30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL ANNUAL MEETING
DECEMBER 9 - 12, 2020

As of November 9, 2020, and Subject to Change

Tampa Marriott Water Street Hotel
Tampa, Florida

NCOIL ANNUAL MEETING
Tampa, Florida
December 9 - 12, 2020
TENTATIVE SCHEDULE

WEDNESDAY, DECEMBER 9th

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Special Committee on Race in Insurance Underwriting	9:30 a.m.	-	5:00 p.m.
Session 1: *9:30 a.m. – 1:00 p.m.*			
Session 2: *2:00 p.m. – 5:00 p.m.*			
Adjournment	5:00 p.m.		
Welcome Reception	6:00 p.m.	-	7:00 p.m.

THURSDAY, DECEMBER 10th

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:30 a.m.	-	10:00 a.m.
Networking Break	10:00 a.m.	-	10:15 a.m.

General Session Bitcoin and Beyond: What Is This Stuff And How Do We Insure It?	10:15 a.m.	-	11:30 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	11:30 a.m.	-	12:45 p.m.
Legislator Luncheon	12:45 p.m.	-	1:45 p.m.
Health Insurance & Long Term Care Issues Committee	1:45 p.m.	-	3:15 p.m.
Networking Break	3:15 p.m.	-	3:30 p.m.
Financial Services & Multi-Lines Issues Committee	3:30 p.m.	-	4:45 p.m.
Adjournment	4:45 p.m.		
CIP Member & Sponsor Reception	5:00 p.m.	-	6:00 p.m.

FRIDAY, DECEMBER 11TH

Registration *Exhibits Open: 8:30 a.m. – 4:30 p.m.*	8:00 a.m.	-	4:00 p.m.
Workers' Compensation Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:45 p.m.

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

Health General Session What Next for Federal Healthcare? A New Presidency – SCOTUS Decision Looming	1:45 p.m.	-	3:15 p.m.
Life Insurance & Financial Planning Committee	3:15 p.m.	-	4:30 p.m.
Adjournment	4:30 p.m.		

SATURDAY, DECEMBER 12TH

Registration *Exhibits Open: 8:30 a.m. – 12:00 p.m.*	8:00 a.m.	-	12:00 p.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:45 a.m.
Networking Break	10:45 a.m.	-	11:00 a.m.
NCOIL Innovation Series Medical Cannabis: Evaluating the Evidence	11:00 a.m.	-	12:30 p.m.
Business Planning Committee and Executive Committee	12:30 p.m.	-	1:15 p.m.

******Please note all speakers listed are scheduled to speak as of November 9, 2020. There will be modifications between now and the start of the Meeting.******

WEDNESDAY, DECEMBER 9, 2020

Special Committee on Race in Insurance Underwriting

******The roster of speakers for this Committee is still under development. The Committee welcomes further submissions of any materials and potential speakers.******

Chair: Sen. Neil Breslin (NY)

Session 1: 9:30 a.m. – 1:00 p.m.

1.) Call to Order/Roll Call
2.) Overview of Insurance Ratemaking Statutory Framework
3.) Discussion on Definition of "Proxy Discrimination"
4.) Lunch Recess

Session 2: 2:00 p.m. – 5:00 p.m.

1.) Call to Order
2.) Rating Factor Discussion
3.) Any Other Business
4.) Adjournment

Welcome Reception
Wednesday, December 9, 2020
6:00 p.m. – 7:00 p.m.

THURSDAY, DECEMBER 10, 2020

Welcome Breakfast
Thursday, December 10, 2020
8:30 a.m. – 10:00 a.m.

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

Networking Break
Thursday, December 10, 2020
10:00 a.m. – 10:15 a.m.

General Session
Bitcoin and Beyond: What Is This Stuff And How Do We Insure It?
Thursday, December 10, 2020
10:15 a.m. – 11:30 a.m.

Moderator: Asw. Pam Hunter (NY)

Michael Menapace, Esq.
Partner
Wiggin and Dana

Matthew Kohen, Esq.
Senior Counsel
Carlton Fields

Justin Wales, Esq.
Senior Counsel
Carlton Fields

Jeff Hanson
Executive Risk Team
Paragon Brokers

Joint State-Federal Relations & International Insurance Issues Committee
Thursday, December 10, 2020
11:30 a.m. – 12:45 p.m.

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

1.) Call to Order/Roll Call/Approval of September 24, 2020 Committee Meeting Minutes
2.) Update on Pandemic Business Interruption Coverage Proposals
Deirdre Manna, Senior VP, Head of Gov't & Industry Affairs – Zurich North America
Peter Caminiti, Property Technical Director - Zurich North America
3.) Discussion on Canada's Life and Health Insurance Marketplace Response to COVID-19
Stephen Frank, President & CEO – Canadian Life & Health Insurance Association (CLHIA)
4.) Re-adoption of Model Law
-Market Conduct Annual Statement Model Act (Originally Adopted: November, 2010; Readopted: November, 2015)
5.) Any Other Business
6.) Adjournment

Legislator Luncheon
Thursday, December 10, 2020
12:45 p.m. – 1:45 p.m.

Dr. Lawrence "Lars" Powell
Director
University of Alabama Center for Insurance Information and Research

Health Insurance & Long Term Care Issues Committee
Thursday, December 10, 2020
1:45 p.m. – 3:15 p.m.

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

1.) Call to Order/Roll Call/Approval of September 26, 2020 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Telemedicine Authorization and Reimbursement Act
Asw. Pam Hunter (NY) – Sponsor

Joann Volk, Research Professor – Georgetown University Center on Health Insurance Reforms
Jennifer DeYoung, Director of Public Policy, Building Blocks of Health Reform - United States of Care
Brendan Peppard, Regional Director of State Affairs – America's Health Insurance Plans (AHIP)

3.) Consideration of NCOIL Vision Care Services Model Act
Sen. Bob Hackett (OH) – Sponsor
Brendan Peppard, Regional Director of State Affairs – America's Health Insurance Plans (AHIP)
Robert Holden, State Gov't Affairs Director – National Association of Vision Care Plans (NAVCP)
American Optometric Association (AOA) Representative

4.) Consideration of 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)
National Association of Dental Plans (NADP) Representative
Brendan Peppard, Regional Director of State Affairs – America's Health Insurance Plans (AHIP)

5.) Introduction of Air Ambulance Subscription Service Model Act
Rep. Tom Oliverson, M.D. (TX); Del. Steve Westfall (WV) – Sponsors
Chris Myers, Executive Vice President, Reimbursement and Strategic Initiatives – Air Methods Corporation
Global Medical Response (GMR) Representative

6.) Any Other Business
7.) Adjournment

Networking Break
Thursday, December 10, 2020
3:15 p.m. – 3:30 p.m.

Financial Services & Multi-Lines Issues Committee
Thursday, December 10, 2020
3:30 p.m. – 4:45 p.m.

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

1.) Call to Order/Roll Call/Approval of September 26, 2020 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Insurer Division Model Act
Sen. Matt Lesser (CT) – Sponsor
3.) Discussion on COVID-19 Insurance Modernization Initiatives

a.) Remote Notarization

Frank O'Brien, VP of State Gov't Relations – American Property Casualty Insurance Association (APCIA)

b.) Producer Licensing

Wes Bissett, Senior Counsel, Gov't Affairs, Independent Insurance Agents & Brokers of America (IIABA)

c.) Other

4.) Any other business

5.) Adjournment

CIP Member & Sponsor Reception
Thursday, December 10, 2020
5:00 p.m. – 6:00 p.m.

FRIDAY, DECEMBER 11, 2020

Workers' Compensation Insurance Committee
Friday, December 11, 2020
9:00 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of September 25, 2020 Committee Meeting Minutes

2.) The ABC's of Experience Rating

National Council on Compensation Insurance (NCCI) Representative

3.) Discussion on Florida's Workers' Compensation Insurance Marketplace Responses to COVID-19

David W. Langham, Deputy Chief Judge of Compensation Claims – Florida Office of Judges of Compensation Claims

Ya'Sheaka Williams, Esq., Partner – Eraclides Gelman

Geoff Bichler, Esq., Founding Member & Managing Partner – Bichler & Longo, PLLC

4.) Any Other Business

5.) Adjournment

Networking Break
Friday, December 11, 2020
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, December 11, 2020
10:45 a.m. – 12:00 p.m.

