners (NAIC) Casualty Actuarial and Statistical Task Force (CASTF). Earlier this month the NCOIL Executive Committee met via conference call and, among other things, adopted a Resolution in response to the work of CASTF. However, while the Committee did adopt the Resolution, it was agreed upon that the Resolution would be held pending further discussion with the NAIC in the hope that the work of the CASTF might be altered. Rep. Rowland stated that the Committee today will then discuss the first draft of an NCOIL Distracted Driving Model Act, sponsored by Ohio Senator Bob Hackett and California Assemblyman Ken Cooley. This will be a good opportunity to discuss the issue of distracted driving in general and examine the Model's provisions so that the Committee doesn't have to start from scratch at its meeting in September.

Rep. Rowland further stated that the Committee today will then provide an opportunity for comment and discussion on the five NCOIL Model Acts that are scheduled for re-adoption. Per NCOIL's bylaws, all NCOIL Model Acts are scheduled to be considered for re-adoption every five years. If a Model is not re-adopted, it sunsets. Rep. Rowland noted that the Models will not be voted on for re-adoption today. Rather, this will be an opportunity for comment and discussion in advance of the "Summer" Meeting where the actual vote will take place. It is very unlikely that the September agenda will allow time for additional discussion on these five Models, so the Committee will hold the entire discussion now, but simply hold the vote until September.

UPDATE ON NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS (NAIC) CASUALTY ACTUARIAL AND STATISTICAL TASK FORCE (CASTF)

The Honorable Tom Considine, NCOIL CEO, referenced the Executive Committee meeting mentioned earlier by Rep. Rowland and noted that there had been some discussions at the NCOIL Spring National Meeting regarding passing a Resolution but it was ultimately decided to not do so in order to give the NAIC an opportunity to respond to NCOIL's concerns with CASTF's work. In the ensuing months, the concerns were not addressed which led to the meeting of the Executive Committee during which the Resolution was adopted. It was the decision of the Executive Committee to hold the

Resolution and not send it to the NAIC pending further discussions – specifically to add some language to the CASTF’s White Paper stating that the White Paper would not carry any weight of law or be binding on any state regulators.

Cmsr. Considine stated that the NAIC did not respond to NCOIL’s concerns for quite some time but there was some recent Officer to Officer conversations. NCOIL is not aware of any changes being made to the White Paper but the NAIC’s principles on artificial intelligence which is before the NAIC’s Innovation and Technology Task Force does contain language stating “these principles are guidance and do not carry the weight of law or impose any legal liability.” That is just the type of language that NCOIL had in mind although NCOIL did not suggest said language. It would be ideal if such language was included in the White Paper. Cmsr. Considine stated that he must note that the aforementioned language does continue “however, this guidance can serve to inform and establish general expectations for AI actors and systems emphasizing the importance of accountability, compliance, transparency, and safe, secure and robust outputs.” That language, in total, is a good step but Cmsr. Considine stated that he believes the NCOIL Executive Committee and Asm. Cooley, sponsor of the Resolution, need to consider whether that language meets the thoughts and intent of the Executive Committee when it decided to hold the Resolution.

Asm. Cooley stated that the language is interesting but the concern is that the NAIC is bootstrapping authority and trying to shape what is the relevant yardstick in different jurisdictions. Asm. Cooley stated that he needs to look at the language more closely. The first sentence is fine but the second sentence is problematic and almost reels back the first sentence.

INTRODUCTION AND DISCUSSION OF NCOIL DISTRACTED DRIVING MODEL ACT

Sen. Hackett stated that he is very pleased to join Asm. Cooley in sponsoring model legislation that would save countless lives from the dangers of distracted driving. The purpose of the Model is not to make more traffic stops or put people in jail; it is to get drivers to put down their phones and save lives and prevent injuries. Despite increased public awareness and education efforts, distracted driving continues to needlessly kill and injure thousands of Americans every year. Sen. Hackett stated that as a lawmaker from Ohio he knows this all too well. Traffic fatalities have increased in Ohio for five out of the last six years, all during a time period of having safer cars on the road. Distracted driving crashes and fatalities are significantly underreported. In 2018, 2,841 people were killed in motor vehicle crashes involving distracted drivers. The National Highway Traffic Safety Administration (NHTSA) reports that 80% of fatal crashes and 15% of injury crashes in 2018 were distracted affected. And those numbers are likely much higher.

Sen. Hackett stated that we know that texting and handheld cell phones used are leading contributors to distraction related crashes. These crashes are preventable but we must make the use of wireless devices behind the wheel as unacceptable as drinking and driving. The Model creates a strong deterrent and is a big step towards changing the culture of distracted driving. Currently, 24 states plus the District of Columbia have enacted laws prohibiting all drivers from using handheld cell phones. Ohio is hoping to make that number 25 as there is currently legislation pending. However, no such model law currently exists. The proposed Model closely mirrors the work in Ohio but draws heavily on the provisions and experiences in other states that have enacted handheld

cell phone bans such as Georgia, Tennessee, and Arizona, thus making it ideal to pass as a Model law.

Ohio's bill is the result of a Task Force study that began in 2018. At that time, only 15 states and the District of Columbia had enacted primary hands free laws. The task force found that 12 of the 15 states experienced a decrease in fatality rates within two years of passing hands-free laws while two states did not yet have sufficient data to report. Six of the states saw more than a 20% decrease in fatality rates, including a 31% decrease in California. Sen. Hackett stated that he is honored that Asm. Cooley agreed to co-sponsor the Model. We know that these laws are an important part of the strategy to reduce traffic deaths and crashes.

The Model defines "wireless communications device" (WCD) to include not only cell phones but all tablets, laptops, and other devices. The Model prohibits the use of a WCD while driving and the Model makes it a primary offense, allowing an officer to cite a driver if they are using a device without any other traffic offense taking place at the same time. The model includes language similar to texting bans in 48 states by prohibiting writing, sending or reading text-based communications. The Model also bans all non-navigational dealing such as watching videos, recording videos, taking photos, looking at images, live streaming, or using applications. However, the Model does provide exemptions for voice operated hands-free use, emergency situations, first responders, and a single swipe.

The Model also prohibits all WCDs used by school bus drivers. That is a common provision in bills advancing across the country. The Model also creates a tiered penalty enforcement section that establishes both monetary penalties and points. States have found that strong enforcement is key to ensuring effectiveness. Ohio attempted to align with similar dangerous vehicle infractions.

Asm. Cooley stated that the Model is very important and can be compared to similar actions taken in California throughout the years. California does have a hands-free law in place, but Asm. Cooley noted that he remembers early in his career when everyone was anxious about a mandatory seatbelt law. There was a time when that seemed like a big hill to climb – enacting a mandatory seatbelt law. It started with a secondary enforcement but it was then realized that the law saves lives and provides immediate practical value so the jump to primary enforcement was made. Now, seatbelt laws are ubiquitous. Asm. Cooley stated that he also can think back to when lawmakers had issues with whether kids should wear helmets when riding bicycles. So many injuries occurred that you could not turn a blind eye so the legislature stepped up and enacted a helmet law. Those two examples are important because when dealing with this type of legislation, people struggle with enforcement provisions, but such provisions really drive home that fact that this ought to be the new routine and people should adjust their lives accordingly. These types of laws are not revenue generators although they have financial elements in order to have an authentic encouragement for compliance.

Asm. Cooley stated that the role of enforcement in this type of statute is to drive the behavior and the practice. It is extremely significant that the American Academy of Pediatrics (AAP) is supportive of these types of statutes. Asm. Cooley noted that similar to his remarks earlier regarding how the NAIC is attempting to break new ground without any legislative authority to do so, the AAP exists to save lives and provide medical guidance. Asm. Cooley noted that in his experience, California has actually delegated

certain authority to the AAP where if they felt a standard was correct, the legislature would incorporate that into the law. The AAP is a very prestigious organization and they have stated: in the United States, primarily enforced distracted driving laws are associated with a lower incidence of fatal motor vehicle crashes involving 16 to 19-year-old drivers; bans on all handheld device use and texting bans for all drivers are associated with the greatest decrease in fatal motor vehicle crashes; and adoption of universal handheld cellphone bans in all states may reduce the incidence of distracted driving and decrease motor vehicle crash fatalities.

Asm. Cooley stated that he believes primary enforcement is very important. Secondary enforcement means that an officer can only issue a citation for distracted driving if the driver was pulled over for another offense. It is commonplace when driving to see people watching movies, talking on their phone, watching videos. It is blatant, observable behavior which makes primary enforcement the best way to enforce this and make clear that such behavior is not acceptable. Distracted driving will always remain a part of our lives but the Model is very strong and important. California has already enacted similar legislation. The job of lawmakers is to work on the future and this is a new phenomenon and WCDs are everywhere. This is an opportunity to recognize that action is needed and to be bold in providing guidance to states seeking to develop distracted driving legislation.

Cathy Chase, President of the Advocates for Highway and Auto Safety (Advocates), thanked the Committee for the invitation and stated that in 1997, NHTSA issued its first report on distracted driving. In 2001, New York became the first state to address distracted driving by enacting a ban on handheld cell phone use. In 2003, research determined that merely talking on a cell phone while operating a vehicle disrupts the driver's attention which can lead to inattention blindness or the inability to recognize objects in a driver's field of vision. In 2007, Washington became the first state to enact an all driver texting ban, and returned in 2010 to upgrade the law to primary enforcement. In 2009, the National Transportation Safety (NTSB) announced a ban on text messaging while talking on cell phones for their staff. In 2011, NTSB became the first government agency to call for a complete ban of non-emergency use of portable electronic devices including hands-free devices while driving.

Ms. Chase stated that the NTSB has also repeatedly included ending distraction on its most wanted list of transportation safety improvements. Between 2011 and 2020, state legislatures have addressed distracted driving by enacting all driver texting bans, graduated driver licensing (GDL), cell phone bans which are complete prohibitions on use, and bans on the use of handheld cell phones.

Ms. Chase noted that Advocates is a unique alliance of consumer safety, law enforcement, medical and public health groups, and insurance companies working together. Created in 1989, Advocates' mission is the adoption of federal and state laws, policies and programs that prevent motor vehicle crashes, save lives, reduce injuries, and contain costs. Advocates targets improvements for safer occupants and road users, safer vehicles, and safer roads. By addressing those aspects of road safety through its three program areas, Advocates pursues a comprehensive approach to yield the greatest benefits.

Ms. Chase stated that the improvements to vehicle and road safety throughout the years were realized by collaboration among many partners including victim advocates, other

safety organizations, insurance industry members, state legislators, and Members of Congress. Some of the successes were realized after decades of consistent and dogged advocacy. This work is vital, considering that 36,560 people were killed on our nation's roads in 2018 at an annual cost of \$836 billion dollars. To drill down on distracted driving crashes, in 2018, nearly 10% of drivers were using a handheld or hands-free cell phone at any moment during the day; 8% of fatal crashes and 15% of injury crashes were reported as distraction effected crashes. 2,041 people were killed and 400,000 injured in crashes involving a distracted driver.

Distraction effected crashes impose an economic cost of \$40 billion dollars. As mentioned earlier, these crashes are very well known to be underreported for multiple reasons including issues with police reporting and data bases. To get a pulse on how the public is feeling about distracted driving, Advocates commissioned a public opinion poll in January which shows the public both supports state laws and the issuance of grants to states to improve their current laws. That was tied in with other advocacy efforts.

Ms. Chase noted that the question is: what do we do to address this problem? On the state level, every January Advocates releases its annual report titled Roadmap of State Highway Safety Laws in which the states are rated on the adoption of 16 optimal laws including addressing distracted driving. The report also highlights the issue of distracted viewing and the need for laws to be updated to ban such use. Highlighting an issue is a signal that Advocates may be rating it in future reports. The current report showed that 46 states and D.C. have enacted primary enforcement all driver texting bans; 31 states and D.C. have enacted primary enforcement GDL cell phone bans. The Insurance Institute for Highway Safety (IIHS) has found that 25 states and D.C. have enacted primary enforcement handheld device bans. Some states that have passed all three distracted driving laws are upgrading their laws by banning distracted viewing such as Illinois in 2019, or are considering bills to do so such as New Jersey and Ohio.

Ms. Chase stated that as technology has evolved, so must our laws. Laws banning texting while driving remain critical but they must now be expanded to also ban the breadth of distracted platforms and uses such as video chatting like Facetime, streaming video, taking photos, playing games, and using social media apps. Ms. Chase stated that on the federal level, Advocates is recovering from a herculean effort on H.R. 2, the massive House bill called the Moving Forward Act. It included a provision to incentivize states to ban distracting viewing by offering a grant award and a provision to require automatic emergency breaking (AEB) in all new vehicles. AEB in particular will be very helpful to preventing crashes when a driver is not paying attention. Unfortunately, the bill is DOA in the Senate so Advocates will continue to push to accelerate the adoption of proven crash-avoidance technologies. Those systems can help prevent crashes from occurring as well as mitigate crashes that do occur, potentially lessening the severity. Unfortunately, the systems are mostly in high-end vehicles or sold as expensive packages which often include non-safety items and luxury upgrades. Advocates believes that everyone should benefit from improvements in safety technologies and as such, there should be standard equipment with compliance with minimum performance standards.

Ms. Chase stated that the issues covered in H.R. 2 include: technology to prevent impaired driving; updates in the New Car Assessment Program (NCAP) to educate consumers about safer cars; limo safety; potentially fatal issues regarding keyless

ignition and pushbutton starts; the incidents of children dying in hot cars; truck safety; and AEB and other crash avoidance solutions.

Ms. Chase stated that Advocates works closely with IIHS and relies on their great work to inform and support Advocates positions, particularly with vehicle safety technologies. Vehicle safety technologies represent crucial stepping stones to autonomous vehicles (AVs) – not only for performance standards but also to get customers accustomed to the technology. However, distraction associated with partially autonomous vehicles and vehicles with driver assisted technology is a growing concern. The problem is completely predictable considering it is human nature to do something else if you think the car will handle the driver components. That underlies why performance standards for driver monitoring engagement systems are needed. In fact, the NTSB has also called for performance standards for driver monitoring engagement systems for partially autonomous vehicles to ensure driver engagement. That recommendation followed their investigations into multiple crashes in which automated driving systems were used or were being tested and the driver was distracted by device use, including the Uber crash in Tempe, Arizona and the Tesla crash in California which both resulted in fatalities.

On the issue of automation complacency, Ms. Chase shared two quotes from two industry leaders. From Dr. Missy Cummings of the Duke Pratt School of Engineering: “not only do drivers get distracted by self driving technology, not understand its capabilities, and ignore its alerts, it also gradually erodes their skills, leaving them unprepared to handle regular operations when the time comes.” Costa Samaras of the Carnegie Mellon College of Engineering: “robots make excellent backup drivers to humans. Humans make terrible backup drivers to robots.” Looking further down the road with highly autonomous vehicles, it will be essential that proper safeguards and oversight are put into place. Advocates has been working with a broad coalition to ensure AV legislation and regulation include provisions to best ensure public safety.