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

1.) Call to Order/Roll Call/Approval of September 25, 2020 Committee Meeting Minutes
2.) Update on State Adoption of Amended NAIC Credit for Reinsurance Models
3.) Update on Proposed Changes to SSAP No. 71
4.) Discussion on NAIC Special Committee on Race in Insurance
5.) Discussion on NAIC Market Conduct Annual Statement (MCAS) Blanks (D) Working Group Initiatives
6.) Any Other Business
7.) Adjournment

Luncheon with Keynote Address
Friday, December 11, 2020
12:00 p.m. – 1:45 p.m.

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

Health General Session
What Next For Federal Healthcare? A New Presidency – SCOTUS Decision Looming
Friday, December 11, 2020
1:45 p.m. – 3:15 p.m.

Abbe R. Gluck
Professor of Law and Faculty Director of the Solomon Center for Health Law and Policy - Yale Law School
Professor of Internal Medicine (General Medicine) - Yale Medical School

Chris Pope, Ph.D
Senior Fellow
Manhattan Institute

The Hon. Jim Atterholt
Former Indiana Insurance Commissioner and
Former Chief of Staff to Governor Mike Pence

Life Insurance & Financial Planning Committee
Friday, December 11, 2020
3:15 p.m. – 4:30 p.m.

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

1.) Call to Order/Roll Call/Approval of September 26, 2020 Committee Meeting Minutes
2.) Regulatory Challenges and Temp-to-Perm Efforts in a Touchless Society
Jordan Martell, Vice President, Innovation Counsel – Pacific Life
3.) Accelerating Life Insurance Innovation to Create Meaningful Change
Brooks Tingle, President & CEO – John Hancock Insurance
4.) Any Other Business
5.) Adjournment

SATURDAY, DECEMBER 12, 2020

Property & Casualty Insurance Committee
Saturday, December 12, 2020
9:00 a.m. – 10:45 a.m.

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

1.) Call to Order/Roll Call/Approval of September 24, 2020 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Distracted Driving Model Act
Asm. Ken Cooley (CA), NCOIL Vice President; Sen. Bob Hackett (OH) – Sponsors
Wayne Weikel, Senior Director – Alliance for Automotive Innovation
3.) Introduction of NCOIL Coronavirus Limited Immunity Model Act
Rep. Bart Rowland (KY) – Sponsor
Rep. Matt Lehman (IN), NCOIL President – Co-Sponsor
Rebecca Dixon, Executive Director – National Employment Law Project (NELP)
Frank O'Brien, VP of State Gov't Relations – American Property Casualty Insurance Association (APCIA)
Andrew Kirkner, Regional VP – Ohio/Mid-Atlantic Region – National Association of Mutual Insurance Companies (NAMIC)
Lauren Pachman, Counsel and Director of Regualtory Affairs – National Association of Professional Insurance Agents (PIA)
4.) Update on No-Pay No-Play Laws
Professor Adam Scales – Rutgers Law School

Andrew Kirkner, Regional VP – Ohio/Mid-Atlantic Region – National Association of Mutual Insurance Companies (NAMIC)

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

Asm. Ken Cooley (CA), NCOIL Vice President – Sponsor
National Conference of Insurance Guaranty Funds (NCIGF) Representative

6.) Any Other Business
7.) Adjournment

Networking Break
Saturday, December 12, 2020
10:45 a.m. – 11:00 a.m.

NCOIL Innovation Series
Medical Cannabis: Evaluating the Evidence
Saturday, December 12, 2020
11:00 a.m. – 12:30 p.m.

Moderator: Rep. Michael Webber (MI)

Wade M. Aubry, MD
Clinical Professor of Medicine and Health Policy
University of California, San Francisco
Former Blue Cross Blue Shield Medical Director

Mark Bolton
Sr. Director, Public Policy
Greenwich Biosciences

Business Planning Committee and Executive Committee
Saturday, December 12, 2020
12:30 p.m. – 1:15 p.m.

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

1.) Call to Order/Roll Call/Approval of September 26, 2020 Committee Meeting Minutes
2.) Update on Future Meetings
3.) Administration
    a.) Meeting Report

b.) Receipt of Financials

4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted therein

5.) Other Sessions

a.) Legislator Luncheon

b.) Featured Speakers

6.) Nominating Committee Report

7.) Any Other Business

-Consideration of Auditor

8.) Adjournment

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Market Conduct Annual Statement Model Act

Readopted by the NCOIL State-Federal Relations Committee on November 13, 2015, and by the Executive Committee on November 15, 2015. Adopted by the NCOIL State-Federal Relations Committee on November 19, 2010, and Executive Committee on November 21, 2010.

To be considered for re-adoption during the Joint State-Federal Relations & International Insurance Issues Committee on December 10, 2020.

Section 1. Short Title

This Act shall be known as the *Market Conduct Annual Statement Act.*

Section 2. Purpose

The purpose of this Act is to enable the Commissioner to collect Market Conduct Annual Statement ("MCAS") data for analysis purposes. The procedures set forth under this statute shall be the exclusive method for collecting and sharing MCAS information.

Drafting Note: Each state shall determine whether participating in the Market Conduct Annual Statement and providing such information under this Act is a condition precedent to accreditation by the National Association of Insurance Commissioners.

Section 3. Scope

This Act applies to admitted insurers with direct written premium exceeding $50,000 in this state in lines of business subject to NAIC MCAS.

Section 4. Definitions

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

A. "Commissioner" means [insert the title of the chief insurance regulatory official].

B. "Designee" means an entity that meets the requirements under this Act serving as an MCAS statistical agent the Commissioner designates under Subsection 5(C) or a qualified professional organization or person outside his or her department under Subsection 6(B).

C. "Insurer" means an admitted insurance company subject to the scope of Section 3 of this Act and to filing submission under Subsection 5(B).

D. “Market Analysis” means a process whereby market conduct surveillance personnel collect and analyze information from filed schedules, surveys, required reports and other sources in order to develop a baseline and to identify patterns or practices of insurers licensed to do business in this state pertaining to company operations and management, complaint handling, marketing and sales, producer licensing, policyholder services, underwriting, and claims. Such analysis may include, but is not limited to, practices that may pose a potential risk to the insurance consumer. Market Analysis does not represent standards for market behavior and does not establish compliance or non-compliance.

E. "Market Conduct Annual Statement" or "MCAS" means the Market Conduct Annual Statement as approved by the National Association of Insurance Commissioners ("NAIC") and as amended by the NAIC from time to time in accordance with the established procedures of that organization, provided that the MCAS and any changes thereto have been adopted as law in this state or have been recommended by the Commissioner and approved pursuant to the Administrative Procedures Act.

F. “MCAS Data” means the information and documents required by MCAS and filed by Insurers pursuant to this Act.

G. "MCAS Statistical Agent" means an entity or entities that have been designated by the Commissioner to collect statistics from insurers and provide reports developed from these statistics to the Commissioner for the purpose of fulfilling the MCAS obligations of those insurers.

Section 5. Submission and Collection of MCAS Information

A. The Commissioner may annually gather MCAS Data pursuant to the law of this state. In order to allow insurers time to prepare to submit the information required, the Commissioner, or his or her MCAS statistical agent, shall provide advance notice to insurers. For information the insurer presently has, the Commissioner, or his or her MCAS statistical agent, shall notify insurers before July of the preceding year of the MCAS Data to be submitted. For information that the insurer does not presently collect, the Commissioner, or his or her MCAS statistical agent, shall notify insurers before the July two years preceding the year the MCAS Data is to be submitted.

B. If the Commissioner determines that it will gather MCAS Data, every insurer shall annually file with the Commissioner, or the Commissioner’s designated MCAS statistical agent, MCAS Data for each applicable line of business which it writes more than $50,000 in direct written premium in this state. If the Commissioner determines either that he or she is not using MCAS Data or that he or she does not need to review the information each year, he or she may suspend some or all of the filing requirements or reduce the frequency of the filing

requirement for a line of business or for insurers meeting a requirement specified by the Commissioner.