Ms. Chase noted that the Model includes provisions that retain the ban on the most distracting activity - texting – which involves manual, visual and cognitive distraction, while banning new distracting uses that have become available as the technology has developed. Advocates supports the Model with two essential changes. Primary enforcement should be required; secondary enforcement is weak and unnecessarily difficult to enforce. In fact, pending legislation in Ohio to update its distracted driving law would make it a primary enforcement and that is a change that Advocates has weighed in to support. Also, language to require complete GDL cell phone bans should be added – this age group has the highest proportion of drivers and fatal crashes reported as distracted. Recent research on distracted driving found that states with primary enforcement distracted driving laws had lower rates of fatal crashes involving 16-19 year old drivers and passengers, and reinforces Advocates recommendation for primary enforcement. From a purely safety point of view, Advocates would also of course prefer that use is not permitted hands free. However, Advocates understands the political reality and appreciates the effort made to restrict hand free use.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) thanked the sponsors for introducing the Model and stated that APCIA has long been active on distracted driving issues in a number of states and APCIA views the Model as a worthy addition to the arsenal of legislation that would deal with this issue. Fighting distracted driving is important both from an insurance perspective but more importantly from a societal perspective – it is the right thing to do.

APCIA looks forward to participating in the process leading to further development of the Model.

Rep. Smith stated that Georgia passed distracted driving legislation two years ago and a report was issued this past Spring stating that the Georgia Highway Patrol issued about 50,000 distracted driving tickets. The highway patrol probably could have written 2 million tickets if they so desired as distracted driving is indeed that prevalent. Rep. Smith stated that he was adamantly opposed to the penalties provision in the Georgia legislation. There was a \$50 penalty and if you went to court and showed that you had bought a hands free device, the penalty was removed. Rep. Smith recommended, and he still does, that in order to get someone's attention you have to get in their pocket book. Rep. Smith had proposed to impose a \$300 penalty for the first violation, \$500 for the second, and \$700 for third combined with a loss of license for six months. Distracted driving remains as serious a problem there as it was before the legislation was enacted.

Andrew Kirkner, Regional VP, Ohio Valley/Mid-Atlantic at the National Association of Mutual Insurance Companies (NAMIC) thanked the sponsors for introducing the Model and stated that NAMIC supports the Model. Upon review, NAMIC has received some technical comments from its members and looks forward to working with the Committee and NCOIL staff to make technical corrections. Overall, the Model is a big step towards improving safety on roads throughout the country and NAMIC appreciates NCOIL's leadership in this area.

Wayne Weikel, Senior Director at the Alliance for Automotive Innovations (Alliance) stated that the Alliance represents 99% of the all the manufacturers selling in the U.S., as well as tier 1 suppliers and other automobile technology companies. Mr. Weikel thanked the sponsors for introducing the Model and stated that Alliance members have been working for years to improve roadway safety and the first step in doing so is helping consumers keep their hands on the wheel and eyes on the road. As such, they have supported texting bans and handheld bans all across the country, and they are supportive of NCOIL's efforts. There are some concerns that some of the Model's language may inadvertently loop in some vehicle systems. Vehicle systems have been designed by engineers to be used safely while driving. For example, the prohibition on entering in a new address while driving is something that is worked into vehicle systems but not in an actual handheld phone. Alliance would like the opportunity to work with the sponsors and NCOIL staff in advance of the September meeting and is supportive of NCOIL's efforts in this space.

Eric Henning of General Motors (GM) stated that GM is supportive of the Model and noted that he has worked on this issue in a number of states including Georgia, Virginia and Tennessee, and Florida. If the language is worded correctly, GM likes to see these efforts pass, not only from a company perspective but also from a personal perspective as the son of GM's President of International Operations was killed by a driver that was texting. Accordingly, he has made this a very personal mission for these laws to pass. GM has proposed some clean-up amendments to the Model that do not take anything away from the Model's intent. GM looks forward to working on the Model with the sponsors and NCOIL staff.

Kristin Smith, Head of Global Road Safety Policy at Uber, stated that distracted driving is a very serious road safety issue in this country and Uber is committed to working with partners to address these issues. Uber designs its app with safety in mind in terms of

riders, drivers and other road users. In general, Uber supports the aims of the Model. Uber has a few recommendations for clarifying the Model. In general, Uber is very supportive of hands free legislation that prohibits individuals from interacting with devices in a way that could cause them to be distracted while driving. But at the same time, Uber wants to make sure that any hands free legislation is carefully crafted to ensure that individuals continue to use technology that they rely on in a safe way.

For example, Uber agrees with the language in the Model that would clarify that individuals can engage with an app with one swipe or tap which mirrors language in key state distracted driving laws. In this modern world, we know there is a range of different apps that people might be using for navigation and Uber is concerned that as-is, the Model could be interpreted as limiting an individual's access to obtaining basic text information or visual cues from the ride-sharing or navigation apps. This goes beyond ride-sharing as drivers of all types are using an array of navigation and other apps to get around safely whether that is google maps or Waze and those products can make it easier and safer and convenient to travel.

Ms. Smith stated that Uber does not believe it was the intent of the sponsors of the Model to limit these types of tools, and Uber plans to submit some proposed technical edits to make sure that the Model does not have unintended consequences that could prevent information that the driver may need in order to safely navigate the vehicle.

Cmsr. Considine stated that it is his understanding that the intent of both Sen. Hackett and Asm. Cooley was to have people not fumbling with things such as Waze. Asm. Cooley stated that he agrees and noted that the sooner the legislature sets some boundaries and rules, people who are innovators will integrate that into their product design. It is important for the Committee to listen to GM and it would be asinine to invalidate systems built into cars to be safe. The sooner we have a clear set of rules, other innovators making apps and other things can factor these sorts of rules into their product design. That is another reason why it makes sense for setting some legal standards across the U.S. to shape the marketplace and even product design.

Sen. Hackett stated that when looking at the Ohio legislation, it does ban a lot of viewing but it's all non-navigation viewing. Sen. Hackett stated that he believes Uber may want to talk about more navigational issues and how their systems work in day to day operations. Sen. Hackett stated that it is important to be careful when creating language for inclusion in the Model and noted that he agrees with Asm. Cooley that innovators will probably incorporate the rules into their design to make the equipment work. In Ohio, it was important to make sure that navigational viewing was permitted.

OPPORTUNITY FOR COMMENT/DISCUSSION ON NCOIL MODEL LAWS SCHEDULED FOR RE-ADOPTION AT NCOIL "SUMMER" MEETING

a.) Post-Assessment Property and Liability Insurance Guaranty Association Model Act (originally adopted November 2007; amended March 2015)

Rep. Rowland stated that this Model has been very successful. Essentially every state's property and liability guaranty association laws have adopted provisions from the NCOIL Model, the NAIC's Model, and the National Conference of Insurance Guaranty Fund's Model (NCIGF). Rep. Lehman stated that he had to leave the call early but noted that if anyone had any questions or comments on the Model Act to Regulate Insurance

Requirements for Transportation Network Companies and Transportation Network Drivers to please reach out to him as he sponsored that Model in Indiana.

Barbara Cox of NCIGF stated that NCIGF has some language for NCOIL to consider including in the guaranty fund Model. NCIGF has some language that would permit a guaranty fund explicitly to assess members in certain situations which is a matter of keeping the guaranty fund safety net open and operational. As much as everyone tries to pre-plan with insurance departments, liquidations do often happen suddenly and NCIGF feels that the always-ready posture is what's best for the policyholders and policy claimants. An additional amendment would address restructuring transactions which is something that has been much discussed at NCOIL. The position of NCIGF is that claims that would have been paid by the guaranty fund before the transaction continue to be covered after. Conversely, restructuring transactions such as an insurance business transfer should not create guaranty fund coverage where there was none before. NCIGF has language it can submit to NCOIL on both of those issues. NCIGF supports re-adoption of the Model.

Asm. Cooley stated that it would be helpful to have the amendments suggested by NCIGF submitted to NCOIL. In general, guaranty funds are doing their work in a constantly changing marketplace and new ideas emerge. It is very important to listen to the guaranty funds as to what they feel is the right set of current authorities for the NCOIL Model to incorporate with their understanding of their operating environment. It is important to see those amendments before the Committee's next meeting.

b.) Model Act Regarding Medicaid Interception of Insurance Payments (adopted November 2014; amended March 2015)

Rep. Rowland stated that this Model is based on a Rhode Island statute, and Texas also has a similar system. No comments from legislators or interested persons were offered.

c.) Storm Chaser Consumer Protection Act – (adopted July 2015)

Rep. Rowland stated that about half of the states have either adopted the Model or a similar statute regarding contractor fraud and abuse. No comments from legislators or interested persons were offered.

d.) Model Act Regarding Use of Credit Information in Personal Insurance – (originally adopted November 2002; re-adopted November 2005; amended 2009; re-adopted November 2015)

Rep. Rowland stated that this Model has been one of NCOIL's most successful, having been adopted in approximately 30 States. Cmsr. Considine noted that the original sponsor of the Model, Rep. Tim Osmond of Illinois, unfortunately cannot speak to the Model as he passed away shortly after the Model's passage.

Mr. O'Brien stated that this Model is one of, if not the most, influential Models that NCOIL has ever adopted. The Model has been debated and passed in a significant number of states. Vermont was the most recent state to adopt the Model in 2018. The fact of the matter is that when states consider this issue, both on the legislative and regulatory side, the Model's provisions are always considered. The most recent example is just this past May when Maine Superintendent of Insurance Eric Cioppa

pointed to the Model's extraordinary life circumstances provisions when issuing a bulletin encouraging insurers to work with customers whose credit may have been affected by the pandemic. Supt. Cioppa did so notwithstanding the fact that Maine is one of the states that has not adopted the Model. NCOIL has carved itself out a leading role in this issue. The Model has been a key feature of the debate and that has been the case for a long time. The Model has been re-adopted several times and given its influence and the attention that the issue is getting, APCIA urges NCOIL to re-adopt the Model once again.

Wes Bissett, Senior Counsel of Gov't Affairs at the Independent Insurance Agents and Brokers of America (IIABA) stated that IIABA has been a strong supporter of the Model since it was first adopted and supports NCOIL re-adopting the Model once again. The chief proponent and sponsor, Rep. Osmond, was a great legislator and also an independent agent. What he saw in the late 1990s when insurers began using credit in underwriting was some troubling business practices. As a legislator and insurance agent he was able to do something about that. He came to NCOIL and developed a Model that has arguably been NCOIL's most successful Model. The Model imposes guardrails and allows for the use of credit information in underwriting in responsible and customer-friendly ways. The Model remains as important and viable today as it did when first adopted. Given its success and relevance, IIABA encourages NCOIL to re-adopt the Model at its September meeting.

e.) Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers – (adopted July 2015)

Rep. Rowland stated that this Model has also been one of NCOIL's most successful. Nearly every state has enacted TNC legislation which either mirrors or is similar to the NCOIL Model – some of those statutes were enacted before the NCOIL Model. No comments from legislators or interested persons were offered

Rep. Rowland noted that there were some technical difficulties with Zoom earlier in the meeting and offered anyone that was not present during the discussion of the Distracted Driving Model to offer comments. No comments from legislators or interested persons were offered. Rep. Rowland again noted that since the Models scheduled for re-adoption were offered for discussion today, the plan is for the Committee to simply vote on them without further discussion during its September meeting.

ANY OTHER BUSINESS

Rep. Rowland stated that registration for the NCOIL "Summer" Meeting is now open. The meeting will be a hybrid format such that there will be both in-person and virtual attendance options available. However, for those who plan on attending in-person and have not yet registered, they are urged to do so as soon as possible as there is a limited amount of space available due to capacity constraints required by social distancing protocols at the hotel. All registration information can be found on the NCOIL website or by reaching out to NCOIL staff.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Del. Steve Westfall (WV), the Committee adjourned at 2:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING
AUGUST 21, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, August 21, 2020 at 1:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Asm. Ken Cooley (CA)
Sen. Jack Tate (CO)
Rep. Colleen Burton (FL)
Rep. Martin Carbaugh (IN)
Rep. Peggy Mayfield (IN)
Rep. Joe Fischer (KY)

Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)
Sen. Bob Hackett (OH)
Rep. Wendi Thomas (PA)
Rep. Carl Anderson (SC)
Del. Steve Westfall (WV)

Other legislators present were:

Sen. Thomas Alexander (SC)
Rep. Robin Smith (TN)

Also in attendance were:

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

QUORUM

Upon a motion made by Sen. Bob Hackett (OH), and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee waived the quorum requirement without objection by way of a voice vote.

INTRODUCTORY REMARKS

Asw. Pam Hunter (NY), Chair of the Committee, thanked everyone for joining the meeting and stated that she asked to call this interim meeting because she wanted to make sure that when the Committee meets at the "Summer" Meeting in September, the Committee is not pressed for time such that people feel unduly rushed and topics do not get properly vetted.

Asw. Hunter stated that the Committee will get started today with the final discussion on the NCOIL Short Term Limited Duration Insurance Model Act, sponsored by Rep. Martin Carbaugh (IN). The Model was first introduced at last year's Summer Meeting and the Committee has had extensive discussions and has heard from those on both sides of

the issue. Accordingly, today will be a final opportunity for legislators and interested persons to offer comments on the Model before a vote is taken at the Committee's next meeting in September. Of course, feedback between now and the September meeting is still welcome.

Next, the Committee will discuss the NCOIL Health Care Sharing Ministry Registration Model Act, also sponsored by Representative Carbaugh. This Model was also introduced at last year's Summer Meeting and thus far, opinions on the Model and the issue of health care sharing ministries in general, have varied significantly enough that a formal decision on how to proceed is proper. Therefore, today will be an opportunity to determine if the Committee should move forward with developing the Model, or table it for possible consideration at a later date.

The Committee will next hear from Chris Myers, Executive Vice President, Reimbursement & Strategic Initiatives at Air Methods Corporation (AMC), regarding air ambulance subscription membership products and the legislative and regulatory environment surrounding them. Lastly, the Committee will have an initial discussion on the possible development of an NCOIL Telemedicine Model Act.

FINAL DISCUSSION ON NCOIL SHORT TERM LIMITED DURATION INSURANCE MODEL ACT

Rep. Carbaugh thanked everyone that has worked on this Model and noted that it is almost time for a vote. Rep. Carbaugh stated that he believes very strongly that short term limited duration insurance plans are products that can really help people. This Model is based on the bill that he sponsored in Indiana and upon that bill being signed into law, he thought it was a great opportunity to present it to NCOIL for development of a model act that other states can look at. Rep. Carbaugh noted that since the bill was signed into law, many uninsured people in Indiana have been helped by these plans, and many businesses have come into the state to provide more competition and therefore lower prices. It is important to note that States are free to oversee, regulate, and even ban short-term plans – that is why he included the drafting note in Section 2 of the Model stating: "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."