C. The Commissioner may approve and designate one or more MCAS statistical agent for the purpose of gathering, compiling, aggregating and reporting to the Commissioner MCAS statistical data. The Commissioner may also direct the designee to perform statistical activities related to the receipt and presentation of MCAS Data to assist the Commissioner in the review and subsequent analysis of MCAS Data. Not more than one MCAS statistical agent may be designated for each line of business that is subject to MCAS. The designation of an MCAS statistical agent by the Commissioner does not mean that admitted insurers must report to such agent any MCAS statistics other than those statistics required to be reported under this Section.

D. Such designation shall be made pursuant to written contract, and shall be subject to the provisions of this Act. The written contract which terms shall include the scope of work, including all provisions relating to compensation and costs, shall be a public record of the Commissioner.

E. A designee may not use the MCAS Data or any related analysis or other information, including any analysis or other information created or produced by the designee, for any other purpose.

Section 6. Review and Analysis of MCAS Data

A. The Commissioner may review MCAS Data for the purpose of market analysis.

B. The Commissioner may authorize a qualified professional organization or person outside his or her department to assist in the analysis and reporting of MCAS Data subject to the confidentiality and sharing provisions in this Act. Such designated entity or person may not use the information collected for any purpose other than as stated in Section 2 of this Act and as within the scope of this designation.

Section 7. Selection and Standards for Designees

A. The Commissioner shall designate in accordance with applicable state contracting procedures. In no event shall a designee charge more than reasonable and necessary costs and/or fees. The Commissioner or an insurer may request that a designee provide an accounting and/or itemized invoices.

B. Nothing in this Act shall be construed to prevent an organization or person from providing services under both Sections 5 and 6, provided the organization or person is qualified for both functions and agrees to the terms and conditions set forth in this section.

C. The designee shall be the agent for the Commissioner and not for a reporting insurer.

Drafting Note: It is recommended that States review their existing contract laws, and consider the following procedures, for approving and/or hiring designees.

D. The Commissioner may only approve and/or hire a designee under Subsection 5(C) and Subsection 6(B) if the Commissioner takes necessary steps to ensure that such functions are conducted by qualified organizations or persons in accordance with the following procedures:

1. To be selected as a designee under this Act an applicant shall:

a. Follow the procedure the Commissioner outlines for consideration to serve as a designee, which may include licensing, a written application, or a formal request for such a designation;

b. State the applicant's qualifications, whether by education, experience, and where appropriate, professional designations, to act in the capacity for which it seeks designation;

c. State the applicant's record with respect to maintaining compliance, data security, and confidentiality;

d. State that the applicant does not have an ongoing conflict of interest;

e. Agree in writing to:

(i) comply with the all rules, technical advisories and directives issued by the Commissioner;

(ii) report statistical data or provide analysis of that data to the Commissioner in a timely manner;

(iii) submit to an audit or performance review, as required by the Commissioner;

(iv) make continuing efforts to resolve data quality and integrity issues, by working with insurance regulators and insurers on consistent definitions, ratios, interpretations, and protocols, as appropriate for the size and scope of the designation;

(v) maintain the confidentiality and any applicable privilege of all data;

(vi) enter into an agreement, consistent with this Act, with each insurer; and

(vii) implement appropriate measures to establish standards for developing and implementing administrative, technical and physical safeguards to protect the security, confidentiality and integrity of information; and

f. For selection as an MCAS statistical agent, submit a reporting plan that conforms to the MCAS reporting format approved by the NAIC, adopted by the laws of this state and approved by the Commissioner

2. A designee may collect and maintain the MCAS Data on behalf of the Commissioner but shall not own such information and shall not make such information available to any other person or entity except in accordance with this Act.

Section 8. Confidentiality of MCAS Data, Analysis and Reports

A. MCAS Data, the work papers and any analysis or other information produced by a designee, as well as the work papers and any analysis or other information produced by or received from another governmental entity or the NAIC, and the review and analysis of MCAS Data of the Commissioner, is confidential and privileged. It shall be afforded no less protection than materials provided under the Commissioner's examination and investigation authority under [insert cite] and shall not be subject to subpoena or to discovery; shall not be admissible in evidence in a private civil action; and shall be exempt from any applicable freedom of information law, public records law, public records disclosure law, or other similar statute.

B. No person or entity which receives or has access to MCAS Data, materials, or other related information shall be permitted or required to testify in a private civil action concerning such MCAS Data, materials, or other information.

C. Within three business days after receipt by a designee, or any other recipient of MCAS, MCAS Data, or related information, of a subpoena or request for discovery of MCAS Data, related analysis, or other related information submitted by or pertaining to a specific insurer, the designee shall notify the Commissioner and the Insurer of such subpoena or request for data. An Insurer shall have the right to intervene and to assert privileges under this Act and any other law, or to commence an action to:

1. prevent disclosure of any MCAS Data provided by it unless the disclosure will be made pursuant to a regulatory action to which such information is or may be relevant; and

2. recover damages for the disclosure to any person or entity not authorized to receive such information, including costs associated with an unauthorized disclosure or security breach as well as other costs contained in an agreement under Subsection (F) of this section, unless that person or entity is the subject of a legal or regulatory action to which such information is or may be relevant.

D. No waiver of an applicable privilege or a claim of confidentiality in the documents, materials, or other information shall occur as a result of disclosure to the Commissioner or the Commissioner's designee under this Section or as a result of sharing such documents, materials or other information as provided in this Act. Nothing in this Section shall require an insurer to disclose documents, materials, or other information that is not otherwise required by law to be disclosed.

E. The making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly to be made, published, disseminated, circulated, or placed before the public, any MCAS Data provided to a designee under this Act is prohibited.

F. Consistent with this Act, a designee or other third party with whom MCAS Data is shared shall enter into an agreement with each insurer. Such agreement shall include, but is not limited to, language addressing:

1. Protections contained in this Act;

2. Data security safeguards and liability for damages due to unauthorized release of insurer data; and

3. Prohibition against release of data to any third party, unless the insurer is provided advance written notice of the identity of the third party to whom the information would be released and unless such third party agrees on the same terms outlined in this Subsection.

G. Nothing in this Section shall be construed to prohibit an insurer from making information about its operations public.

Section 9. Sharing MCAS Data and Analysis

In accordance with the purpose of this Act, as set forth in Section 2 above, the Commissioner or the Commissioner's designee, with the express consent of the Commissioner, may:

A. Share MCAS Data gathered under this statute, as well as any analysis of that information, with the following authorized recipients:

1. State, federal, and international regulatory agencies or law enforcement authorities; provided that the recipient has a reasonable need to review the information, and that the recipient agrees, and has the legal authority, to maintain the confidentiality and privileged status of the documents, materials, or other information, including any analysis of such information.

2. The NAIC, provided that the NAIC will maintain the confidentiality and privileged status of the documents, materials, or other information, including any analysis of information, as contained in written agreements with:

(a) The Commissioner, consistent with this Act; and

(b) The insurer consistent with this Act, including Subsection 8(F);

B. Receive MCAS Data and related analysis, documents, materials, or other information, including otherwise confidential and privileged analysis, documents, materials, or other information, from the NAIC, from other state and federal and international regulatory agencies, and from law enforcement authorities and shall maintain as privileged and confidential such analysis, documents, materials, or other information, and may enter into agreements governing the sharing and use of consistent with this Act.

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National Council of Insurance Legislators (NCOIL)

~~Draft~~ Model Act Regarding Vision Care Services

Sponsored by Sen. Bob Hackett (OH)

Discussion Draft as of November 11th, 2019. To be considered ~~discussed~~introduced during the Health Insurance & Long Term Care Issues Committee on December 10th, 2020. ~~March 7th, 2020December 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, orthopics, vision training, and any prosthetic device necessary to correct, relieve, or treat any defect or abnormal condition of the human eye or its adnexa.

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

(1) An optometrist licensed under Chapter XXX;

(2) A physician authorized under Chapter XXX.