The drafting note is important because opinions differ as to the value of short-term insurance plans, and some states have in fact prohibited their sale. Rep. Carbaugh noted that he of course disagrees with those states and he is a strong believer in the product, but nonetheless, it's important for the Model to be clear that states are not required to offer these plans and the Model is meant to be a framework to build on for those states that do offer such plans.

Rep. Carbaugh then noted some changes that he will be offering in the next version of the Model which will be distributed in the 30 day materials next week. The changes are largely based on the comment letter submitted by Blue Cross dated January 31, 2020. First, a new Section will be added titled "Applicability" and it will read "This Act shall apply to short term insurance plans delivered or issued for delivery to residents of this state, regardless of the situs of the contract or policy; however, nothing in this Section shall invalidate a plan validly delivered in another state."

Rep. Carbaugh stated that such language is important to include to recognize the fact that, in situations such as when short-term insurance plans are delivered to a group or association in one state and then sold to consumers in another state, insurance regulators have jurisdiction to regulate all short-term insurance plans covering residents in their state. However, the language he is proposing makes clear that a short-term plan is not nullified if it is delivered or sold in a state that permits the sale of such plans, but then resides with the consumer in a state that prohibits such plans. For instance, if someone purchased a short-term plan in Indiana and then moves to a state that prohibits such plans, the plan should not be invalidated only because that person moved to a state that prohibits them. That person may not be able to renew the plan in that state, but the plan should not be invalidated.

Next, a new Section will be added regarding rescissions that will incorporate the same rescission standards as applied to group and individual health insurance coverage. Essentially, an insurer that issues a short-term insurance plan cannot rescind such a plan once the enrollee is covered except for an act or practice that constitutes fraud or intentional misrepresentations of material fact. This is consistent with the requirements in the Public Health Service Act and is an important consumer protection to include in the Model.

Lastly, current Sections 3(c) and 6 will be amended to replace the term “participating provider organization” with “network based plan.” Rep. Carbaugh noted that in the last draft of the Model, he had changed the title of Section 6 from “preferred provider requirements” to “network based plan requirements” so that it applies to network based-plans, including preferred provider organizations, health maintenance organizations and exclusive provider organizations. Accordingly, using the term “network based plan” throughout the Model is appropriate for consistency.

Also, in current Section 6(b)(3)(i), a couple of housekeeping amendments will be made to the citations to the federal code in the form of periods between CFR and the inclusion of the section symbol. Rep. Carbaugh stated that he is open to making some further edits to the Model, but would like to have the Model ready for a vote at the “Summer” Meeting in September.

J.P. Wieske, Executive Director of the Health Benefits Institute (HBI), stated that he has some concerns with the proposed amendment offered by Rep. Carbaugh regarding “Applicability.” There is a concern that in a lot of cases, short-term plans are issued from an administrative standpoint from one state and then sold into other states. It sounds like the language offered by Rep. Carbaugh does not allow consumers to take their plan with them and limits the ability of consumers to buy short-term plans through associations. It might limit the ability of insurers to continue to sell the products in states without directly filing them in all 50 states which could create an administrative difficulty. Mr. Wieske asked Rep. Carbaugh if that is his intent because that is something that Blue Cross has pushed in other states and that would be a concern for HBI. Rep. Carbaugh stated that he does not see the point raised by Mr. Wieske to be an issue but would be happy to discuss it with him once the new language is distributed.

Brian Blase, President & CEO of Blase Policy Strategies, thanked Rep. Carbaugh for the work he has done on the Model and stated that it is good to hear about all the good things happening in Indiana since his bill was signed into law. Mr. Blase noted that he spoke at the 2019 NCOIL Annual Meeting in December on this issue and stated that he

served as Special Assistant to President Trump at the National Economic Council from 2017-2019. He also noted that he wrote a piece recently in the Health Affairs Blog on what he believes is the proper role of government regulation of the short-term market. We know exchange enrollment remains well below expectation as there are about 15 million fewer people enrolled in the exchange plans as the coverage is simply unaffordable for most people who don't receive large subsidies.

Accordingly, short term plans are a crucial option for millions of Americans. Chris Pope, a healthcare economist, conducted a study last year that compared ACA plans with short term plans and found that for equivalent insurance protection, short term plans are much lower – in some cases half the cost. Unlike the ACA markets, people do have an incentive to obtain high value from short term plans because they are spending their own money. States should allow people to purchase what works best for them. For market innovation and so that plans can best meet people's needs, policymakers should avoid imposing sweeping mandates on short-term plans. Mr. Blase stated that he believes the proposed amendments to the Model largely make sense and many of the Model's provisions are reasonable, particularly those pertaining to robust disclosure of benefits and limitations.

Mr. Blase stated that he believes two sections of the Model do merit further review – Section 6 regarding network requirements and Section 8 regarding restrictions as to how short-term plans can be priced. Those Sections will do more harm than good – particularly section 8 which will reduce choice in plan innovation, increase the number of people without insurance, harm those with pre-existing conditions and lead to more denials of coverage. Mr. Blase urged the Committee to arm consumers with information about short term plans while allowing maximum consumer choice and market innovation.

Rep. Carbaugh stated that he has previously spoken with Mr. Blase about Section 8. With regard to Section 6, it is important as networks are so prevalent and in Indiana, that Section was included as a request from the healthcare folks who have called into questions with some short term plans. Rep. Carbaugh noted that he believes short terms plans are sometimes conflated with other limited benefit health programs such as indemnity type plans but they are not the same thing. Short term plans are a substantial health insurance policy, particularly with a \$2 million minimum annual limit as the Model requires. Further, prior to changes being made in Indiana, a \$250,000 max benefit plan and a \$2 million max benefit plan had very small premium differences which made it appropriate to call for a high minimum benefit in order to provide robust benefits that can be kept for three years. With regard to Section 8, Rep. Carbaugh stated that he would be interested to hear what the Committee's thoughts are as that came out of compromise discussions in Indiana.

CONTINUED DISCUSSION ON NCOIL HEALTH CARE SHARING MINISTRY REGISTRATION MODEL ACT

Rep. Carbaugh stated that the Committee has had three very in-depth discussions on this issue at its past three meetings. Rep. Carbaugh noted that he brought this issue forward to this Committee primarily because of an experience a friend of a friend had with one of the sharing ministries that dealt with her having to pay some health expenses out-of-pocket that she expected to be "shared" within the ministry. Rep. Carbaugh then began to hear and read some other similar stories making news headlines and thought that NCOIL would be a perfect forum to discuss what the current legislative and

regulatory landscape surrounding health care sharing ministries is like, and whether any model legislation should be developed.

Rep. Carbaugh stated that if you have been involved in the discussions on this issue here at NCOIL, you know that the opinions on what should be done vary greatly. Accordingly, before NCOIL dedicates more time and resources on this issue, Rep. Carbaugh stated that he wanted to check the pulse of the Committee members and interested persons to determine whether the organization should move forward with developing a Model law, or table the issue and perhaps return to it at a later date. It seems that those who favor the sharing ministries do not want much of anything in the form of regulation while others who are not supportive of the sharing ministries do not want any regulation as that would validate such ministries. Accordingly, the Committee is at somewhat of an impasse. Before opening it up for comments, Rep. Carbaugh stated that he does believe there is a proper role for health care sharing ministries and that they can provide a lot of value and help for people but at this time it seems like it may be best to table the Model due to the wide array of opinions on the issue.