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

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

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

(b) No contract between a vision care provider and a vision care plan to provide covered vision services or vision care materials shall be contingent on whether the

vision care provider has entered into an agreement addressing noncovered vision services pursuant to division (D)(1)(a).

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

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

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

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

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

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National Council of Insurance Legislators (NCOIL)

Transparency in Dental Benefits Contracting Model Act ~~Patient Dental Care Bill of Rights~~

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

Discussion Draft as of November 9,2020~~September 10, 2020August 25th, 2020November 11th, 2019~~. To be considered ~~discussed~~introduced during the Health Insurance & Long Term Care Issues Committee on December 10th, 2020. ~~September 26, 2020March 7th, 2020December 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:

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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. <u>“Dental services” does not include services delivered by a provider that are billed as medical expenses under a health benefits plan</u> ~~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.

"Pre-treatment estimate" means an informal cost estimate of a dental treatment plan provided through a website by the insurer to patients and providers.

"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 specifiesspecifying the rights and responsibilities of the contracting entity and providesing 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" doesshall 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:

B~~1.~~ At the time the contract is entered into, sold, leased or renewed, or a when there are material modifications to a contract relevant to granting access to a provider network contract to a third party, the dental carrier allows any provider which is part of the carrier's provider network to choose to not participate in third party access to the contract or to enter into a contract directly with the health insurer that acquired the provider network. A provider ~~O~~opting out of lease arrangements shall not ~~require dentists to~~ permit the contracting entity to cancel or otherwise end a contractual relationship with the ~~original~~ dental carrier that leases its network. When initially contracting with a provider, a contracting entity must accept a qualified provider even if a provider rejects a network lease provision.

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:

1~~2~~. The contract specifically states that the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and when the contracting entity is a dental carrier, the provider chose to participate in third party access at the time the provider network contract was entered into or renewed. The third party access provision of any provider contract shall be clearly identified in the provider contract including notice that the contract grants third-party access to the provider network and that the dentist has the right to choose not to participate in third-party access. ~~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."~~

2~~3~~. The third party accessing the contract agrees to comply with all of the contract's terms~~, including third party's obligation concerning patient steerage~~;

3~~4~~. The contracting entity identifies, in writing or electronic form to the provider, all third parties in existence as of the date the contract is entered into~~, sold, leased~~ or renewed;

~~4~~5. 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~~;

5. The contracting entity notifies network providers that a new third party is leasing or purchasing the network at least 30 days ~~before discounted rates and other contractual obligations placed on the provider take effect~~in advance of the relationship taking effect;

~~5~~6. The contracting entity requires a~~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~~;

~~6~~7. The contracting entity notifies the third party of the termination of a provider network contract no later than 30 days from the termination date with the contracting entity;

~~7~~8. 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~~;

~~8~~9. 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

2~~1~~. A provider network contract for dental services provided to beneficiaries of the state sponsored health programs such as Medicaid and CHIP;

~~2. Situations in which access to a provider network contract is granted to a contracting entity or dental carrier operating under the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A listing of all affiliates of the contracting~~

~~entity shall be made available to the provider, in writing or electronic form, prior to access being granted; or,~~

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

Section 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.

DRAFTING NOTE: Dental services are not authorized through pre-treatment estimates. Pre-treatment estimates are provided by dental benefit plans through a website and must include an explicit disclaimer that the estimates are informal and non-binding.

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.~~

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

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

~~**Section I.**~~
Method of Payment Option

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

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

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

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

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

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

management, data management, portal services and other value-added services in addition to the bank transmittal.

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

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

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

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

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

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

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

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

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

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

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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 December 10, 2020. ~~September 26, 2020~~

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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 Regarding Air Ambulance Patient Protections

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

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

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

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

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

Section 2. Air Ambulance Patient Billing Protections:

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

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

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

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

(B) Frequently asked questions and answers,

(C) Frequently used forms,

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

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

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

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

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

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

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

Section 3. Consumer disclosures.

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

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

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

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

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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 December 10, 2020. ~~September 26, 2020.~~

This Model will be discussed alongside Colorado HB 1091.

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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 _____.

Second Regular Session
Seventy-second General Assembly
STATE OF COLORADO

PREAMENDED
This Unofficial Version Includes Committee Amendments Not Yet Adopted on Second Reading

LLS NO. 20-0765.01 Richard Sweetman x4333 **HOUSE BILL 20-1091**

HOUSE SPONSORSHIP

Snyder,

SENATE SPONSORSHIP

Williams A.,

House Committees
Business Affairs & Labor
Appropriations

Senate Committees

A BILL FOR AN ACT
CONCERNING THE DIVISION OF A DOMESTIC STOCK INSURER INTO MULTIPLE RESULTING DOMESTIC STOCK INSURERS.

Bill Summary

(Note: This summary applies to this bill as introduced and does not reflect any amendments that may be subsequently adopted. If this bill passes third reading in the house of introduction, a bill summary that applies to the re-engrossed version of this bill will be available at http://leg.colorado.gov.)

The bill states that a domestic stock insurer (dividing insurer) may divide into 2 or more resulting insurers pursuant to a plan of division. A plan of division must include:

-The name of the dividing insurer;
-The name of each resulting insurer created by the proposed division and, for each resulting insurer, a copy of proposed articles of incorporation and proposed bylaws;
-The manner of allocating assets and liabilities, including policy liabilities, between or among all resulting insurers;
-The manner of distributing shares in the resulting insurers to the dividing insurer or the dividing insurer's shareholders;
-A reasonable description of all liabilities and all assets that the dividing insurer proposes to allocate to each resulting insurer, including the manner by which the dividing insurer proposes to allocate all reinsurance contracts;

-All terms and conditions required by the laws of this state and the articles of incorporation and bylaws of the dividing insurer; and
-All other terms and conditions required by the division.

A plan of division must include additional provisions, the nature of which depends on whether the dividing insurer will survive the division.

A dividing insurer may not file a plan of division with the commissioner of insurance (commissioner) until the plan of division has been approved in accordance with all provisions of the dividing insurer's articles of incorporation and bylaws. After a dividing insurer approves a plan of division, the dividing insurer shall file the plan of division with the commissioner. The commissioner shall approve the plan of division if, after considering certain criteria, the commissioner finds that certain requirements are met. If the commissioner approves a dividing insurer's plan of division, an officer or duly authorized representative of the dividing insurer shall sign a certificate of division that sets forth certain information concerning the division.

The bill establishes procedures for amending and abandoning plans of division.

The bill provides for the protection of confidential information, documents, and materials that are submitted to, obtained by, or disclosed to the commissioner in connection with a plan of division or in contemplation of a plan of division.

Be it enacted by the General Assembly of the State of Colorado:

SECTION 1. In Colorado Revised Statutes, **add** part 17 to article 3 of title 10 as follows:

PART 17 - DOMESTIC STOCK INSURER DIVISION

10-3-1701. Definitions. AS USED IN THIS PART 17, UNLESS THE CONTEXT OTHERWISE REQUIRES:

(1) "ASSET" MEANS PROPERTY, WHETHER REAL, PERSONAL, MIXED, TANGIBLE, OR INTANGIBLE, AND ANY RIGHT OR INTEREST IN THE PROPERTY, INCLUDING ALL RIGHTS UNDER A CONTRACT OR OTHER AGREEMENT.

(2) "CAPITAL" MEANS THE CAPITAL STOCK COMPONENT OF A STATUTORY SURPLUS, AS DEFINED IN THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' ACCOUNTING PRACTICES AND PROCEDURES MANUAL, VERSION EFFECTIVE JANUARY 1, 2001, AS REVISED.

(3) (a) "CONTRACT HOLDER" MEANS THE OWNER OF AN ANNUITY CONTRACT.

(b) "CONTRACT HOLDER" DOES NOT MEAN A CERTIFICATE HOLDER OF A GROUP ANNUITY CONTRACT OR ANY OTHER COVERED PERSON UNDER A GROUP ANNUITY CONTRACT.

(4) "DIVIDE" OR "DIVISION" MEANS THE ACT BY OPERATION OF LAW BY WHICH A DOMESTIC STOCK INSURER SPLITS INTO TWO OR MORE RESULTING DOMESTIC STOCK INSURERS IN ACCORDANCE WITH A PLAN OF DIVISION AND THIS PART 17.

(5) "DIVIDING INSURER" MEANS A DOMESTIC STOCK INSURER THAT APPROVES A PLAN OF DIVISION.

(6) "DOMESTIC STOCK INSURER" MEANS AN INSURANCE COMPANY THAT HAS CAPITAL STOCK AND IS INCORPORATED UNDER THE LAWS OF THIS STATE.

(7) "LIABILITY" MEANS ANY LIABILITY OR OBLIGATION ARISING IN ANY MANNER.

(8) "PLAN OF DIVISION" MEANS A PLAN OF DIVISION THAT IS APPROVED BY A DIVIDING INSURER PURSUANT TO SECTION 10-3-1707.

(9) (a) "POLICYHOLDER" MEANS THE OWNER OF AN INSURANCE POLICY.

(b) "POLICYHOLDER" DOES NOT MEAN A CERTIFICATE HOLDER OF A GROUP INSURANCE POLICY OR ANY OTHER COVERED PERSON UNDER A GROUP INSURANCE POLICY.

(10) "RESULTING INSURER" MEANS A DIVIDING DOMESTIC STOCK INSURER THAT SURVIVES A DIVISION OR A NEW DOMESTIC STOCK INSURER THAT IS CREATED BY A DIVISION.

(11) "SHAREHOLDER" MEANS A PERSON IN WHOSE NAME SHARES ARE REGISTERED IN THE RECORDS OF A CORPORATION OR THE BENEFICIAL OWNER OF SHARES TO THE EXTENT OF THE RIGHTS GRANTED BY A NOMINEE CERTIFICATE ON FILE WITH A CORPORATION.

(12) "SURPLUS" MEANS THE TOTAL STATUTORY SURPLUS MINUS CAPITAL, CALCULATED IN ACCORDANCE WITH THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' ACCOUNTING PRACTICES AND PROCEDURES MANUAL, VERSION EFFECTIVE JANUARY 1, 2001, AS REVISED.

(13) "TRANSFER" MEANS AN ASSIGNMENT; ASSUMPTION; CONVEYANCE; SALE; LEASE; ENCUMBRANCE, INCLUDING A MORTGAGE OR SECURITY INTEREST; GIFT; OR TRANSFER BY OPERATION OF LAW.

10-3-1702. Plan of division - general requirements. (1) A STOCK INSURER MAY, IN ACCORDANCE WITH THIS PART 17, DIVIDE INTO TWO OR MORE RESULTING INSURERS PURSUANT TO A PLAN OF DIVISION.A DOMESTIC STOCK INSURER'S PLAN OF DIVISION MUST INCLUDE:

(a) THE NAME OF THE DOMESTIC STOCK INSURER SEEKING TO DIVIDE;

(b) THE NAME OF EACH RESULTING INSURER CREATED BY THE PROPOSED DIVISION AND, FOR EACH RESULTING INSURER, A COPY OF THE RESULTING INSURER'S:

(I) PROPOSED ARTICLES OF INCORPORATION; AND

(II) PROPOSED BYLAWS;

(c) THE MANNER OF ALLOCATING ASSETS AND LIABILITIES, INCLUDING POLICY LIABILITIES, BETWEEN OR AMONG ALL RESULTING INSURERS;

(d) THE MANNER OF DISTRIBUTING SHARES IN THE RESULTING INSURERS TO THE DIVIDING INSURER OR THE DIVIDING INSURER'S SHAREHOLDERS;

(e) A REASONABLE DESCRIPTION OF ALL LIABILITIES AND ALL ASSETS THAT THE DIVIDING INSURER PROPOSES TO ALLOCATE TO EACH RESULTING INSURER, INCLUDING THE MANNER BY WHICH THE DIVIDING INSURER PROPOSES TO ALLOCATE ALL REINSURANCE CONTRACTS;

(f) ALL TERMS AND CONDITIONS REQUIRED BY THE LAWS OF THIS STATE AND THE ARTICLES OF INCORPORATION AND BYLAWS OF THE DIVIDING INSURER; AND

(g) ALL OTHER TERMS AND CONDITIONS REQUIRED BY THE DIVISION.

10-3-1703. Plan of division - dividing insurer to survive division. (1) IF A DIVIDING INSURER WILL SURVIVE A DIVISION, THE PLAN OF DIVISION MUST INCLUDE, IN ADDITION TO THE REQUIREMENTS DESCRIBED IN SECTION 10-3-1702:

(a) ALL PROPOSED AMENDMENTS TO THE DIVIDING INSURER'S ARTICLES OF INCORPORATION AND BYLAWS;

(b) IF THE DIVIDING INSURER INTENDS TO CANCEL SOME BUT NOT ALL SHARES IN THE DIVIDING INSURER, THE MANNER IN WHICH THE DIVIDING INSURER INTENDS TO CANCEL THE SHARES; AND

(c) IF THE DIVIDING INSURER INTENDS TO CONVERT SOME BUT NOT ALL SHARES IN THE DIVIDING INSURER INTO SHARES, SECURITIES, OBLIGATIONS, RIGHTS TO ACQUIRE SHARES OR SECURITIES, CASH, PROPERTY, OR ANY COMBINATION THEREOF, A STATEMENT DISCLOSING THE MANNER IN WHICH THE DIVIDING INSURER INTENDS TO CONVERT THE SHARES.

10-3-1704. Plan of division - dividing insurer to not survive division. IF A DIVIDING INSURER WILL NOT SURVIVE A DIVISION, THE PLAN OF DIVISION MUST INCLUDE, IN ADDITION TO THE REQUIREMENTS DESCRIBED IN SECTION 10-3-1702, THE MANNER IN WHICH THE DIVIDING INSURER WILL CANCEL OR CONVERT SHARES IN THE DIVIDING INSURER INTO SHARES, SECURITIES,

OBLIGATIONS, RIGHTS TO ACQUIRE SHARES OR SECURITIES, CASH, PROPERTY, OR ANY COMBINATION THEREOF.

10-3-1705. Amending plan of division. (1) A DIVIDING INSURER MAY AMEND THE DIVIDING INSURER'S PLAN OF DIVISION IN ACCORDANCE WITH ANY PROCEDURES SET FORTH IN THE PLAN OF DIVISION, OR, IF NO SUCH PROCEDURES ARE SET FORTH IN THE PLAN OF DIVISION, IN A MANNER DETERMINED BY THE BOARD OF DIRECTORS OF THE DIVIDING INSURER. A SHAREHOLDER THAT IS ENTITLED TO VOTE ON OR CONSENT TO APPROVAL OF THE PLAN OF DIVISION IS ENTITLED TO VOTE ON OR CONSENT TO AN AMENDMENT OF THE PLAN OF DIVISION THAT WILL AFFECT:

(a) THE AMOUNT OR KIND OF SHARES, SECURITIES, OBLIGATIONS, RIGHTS TO ACQUIRE SHARES OR SECURITIES, CASH, PROPERTY, OR ANY COMBINATION THEREOF TO BE RECEIVED BY ANY OF THE SHAREHOLDERS OF THE DIVIDING INSURER UNDER THE PLAN OF DIVISION;

(b) THE ARTICLES OF INCORPORATION OR BYLAWS OF ANY RESULTING INSURER THAT BECOME EFFECTIVE WHEN THE DIVISION BECOMES EFFECTIVE, EXCEPT FOR CHANGES THAT DO NOT REQUIRE APPROVAL OF THE SHAREHOLDERS OF THE RESULTING INSURER UNDER ITS ARTICLES OF INCORPORATION OR BYLAWS; OR

(c) ANY OTHER TERMS OR CONDITIONS OF THE PLAN OF DIVISION THAT EFFECT A CHANGE THAT MAY ADVERSELY AFFECT THE SHAREHOLDERS IN ANY MATERIAL RESPECT.