On behalf of the Alliance for Healthcare Sharing Ministries, Brad Nail stated that the Alliance agrees that this issue could use some more development and discussion. The Alliance has no problem with tabling the Model and the Alliance still sees a benefit to an organization like NCOIL promulgating a Model for states to use. Accordingly, the Alliance may return to NCOIL at a later date and ask for a Model to be developed.

Kevin McBride, attorney for Sharable LLC which is a technology provider for health care sharing, stated that Sharable and many others are working with the IRS on a tax deduction for health care sharing ministries. That issue should be worked through in the coming months and might include a definition of a health care sharing ministry. Therefore, Sharable's request is to table the Model, but not permanently as there may be future developments after the IRS finishes its work that would warrant action by the Committee. Rep. Carbaugh then stated that he would like to table the Model from the Committee's agenda.

DISCUSSION ON AIR AMBULANCE SUBSCRIPTION MEMBERSHIP PRODUCTS

Chris Myers, Executive Vice President, Reimbursement & Strategic Initiatives at Air Methods Corporation (AMC), stated that his goal today is to stress why this is an issue and to request that states regulate air ambulance subscription membership products. Emergency air medical services are extremely rare services, used on average about 350,000 times per year compared to 15 million ground ambulance uses per year. Emergency air medical services do not self-dispatch – they get a call from a medical professional or a first responder following state protocols for emergency services. Air medical services are then off the ground in 15 minutes after receiving the call and they do not know much about the patient other than size and weight to make sure they can fit in the aircraft. The services are essentially a flying ICU – it's not just the speed in which the patient is moved but also the services provided including those of a medic and nurse who have specialty care and can do things most clinicians don't do like intubating or providing drugs during flight. Mr. Myers stated that emergency air medical services largely service rural America. A typical situation is such that a patient in a rural hospital will have a condition like a stroke and they are immediately transported to a Level 1 trauma center with the opportunity to receive proper treatment.

With regard to the current state of the industry, Air Methods saw a history of some billing practices that were not great and asked themselves “how can we change that?” Accordingly, Air Methods essentially adopted four pillars focused on eliminating balance billing and getting the patient out of the middle. The best way to do that is go out and get in-network agreements with payers. Air Methods has done that over the past few years and has gone from less than 10% in network with commercial payers to 50% today. Some remaining payers that have to be brought in are Cigna and Aetna. Despite persistent efforts, no major independent national payers have been willing to go in-network.

Air Methods uses a patient advocacy philosophy so for those patients that are transported that have an out of network payer, as soon as that is understood which is usually about 10 days after transport Air Methods will reach out to the patients and assign them an individual and let them know from the beginning saying, for example: “Hi, my name is Chris. We understand that you have Aetna as an insurance provider. Unfortunately, they are out of network with us and we are going to have a long process to get your claim paid but we are going to work with you throughout that process which will require, unfortunately, you – the patient – to be involved because your payer won’t respond to us as an out of network provider. If you can work with us throughout the process to file appeals and to provide information to them, we will get your claim paid and you will have no balance bill – you will only be responsible for the copay and deductible.” That has been very effective both by reducing out of pocket expenses and balance bills and also just giving patients a sense of comfort during a difficult time.

Mr. Myers stated that the next opportunity for Air Methods is to fix the cost shift in the industry. Today, 70% of the patients that Air Methods flies reimburse at Medicare or less. Medicare reimburses about \$5,800 per transport and the average cost is about \$12,000 per transport. That represents about 30% of their population that is just Medicare. Another 40% pay less than Medicare. So, there is a massive cost shift in the industry that needs to be fixed and Air Methods is working hard with CMS and HHS to allow themselves to do cost reporting so that there can be a Medicare rate that is at least close to their cost.

With regard to air ambulance subscription products, the reality is that Air Methods has been able to have a lot of success without having memberships. Air Methods’ average out of pocket cost for all patients, including self-pay, is only \$167. Mr. Myers stated that he paid more than that this morning at the dentist’s office. The strategies that Air Methods has deployed have been very effective and they will not stop until they can get rid of all balance bills. 90% of Air Method’s patients never receive a balance bill because of the in-network progress that has been made in the commercial space.

Air ambulance membership products were started with a good intention and that intention was that since payers are rejecting more and more claims patients need to be protected from big out of pocket expenses. However, that landscape has changed and memberships have become less relevant and at this point have become problematic. They are problematic because patients really don’t need them. Membership is supposed to cover the balance billing portion that a patient may receive if their insurance doesn’t pay. However, that has become less of a problem because of the gains with network participation. Even for those cases that are out of network, Air Methods deploys the patient advocacy strategy so that patients are guided through a balance bill process – and patients don’t have to pay for that strategy, nor should they. The other issues with

membership products is that they are marketed in a way and sold to people who don't need them. Some marketing materials include "senior pricing" – why would someone with Medicare need a membership when they have a defined copay and deductible. It doesn't make any sense. From Air Method's perspective, the folks that are selling memberships are using fear as a tactic to get them to buy a membership when they don't really need it. Membership products started as somewhat of a backstop but they now have a significant revenue stream where they have whole business models just around the membership program which in Air Method's estimation could generate \$100-\$200 million in revenue.

The problem with memberships is that they get marketed from a standpoint of fear. It shouldn't be that way and from Air Method's patient advocacy perspective, it does many of the things for free that the membership products claim that they will do so patients shouldn't have to pay a membership fee for that. The other thing with the way membership products are sold is that a helicopter will be flown into a county fair and people will be told how great it is but that if they don't want to be stuck with huge balance bills they need to buy membership products. The gist of all of that is to say that there are much more effective ways to do these type of things which involve in network advocacy, patient advocacy and working in ways not to collect dollars from patients but from payers.

Mr. Myers stated that you will see some areas where patients will actually refuse a flight even the doctor has ordered it because they have a membership and they don't know if the aircraft that is going to fly them is a part of that membership program. That has created a dynamic where patients are not getting the care they need because they don't know if the membership that they have will cover things. That creates more confusion which is also exacerbated by selling membership products to the elderly population that don't need them. Mr. Myers stated that Air Methods asks that a solution be developed to protect consumers from memberships. Air Methods believes that they act, look, and sound like an insurance product and therefore should be regulated as an insurance product. The hope is that the confusion and fear that is used to sell membership products is eliminated.

Sen. Bob Hackett (OH) stated that Ohio is working very hard to eliminate surprise billing and a deal that has involved compromise with everything is almost complete. Sen. Hackett asked if Ohio will be a state that allows membership products if surprise billing is no longer a problem. Mr. Myers stated that he does not believe just eliminating surprise billing will get rid of memberships. Memberships will still be sold because they have been marketed as a way to cover a copay and deductible as well – so even though you didn't get a surprise bill you may have a high deductible plan and the membership can solve that. Air Methods believes there are issues with that approach as well because copays and deductibles exists as a means to overutilization and they are not supposed to be routinely forgiven. That is problematic and memberships will still continue despite surprise billing legislation.

Mr. Myers further stated that it is important to note that there is a Committee that the Department of Transportation (DOT) has started – the Air Ambulance Patient Billing Advisory Committee – that is tackling this issue. Mr. Myers stated that he is a member of that Committee and the Committee started its work in January with the goal of recommendations ready by June to give to Congress. Since the pandemic occurred that

deadline was not met but meetings have resumed and the goal is to have recommendations ready by the end of the year.

Rep. Deborah Ferguson (AR), Vice Chair of the Committee, stated that she hopes any legislation on this issue would have measures in it to prevent membership products being sold to Medicare and Medicaid patients along with significant penalties for doing so since those are covered services that the patient may not be aware of. Mr. Myers agreed.