10-3-1706. Abandoning plan of division. (1) A DIVIDING INSURER MAY ABANDON ITS PLAN OF DIVISION ONLY AS FOLLOWS:

(a) AFTER THE DIVIDING INSURER HAS APPROVED THE PLAN OF DIVISION WITHOUT ANY ACTION BY THE SHAREHOLDERS AND IN ACCORDANCE WITH ANY PROCEDURES SET FORTH IN THE PLAN OF DIVISION, OR IF NO SUCH PROCEDURES ARE SET FORTH IN THE PLAN OF DIVISION, THE DIVIDING INSURER MAY ABANDON ITS PLAN OF DIVISION IN A MANNER DETERMINED BY THE BOARD OF DIRECTORS OF THE DIVIDING INSURER; OR

(b) AFTER THE DIVIDING INSURER HAS FILED A CERTIFICATE OF DIVISION WITH THE SECRETARY OF STATE PURSUANT TO SECTION 10-3-1710, THE DIVIDING INSURER MAY FILE A SIGNED CERTIFICATE OF ABANDONMENT WITH THE SECRETARY OF STATE AND FILE A COPY WITH THE COMMISSIONER.THE CERTIFICATE OF ABANDONMENT IS EFFECTIVE ON THE DATE IT IS FILED WITH THE SECRETARY OF STATE.

(2) A DIVIDING INSURER SHALL NOT ABANDON ITS PLAN OF DIVISION AFTER THE PLAN OF DIVISION BECOMES EFFECTIVE.

(3) IF A DIVIDING INSURER ELECTS TO ABANDON ITS PLAN OF DIVISION AFTER THE PLAN HAS BEEN FILED WITH THE COMMISSIONER BUT BEFORE IT BECOMES EFFECTIVE, THE DIVIDING INSURER SHALL NOTIFY THE COMMISSIONER.

10-3-1707. Approval of plan of division - articles of incorporation and bylaws. (1) A DIVIDING INSURER SHALL NOT FILE A PLAN OF DIVISION WITH THE COMMISSIONER UNTIL THE PLAN OF DIVISION HAS BEEN APPROVED IN ACCORDANCE WITH ALL PROVISIONS OF THE DIVIDING INSURER'S ARTICLES OF INCORPORATION AND BYLAWS. IF THE DIVIDING INSURER'S ARTICLES OF INCORPORATION AND BYLAWS DO NOT PROVIDE FOR APPROVAL OF A PLAN OF DIVISION, THE DIVIDING INSURER SHALL NOT FILE THE PLAN OF DIVISION WITH THE COMMISSIONER UNLESS THE PLAN OF DIVISION HAS BEEN APPROVED IN ACCORDANCE WITH ALL PROVISIONS OF THE DIVIDING INSURER'S ARTICLES OF INCORPORATION AND BYLAWS THAT PROVIDE FOR APPROVAL OF A MERGER.

(2) IF A PROVISION OF A DIVIDING INSURER'S ARTICLES OF INCORPORATION OR BYLAWS ADOPTED BEFORE THE EFFECTIVE DATE OF THIS PART 17 REQUIRES THAT A SPECIFIC NUMBER OF OR PERCENTAGE OF THE BOARD OF DIRECTORS OR SHAREHOLDERS PROPOSE OR ADOPT A PLAN OF MERGER OR IMPOSE OTHER PROCEDURES FOR THE PROPOSAL OR ADOPTION OF A PLAN OF MERGER, THE DIVIDING INSURER SHALL ADHERE TO THE PROVISION IN PROPOSING OR ADOPTING A PLAN OF DIVISION. IF ANY SUCH PROVISION OF THE ARTICLES OF INCORPORATION OR BYLAWS IS AMENDED ON OR AFTER THE EFFECTIVE DATE OF THIS PART 17, THE PROVISION APPLIES TO A DIVISION THEREAFTER ONLY IN ACCORDANCE WITH ITS EXPRESS TERMS.

10-3-1708. Commissioner approval of plan of division.

(1) AFTER A DIVIDING INSURER APPROVES A PLAN OF DIVISION PURSUANT 27 TO SECTION 10-3-1707, THE DIVIDING INSURER SHALL FILE THE PLAN OF DIVISION WITH THE COMMISSIONER. WITHIN TEN BUSINESS DAYS AFTER FILING THE PLAN OF DIVISION WITH THE COMMISSIONER, THE DIVIDING INSURER SHALL PROVIDE NOTICE OF THE FILING TO EACH REINSURER THAT IS A PARTY TO A REINSURANCE CONTRACT ALLOCATED IN THE PLAN OF DIVISION.

(2) (a) A DIVISION DOES NOT BECOME EFFECTIVE UNTIL IT IS APPROVED BY THE COMMISSIONER IN ACCORDANCE WITH THIS SECTION.

(b) BEFORE APPROVING A PLAN OF DIVISION, THE COMMISSIONER SHALL:

(I) HOLD A PUBLIC HEARING IN ACCORDANCE WITH SECTION 24-4-105, EXCEPT TO THE EXTENT THAT THE PROCEDURES CONTAINED THEREIN CONFLICT WITH THE PROCEDURES SET FORTH IN THIS PART 17;

(II) PROVIDE NOTICE OF THE PUBLIC HEARING REQUIRED PURSUANT TO SUBSECTION (2)(b)(I) OF THIS SECTION TO STATE INSURANCE REGULATORS AND APPROPRIATE STATE GUARANTY ASSOCIATIONS IN STATES IN WHICH THE DIVIDING INSURER IS AUTHORIZED TO DO BUSINESS; AND

(III) BE SATISFIED THAT THE DIVIDING INSURER HAS MADE REASONABLE EFFORTS TO PROVIDE TO ALL POLICYHOLDERS, CONTRACT HOLDERS, REINSURERS, AND OTHER PERSONS WITH AN INTEREST IN THE PROPOSED PLAN OF DIVISION AT LEAST THIRTY DAYS PRIOR NOTICE OF THE PUBLIC HEARING IF THE COMMISSIONER DETERMINES THAT IT WOULD BE UNREASONABLE OR UNFAIR TO NOT PROVIDE SUCH NOTICE TO SUCH OTHER PERSONS. FOR THE PURPOSES OF THIS SUBSECTION (2)(b)(III), A NOTICE MUST:

(A) PROVIDE INFORMATION REGARDING THE PROPOSED DIVISION UNDER CONSIDERATION AND THE LOCATION, DATE, AND TIME OF THE PUBLIC HEARING; AND

(B) IF THE DIVIDING INSURER HAS THE LAST-KNOWN ADDRESS OR LAST-KNOWN E-MAIL ADDRESS OF THE POLICYHOLDER, CONTRACT HOLDER, REINSURER, OR OTHER PERSON ON FILE, EITHER BE MAILED TO THE LAST-KNOWN ADDRESS OF SUCH PERSON OR SENT VIA ELECTRONIC MEANS TO THE LAST-KNOWN E-MAIL ADDRESS OF SUCH PERSON.

(c) THE COMMISSIONER SHALL:

(I) CONSIDER ANY SIMULTANEOUS MERGER OR ACQUISITION OF A RESULTING INSURER AS PART OF THE PLAN OF DIVISION;

(II) IN THE CASE OF A SIMULTANEOUS MERGER, APPLY TO THE RESULTING INSURER INVOLVED IN THE SIMULTANEOUS MERGER THE REQUIREMENTS OFTHIS PART 17 THAT ARE APPLICABLE TO THE RESULTING INSURER AS MERGED INTO THE SURVIVING ENTITY IN THE MERGER AND NOT TO THE RESULTING INSURER PRIOR TO THE MERGER;

(III) CONSIDER, AMONG OTHER THINGS, ALL ASSETS, LIABILITIES, AND CASH FLOWS, THE NATURE AND COMPOSITION OF THE ASSETS PROPOSED TO BE TRANSFERRED IN SUPPORT OFTHE PLAN OFDIVISION, AND ALL PROPOSED ASSETS OF THE RESULTING INSURERS, WHICH CONSIDERATION MUST INCLUDE AN ASSESSMENT OF THE RISKS AND QUALITY, INCLUDING THE LIQUIDITY AND MARKETABILITY, OF THE PROPOSED PORTFOLIO OF THE RESULTING INSURER; CONSIDERATION OF ASSET AND LIABILITY MATCHING; AND THE TREATMENT OF THE MATERIAL ELEMENTS OF THE PORTFOLIO BASED ON STATUTORY ACCOUNTING PRACTICES.