Asw. Hunter asked Mr. Myers to discuss what Air Methods is trying to facilitate with CMS on this issue. Mr. Myers stated that Air Methods has engaged CMS to look into membership products. Air Methods knows of no other similar product that is sold and marketed to Medicare and Medicaid beneficiaries. Air Methods has provided a memo to CMS that outlines these concerns with the goal of regulating these products and above all protecting Medicare and Medicaid patients.

Asw. Hunter thanked Mr. Myers and noted that this issue will not be discussed at the upcoming "Summer" Meeting but noted that it may be on the agenda at the Annual Meeting in December with something concrete to discuss such as a draft Model Act or Resolution. Asw. Hunter urged any comments or questions to be directed to NCOIL staff.

DISCUSSION ON DEVELOPMENT OF NCOIL TELEMEDICINE MODEL ACT

Asw. Hunter stated that as we all know, COVID-19 has impacted several different kinds of industries and forced them to adapt to new ways of doing business. One example of that adaptation is the rapid expansion of telemedicine. Telemedicine is not new – in fact this Committee discussed the issue at length several years ago – but the global pandemic has caused both federal and state telemedicine laws to be examined in order to make sure patients can receive the care they need without any delays; such as when quarantined during a global health emergency like the one in which we find ourselves.

As an example of how significant the expansion of telemedicine has been, CMS reported there was an average of 13,000 telemedicine visits per week prior to the pandemic. But in the last week of April alone, almost 1.7 million Medicare beneficiaries had a telemedicine visit. There appears to be almost unanimous agreement that once we finally return to a sense of normalcy following the pandemic, the expansion of telemedicine is here to stay. Some states have already taken action to enact legislation that would make many of the telemedicine flexibilities expanded during the pandemic permanent. Asw. Hunter stated that she thinks this presents a great opportunity for NCOIL to get involved and provide guidance to states in the form of telemedicine model legislation and she would be proud to sponsor such a model. Asw. Hunter stated that she would like to hear from legislators and interested persons today as to what their thoughts are on what should or should not be in an NCOIL telemedicine model act.

Asw. Hunter stated that she would then like to include a first draft of a model in the 30 day materials for the "Summer" Meeting, which will be distributed next week. The committee will then have an opportunity to discuss the first draft in September. Asw. Hunter noted that during the pandemic she has used telemedicine and has found it to be very easy in a place like Syracuse, NY that is a transportation desert and people don't

have opportunities to get to appointments or are concerned about contracting COVID-19. Telemedicine is a great option to be able to use as a healthcare resource.

Rep. Ferguson stated that if nothing else, this pandemic has really escalated the use of telemedicine. Rep. Ferguson stated that she passed the first telemedicine bill in Arkansas almost six years ago but she still thinks that, despite certain exceptions being made for the pandemic, it still needs to be focused on best practices and the best practice of medicine. Certain things such as waiving copays have been done during this crisis but with regard to establishing a patient-provider relationship, Arkansas law states that it has to be an audio-visual visit. Phone calls are a different thing – Medicare pays for phone calls but if you are really having an audio-visual visit payment parity is important because they are going to follow the same CPT codes and get reimbursed at the same level whether it's a 15 minute visit or a 30 minute visit. Parity is important.

Rep. Ferguson also stated that she does not want to see telemedicine go the way of pharmacy benefit managers (PBMs) where they gradually start impeding on the practice of medicine like they have with pharmacies. Rep. Ferguson further stated that another thing she sees is that a lot of the telemedicine companies when a patient gets online and fills out a 25 page questionnaire are calling that a medical record and they want that to be store and forward. Store and forward has been around a long time and medical records are exchanged all the time between primary care physicians and specialists. Filling out a questionnaire online is not store and forward because that is not sharing medical record information. Those parameters are important. Some states have discussed the issue of telemedicine licensing but that is not an issue in Arkansas because you can conduct telemedicine in Arkansas if you don't have a physical location in the state. Rep. Ferguson stated that it is her understanding that in some states it is more difficult to get a license and telemedicine cannot be conducted unless there is a physical brick and mortar location in the state.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that the concern he has had all along with telemedicine is some of what was expressed by Rep. Ferguson and some of what has been discussed in the past. We cannot allow telemedicine to become a substitute for in-person healthcare when in-person healthcare is the appropriate means of delivering healthcare. Asm. Cahill stated that he is concerned on both fronts – in terms of insurers trying to incentivize or force consumers into telemedicine and also providers who would perhaps find a way to use those services in lieu of in-person visits when in-person visits are more appropriate. Situations involving Medicaid present a problem because many poor people do not have access to broadband technology and video services. Asm. Cahill stated that the federal qualified health plan in his community in the beginning of the pandemic found it virtually impossible to conduct telemedicine visits so what happened was that people went without healthcare. The rule changed at the federal level allowing telephonic meetings that were not consults but actual full blown office visits.

Asm. Cahill stated that we need to have all of these things in consideration when drafting a balanced model act so that when it gets implemented into states it does not change the nature of healthcare. We also need to recognize, which was brought up several years ago to this Committee, the vast differences from one state to another. Some places have a girth of healthcare in urban areas and none in rural areas and telemedicine is an important tool for that purpose. This is not a piece of legislation that should specifically encourage or discourage the use of telemedicine but it does have to

take into consideration all of the competing interests. Asm. Cahill stated that he hopes that an NCOIL model act is consumer centric and has provisions addressing the points that have been raised.

Sen. Hackett stated that years ago he worked hard to get a telehealth bill passed in Ohio but one of the ways that was done is that there was no payment parity – reimbursement was slightly less. Sen. Hackett stated that the expansion of telemedicine has been one of the positive things to come out of the pandemic. He stated that he was just on a Zoom call where a medical hospital system increased their telehealth by over 1,000%. They went from under 500 per month to 30,000 per month. One point to make is that this is working very well in that you are not seeing people run to the emergency room as often as they did in the past. We are also seeing appointments being held with providers. Sen. Hackett stated that he has had several telehealth visits via phone and it works very well. Sen. Hackett stated that he thinks it is a good system and he understands everyone wants their health to be better and telehealth can help people seem providers more than they have in the past. It is important to understand that the emergency room system looks like it has been changing for the better in terms of less frequent visits given the expansion of telehealth. Sen. Hackett stated that he has changed slightly in his views towards payment parity and he knows that providers would make more money in this situation but it is a win-win as costs will be better controlled. We want people to be healthier and providers are seeing patients more than they normally would. Accordingly, the system in this country could be changed for the better because of telehealth. Ohio is currently working on further telehealth legislation.

Rep. Robin Smith (TN) stated that in Tennessee with regard to payment parity and making it friendly to existing providers, Tennessee created a definition of provider based telemedicine and contrasted that with what was existing in code of telehealth. Telehealth being facility to facility and provider based telemedicine being a Tennessee practitioner licensed by a governing board whether it be a nurse or a EA, physician, therapist, etc. – provider based telemedicine would fall under that governance and there would have to be an existing relationship with that Tennessee based provider. That would in no way prohibit a contractual in-network pool of a franchise telemedicine/Teledoc/MD live. The legislation permits Tennessee providers to interact with Tennessee patients. By using CPT codes that currently exists and by putting in code that all of this would be subject to utilization review, Tennessee was able to push payment parity. Rep. Smith stated that she would be happy to work with the Committee to use provisions of the Tennessee law as part of the Model. Tennessee found it was important not to eliminate that which was already in existence which was functioned as telehealth facility to facility – it was just expanded and they made sure that franchise type telemedicine would not be impacted and wouldn't creep into provider based telemedicine which does require a live, virtual visit and the use of store and forward. That is what is eligible.

Rep. Colleen Burton (FL) stated that in 2019, Florida enacted telehealth legislation that relates to the relationship of physicians and patients and other medical practitioners. It is a broad piece of legislation but there is language which deals with out of state providers. There is a process whereby a physician licensed outside Florida can practice. There have been conversations regarding billing but at this point in time no one has moved forward on that issue. Florida is very proud of the legislation enacted and would be happy to work on model legislation with NCOIL.

Rep. Ferguson stated that she wanted to clarify that in Arkansas if there is already an existing patient-provider relationship or if there is access to the medical record then phone calls count but it is important that it is an actual medical record and not just an online document.

Sen. Jack Tate (CO) stated that he was able to carry a telemedicine bill in Colorado and have it enacted. One of the issues that arose at the end was to what degree should the availability of telemedicine clinicians be able to use toward network adequacy requirements. That is a very interesting topic as significant capital investments have been made for brick and mortar locations and this presents a different model. That is a topic that should be discussed further.

Brendan Peppard, Regional Director, State Affairs of America's Health Insurance Plans (AHIP), stated that during the pandemic telehealth has emerged as a tool that improves access by removing traditional barriers to the use of healthcare such as distance, mobility and time constraints and for those individuals who are compromised or for those doctor offices that were closed it has allowed people to access healthcare. Health insurance providers are supportive of the appropriate use of telehealth to provide access and reduce cost to necessary medical services to its members. Prior to this health crisis, telehealth was a growing industry and most health insurance providers offered virtual access to their members but uptake had been low. Trends have begun to change. Access from the government and from health insurance providers have promoted growth. A FAIR Health report showed an 8,000% increase in telehealth visits.

There have been some key areas of increased flexibility during the health crisis including flexibility around originating sites, patient and provider location, increased allowance for the services available, providers eligible to practice via telehealth, and eligible technology. We have also seen rural health clinics and FQHCs being permitted to deliver telehealth. Mr. Peppard stated that in order to move forward following the pandemic, health insurance providers have some recommendations about things that can cement the positive changes we have seen regarding the use of telehealth. First, during the crisis many states lessened restrictions on practicing medicine across state lines. A physician's ability to practice across state lines is determined by a state whenever licensure was granted, potentially restricting the ability of clinicians to deliver virtual care to patients outside the state of their license. AHIP recommends that states allow providers to practice in multiple states to increase access across the entire country and allow for the creation of a national network of providers if that is something that makes sense.

Next, inconsistent state regulations, restrictions or mandates relating to budgets, services or technologies or originating sites may limit health insurance providers ability to design benefits that best meet patient needs. The use of telehealth services should be expanded to provide better access to care for people living in underserved areas. Telehealth can extend the reach of care teams, allow for around the clock monitoring, increase data collection guide an individual's treatment, and may provide more timely responses to crises during treatment. We should leverage telehealth to target services for underserved communities and ensure convenient access to high quality, affordable care. A recent report from Teledoc indicated that half of behavioral telehealth interactions were with men ages 20-35, a notoriously hard to reach demographic. As demonstrated by that example, some populations may be more comfortable using

telehealth as a means to receiving services. Requiring equivalent telehealth and in-person payment rates eliminates the cost-saving potential of telehealth.

Mr. Peppard stated that AHIP's recommendations is to allow for flexibility in negotiating appropriate payment rates for telehealth services. The savings from those negotiations can and do benefit the consumer. Payment parity may have made sense during the pandemic as doctor's offices were closed and people couldn't get to doctor's offices when they were open because they may not have been comfortable or because they should not have been going due to compromised immune systems. However, post-pandemic, AHIP believes that payment parity doesn't make sense and it should be left to a negotiation. Telehealth visits don't always require the same type of intensity, the same amount of time, or the same equipment as brick and mortar visits. Therefore, reimbursement parity should not be required. AHIP also believes that telehealth should not become a replacement for needed in-person visits. One of things that we have seen are concerned about is a drop in necessary vaccination rates. Obviously, those cannot be done via telehealth and we have to encourage people to go to their doctors. We don't want to create an inappropriate incentive to substitute a telehealth visit for a necessary in-person visit.

The explosion of telehealth under COVID-19 has provided opportunities and raised new questions. Ultimately, the growth is good. Health insurance providers have been promoting telehealth use for a decade and it is believed that much of what has been seen regarding the increase in utilization is positive. Telehealth has proven useful, especially among underserved and difficult to reach populations and geographies. Telehealth is not inherently most risky than in-person services but with increased volume we need to make sure it is safe, effective, and efficient care. Mr. Peppard thanked the Committee for the opportunity to speak and stated that AHIP stands ready to work with the Committee going forward.

Mr. Wieske stated that in addition to the HBI he represents Horizon government affairs and he previously was deputy Commissioner for the State of Wisconsin and he worked directly on network adequacy issues which is a very important topic to understand in a model act. For consumers, especially in a rural setting, having access to telehealth can provide access to providers to dermatologists and others that are just not practicing in rural settings. That is important to understand. The NAIC network adequacy model act does include provisions as to how telehealth can be used inside a network adequacy model. Mr. Wieske stated that it is also important to be careful as we go through this process that there is a lot to get wrong around telehealth. We have seen the movement of regulations that have increased the availability of telehealth – not just from COVID-19. That indicates the importance of regulatory flexibility. Looking at sites of service is important. Also, licensing is important - in a lot of cases recently it is not just telehealth licensing flexibility but broader licensing issues including moving beyond the compact licensing of medical doctors in this area. It is also important to look at software issues and not pick winners and losers. In some cases, audio is the only way individuals can access care and there shouldn't be issues surrounding that. In other cases, winners and losers should not be picked between Microsoft, Google and other products. That is something a number of states have looked at.

Emily Carroll, Senior Legislative Attorney at the American Medical Association (AMA), stated that the AMA welcomes the opportunity to work with NCOIL on a telemedicine model act. In the AMA's view, a model act is extremely timely as the pandemic is really

pushing stakeholders to realize the value of care provided via telemedicine. For example, telemedicine is allowing patients, especially those vulnerable to COVID-19 complications to continue access to care safely with their physicians. It is also helping physicians maintain their practice and staff during stay at home orders when providing in-person care is not safe or feasible. It has also been an important tool in addressing longstanding inequities although much work remains there to ensure that patients have access to broadband and other technologies. If the Committee decides to move forward with a telemedicine model act, the AMA would love the opportunity to offer a number of recommendations related to access, coverage, payment. The AMA will plan to offer those recommendations in writing and they will focus on advancing telemedicine not as a replacement for in-person care but as a valuable supplement to in-person care to improve coordination of care and ensure vulnerable populations have access to physicians and realize the efficiencies and ROI that come with expanding the means by which care can be provided. The AMA looks forward to working with the Committee on these issues.

Rep. Burton stated that with regard to payment parity, Florida has not considered mandating any particular formulas for payment. Current Florida law is flexible so it leaves those arrangements between the providers of insurance and providers of medical care. That does require a lot of oversight by regulators which can sometimes be a challenge. Florida is excited about telehealth as it is expanding their just like in other states and it was good that Florida was flexible enough to allow for such frequent telemedicine use during the pandemic. There is a lot of rural space in Florida.

Asw. Hunter thanked everyone for their comments and stated that she looks forward to working with everyone going forward.

ADJOURNMENT

Upon a Motion made by Asm. Cooley (CA), NCOIL Vice President, and seconded by Del. Steve Westfall (WV), the Committee adjourned at 2:15 p.m.