(d) AFTER MAKING THE CONSIDERATIONS DESCRIBED IN SUBSECTION (2)(c) OF THIS SECTION, THE COMMISSIONER SHALL APPROVE A PLAN OF DIVISION IF THE COMMISSIONER FINDS THAT THE FOLLOWING REQUIREMENTS ARE MET:

(I) THE FINANCIAL CONDITION OF A DIVIDING INSURER, A RESULTING INSURER, OR AN ACQUIRING PARTY OF A RESULTING INSURER, IF ANY, WILL NOT JEOPARDIZE THE FINANCIAL STABILITY OF THE DIVIDING INSURER OR PREJUDICE THE INTERESTS OF ITS POLICYHOLDERS, CONTRACT HOLDERS, OR

REINSURERS, IN EACH CASE, IN A MANNER THAT IS UNFAIR TO ITS POLICYHOLDERS, CONTRACT HOLDERS, OR REINSURERS;

(II) THE TERMS OF THE PLAN OF DIVISION ARE FAIR AND REASONABLE TO THE DIVIDING INSURER'S AND ANY RESULTING INSURER'S POLICYHOLDERS, CONTRACT HOLDERS, OR REINSURERS;

(III) NEITHER A DIVIDING INSURER, A RESULTING INSURER, NOR AN ACQUIRING PARTY OF A RESULTING INSURER, IF ANY, HAS PLANS OR PROPOSALS TO LIQUIDATE THE DIVIDING INSURER OR ANY RESULTING INSURER, SELL ASSETS OF THE DIVIDING INSURER OR OF ANY RESULTING INSURER, CONSOLIDATE OR MERGE THE DIVIDING INSURER OR ANY RESULTING INSURER WITH A PERSON, OR MAKE ANY OTHER MATERIAL CHANGE IN THE DIVIDING INSURER'S OR ANY RESULTING INSURER'S BUSINESS OR CORPORATE STRUCTURE OR MANAGEMENT THAT IS UNFAIR OR UNREASONABLE TO THE DIVIDING INSURER'S OR RESULTING INSURERS' POLICYHOLDERS, CONTRACT HOLDERS, OR REINSURERS AND NOT IN THE PUBLIC INTEREST;

(IV) THE COMPETENCE, EXPERIENCE, AND INTEGRITY OF THE PERSONS WHO WOULD CONTROL THE OPERATION OF A DIVIDING INSURER, IF IT SURVIVES THE DIVISION, AND ANY RESULTING INSURER ARE SUCH THAT IT WOULD BE CONSISTENT WITH THE INTEREST OF THE DIVIDING INSURER'S AND ANY RESULTING INSURERS' POLICYHOLDERS, CONTRACT HOLDERS, OR REINSURERS AND THE GENERAL PUBLIC TO PERMIT THE DIVISION;

(V) THE DIVISION IS NOT LIKELY TO BE HAZARDOUS OR PREJUDICIAL TO THE INSURANCE-BUYING PUBLIC;

(VI) THE INTEREST OF THE POLICYHOLDERS OF THE DIVIDING INSURER THAT MAY BECOME POLICYHOLDERS OF A RESULTING INSURER WILL BE ADEQUATELY PROTECTED BY THE RESULTING INSURER OR ACQUIRING PARTY OF A RESULTING INSURER, IF ANY;

(VII) THE DIVIDING INSURER, IF IT SURVIVES THE DIVISION, AND THE RESULTING INSURERS WILL BE SOLVENT UPON THE CONSUMMATION OF THE DIVISION;

(VIII) THE ASSETS ALLOCATED TO THE DIVIDING INSURER, IF IT SURVIVES THE DIVISION, AND TO RESULTING INSURERS WILL NOT, UPON THE CONSUMMATION OF THE DIVISION, BE UNREASONABLY SMALL IN RELATION TO THE BUSINESS AND TRANSACTIONS IN WHICH THE INSURERS WERE ENGAGED OR ARE ABOUT TO ENGAGE;

(IX) THE PROPOSED DIVISION IS NOT BEING MADE FOR THE PURPOSE OF HINDERING, DELAYING, OR DEFRAUDING ANY POLICYHOLDERS, CONTRACT HOLDERS, OR REINSURERS;

(X) EACH RESULTING INSURER THAT WILL BE A MEMBER INSURER UNDER THE "LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION ACT", ARTICLE 20 OF

THIS TITLE 10, WILL BE LICENSED IN EACH LINE OF BUSINESS IN EACH STATE WHERE THE DIVIDING INSURER WAS LICENSED WITH RESPECT TO THE INSURANCE POLICIES OR ANNUITY CONTRACTS ISSUED BY THE DIVIDING INSURER THAT ARE ALLOCATED TO THAT RESULTING INSURER AS PART OFTHE PLAN OFDIVISION;EXCEPT THAT, THE RESULTING INSURER NEED NOT BE LICENSED WITH RESPECT TO ANY LINE OF BUSINESS IN ANY STATE WHERE, AT THE TIME OF DIVISION:

(A) THE DIVIDING INSURERIS NOT LICENSED WITH RESPECT TO THE LINE OF BUSINESS; OR

(B) THE STATE DOES NOT PROVIDE GUARANTY ASSOCIATION COVERAGE OR SIMILAR COVERAGE WITH RESPECT TO THE ALLOCATED POLICIES OR CONTRACTS; AND

(XI) IF THE PLAN OF DIVISION ALLOCATES POLICIES OF LONG-TERM CARE INSURANCE, AS DEFINED IN SECTION 10-19-103 (5), THE LIABILITIES ASSOCIATED WITH THE ALLOCATED POLICIES DO NOT CONSTITUTE MORE THAN A DE MINIMUS AMOUNT OF THE INSURANCE LIABILITIES ALLOCATED TO THE DIVIDING INSURER, IF IT SURVIVES THE DIVISION, OR TO ANY RESULTING INSURER.

(e) A DIVIDING INSURER THAT FILES A PLAN OF DIVISION SHALL PAY ALL EXPENSES INCURRED BY THE COMMISSIONER IN CONNECTION WITH PROCEEDINGS UNDER THIS SECTION, INCLUDING EXPENSES FOR ATTORNEYS, ACTUARIES, ACCOUNTANTS, AND OTHER EXPERTS NOT OTHERWISE A PART OF THE COMMISSIONER'S STAFF AS MAY BE REASONABLY NECESSARY TO ASSIST THE COMMISSIONER IN REVIEWING THE PROPOSED PLAN OF DIVISION. A DIVIDING INSURER MAY ALLOCATE THE EXPENSES IN THE PLAN OF DIVISION IN THE SAME MANNER AS ANY OTHER LIABILITY.

(f) THE COMMISSIONER SHALL SELECT AND RETAIN AN INDEPENDENT EXPERT WHO SHALL REVIEW THE PLAN OF DIVISION AND ISSUE A REPORT TO THE COMMISSIONER, WHICH REPORT ADDRESSES THE FOLLOWING:

(I) THE BUSINESS PURPOSES OF THE PROPOSED DIVISION;

(II) CAPITAL ADEQUACY AND RISK-BASED CAPITAL, INCLUDING CONSIDERATION OF THE EFFECTS OF ASSET QUALITY, NONADMITTED ASSETS, AND ACTUARIAL STRESSES TO RESERVE ASSUMPTIONS;

(III) CASH FLOW AND RESERVE ADEQUACY TESTING, INCLUDING CONSIDERATION OF THE EFFECTS OF DIVERSIFICATION ON POLICY LIABILITIES;

(IV) BUSINESS PLANS;

(V) THE IMPACT, IF ANY, OF CONCENTRATION OF LINES OF BUSINESS FOLLOWING THE PROPOSED DIVISION; AND

(VI) MANAGEMENT'SCOMPETENCE,EXPERIENCE,AND INTEGRITY.

(g) IF THE COMMISSIONER APPROVES A PLAN OF DIVISION, THE COMMISSIONER SHALL ISSUE:

(I) AN ORDER THAT IS ACCOMPANIED BY FINDINGS OF FACT AND CONCLUSIONS OF LAW; AND

(II) A CERTIFICATE OF AUTHORITY AUTHORIZING THE RESULTING INSURERS TO TRANSACT THE BUSINESS OF INSURANCE IN THIS STATE; EXCEPT THAT THE COMMISSIONER MAY WAIVE THIS REQUIREMENT IF A RESULTING INSURER WILL NOT SURVIVE A MERGER SIMULTANEOUS WITH THE DIVISION IN ACCORDANCE WITH THE PLAN OF DIVISION.

(h) THE CONDITIONS IN THIS SECTION FOR FREEING ONE OR MORE OF THE RESULTING INSURERS FROM THE LIABILITIES OF THE DIVIDING INSURER AND FOR ALLOCATING SOME OR ALL OF THE LIABILITIES OF THE DIVIDING INSURER ARE DEEMED TO HAVE BEEN SATISFIED IF THE COMMISSIONER APPROVES THE PLAN OF DIVISION IN A FINAL ORDER.

10-3-1709. Confidentiality - records. (1) ALL INFORMATION, DOCUMENTS, MATERIALS, AND COPIES OF DOCUMENTS AND MATERIALS SUBMITTED TO, OBTAINED BY, OR DISCLOSED TO THE COMMISSIONER IN CONNECTION WITH A PLAN OF DIVISION OR IN CONTEMPLATION OF A PLAN OF DIVISION, INCLUDING ANY INFORMATION, DOCUMENTS, MATERIALS, OR COPIES PROVIDED BY OR ON BEHALF OF A DOMESTIC STOCK INSURER IN ADVANCE OF ITS ADOPTION OR SUBMISSION OF A PLAN OF DIVISION, ARE CONFIDENTIAL AND SUBJECT TO THE SAME PROTECTION AND TREATMENT DESCRIBED IN SECTION 10-3-808 FOR INFORMATION AND DOCUMENTS DISCLOSED TO OR OBTAINED BY THE COMMISSIONER IN THE COURSE OF AN EXAMINATION OR INVESTIGATION MADE UNDER SECTION 10-3-806, UNTIL THE TIME, IF ANY, THAT A NOTICE OF THE HEARING CONTEMPLATED BY SECTION 10-3-1708 IS ISSUED.

(2) AFTER THE ISSUANCE OF A NOTICE OF THE HEARING CONTEMPLATED BY SECTION 10-3-1708, ALL BUSINESS, FINANCIAL, ACTUARIAL, AND OTHER PROPRIETARY INFORMATION FOR WHICH THE DOMESTIC STOCK INSURER REQUESTS CONFIDENTIAL TREATMENT, OTHER THAN THE PLAN OF DIVISION AND ANY MATERIALS INCORPORATED BY REFERENCE INTO OR OTHERWISE MADE A PART OF THE PLAN OF DIVISION THAT MUST NOT BE ELIGIBLE FOR CONFIDENTIAL TREATMENT AFTER THE ISSUANCE OF A NOTICE OF THE HEARING, CONTINUES TO BE CONFIDENTIAL, IS NOT AVAILABLE FOR PUBLIC INSPECTION, AND IS SUBJECT TO THE SAME PROTECTION AND TREATMENT AS DESCRIBED IN SECTION 10-3-808 FOR INFORMATION AND DOCUMENTS DISCLOSED TO OR OBTAINED BY THE COMMISSIONER IN THE COURSE OF AN EXAMINATION OR INVESTIGATION MADE UNDER SECTION 10-3-806. HOWEVER, IF THE COMMISSIONER DETERMINES THAT THE PUBLIC'S INTEREST IN MAKING THE INFORMATION AVAILABLE FOR PUBLIC INSPECTION OUTWEIGHS THE INTEREST

OF THE DIVIDING INSURER IN KEEPING THE INFORMATION CONFIDENTIAL, THE COMMISSIONER MAY, AFTER NOTICE AND AN OPPORTUNITY TO BE HEARD, MAKE THE INFORMATION AVAILABLE TO PUBLIC INSPECTION IN ACCORDANCE WITH THE "COLORADO OPEN RECORDS ACT", PART 2 OF ARTICLE 72 OF TITLE 24.

10-3-1710. Certificate of division. (1) IF THE COMMISSIONER APPROVES A DIVIDING INSURER'S PLAN OF DIVISION PURSUANT TO SECTION 10-3-1708, AN OFFICER OR DULY AUTHORIZED REPRESENTATIVE OF THE DIVIDING INSURER SHALL SIGN A CERTIFICATE OF DIVISION THAT SETS FORTH ALL OF THE FOLLOWING:

(a) THE NAME OF THE DIVIDING INSURER;

(b) A STATEMENT DISCLOSING WHETHER THE DIVIDING INSURER SURVIVED THE DIVISION. IF THE DIVIDING INSURER SURVIVED THE DIVISION, THE CERTIFICATE OF DIVISION MUST INCLUDE ANY AMENDMENTS TO THE DIVIDING INSURER'S ARTICLES OF INCORPORATION OR BYLAWS AS APPROVED AS PART OF THE PLAN OF DIVISION.

(c) THE NAME OF EACH RESULTING INSURER THAT IS CREATED BY THE DIVISION;

(d) THE DATE ON WHICH THE DIVISION IS EFFECTIVE;

(e) A STATEMENT THAT THE DIVISION WAS APPROVED BY THE COMMISSIONER PURSUANT TO SECTION 10-3-1708;

(f) A STATEMENT THAT THE DIVIDING INSURER PROVIDED REASONABLE NOTICE TO EACH REINSURER THAT IS A PARTY TO A REINSURANCE CONTRACT ALLOCATED IN THE PLAN OF DIVISION;

(g) ARTICLES OF INCORPORATION AND BYLAWS FOR EACH RESULTING INSURER CREATED BY THE DIVISION. THE ARTICLES OF INCORPORATION AND BYLAWS OF EACH RESULTING INSURER MUST COMPLY WITH THE APPLICABLE REQUIREMENTS OF THE LAWS OF THIS STATE. THE ARTICLES OF INCORPORATION AND BYLAWS MAY STATE THE NAME OR ADDRESS OF AN INCORPORATOR, MAY BE SIGNED, AND MAY INCLUDE ANY PROVISION THAT IS NOT REQUIRED IN A RESTATEMENT OF THE ARTICLES OF INCORPORATION OR BYLAWS.

(h) A REASONABLE DESCRIPTION OF THE CAPITAL, SURPLUS, OR OTHER ASSETS AND LIABILITIES, INCLUDING POLICY LIABILITIES, OF THE DIVIDING INSURER THAT ARE TO BE ALLOCATED TO EACH RESULTING INSURER.

(2) A DIVIDING INSURER'S CERTIFICATE OF DIVISION IS EFFECTIVE ON THE DATE THE DIVIDING INSURER FILES THE CERTIFICATE WITH THE SECRETARY OF STATE AND PROVIDES A CONCURRENT COPY TO THE COMMISSIONER, OR ON ANOTHER DATE AS SPECIFIED IN THE PLAN OF DIVISION, WHICHEVER IS LATER.HOWEVER, THE CERTIFICATE OF DIVISION BECOMES EFFECTIVE NOT

LATER THAN NINETY CALENDAR DAYS AFTER IT IS FILED WITH THE SECRETARY OF STATE. A DIVISION IS EFFECTIVE WHEN THE RELEVANT CERTIFICATE OF DIVISION IS EFFECTIVE.

10-3-1711. After division is effective. (1) (a) ON THE EFFECTIVE DATE OF A DIVISION PURSUANT TO SECTION 10-3-1710, IF THE DIVIDING INSURER SURVIVES, ALL OF THE FOLLOWING APPLY:

(I) THE DIVIDING INSURER CONTINUES TO EXIST;

(II) THE DIVIDING INSURER MUST AMEND ITS ARTICLES OF INCORPORATION IF THE AMENDMENTS ARE PROVIDED FOR IN THE PLAN OF DIVISION; AND

(III) THE DIVIDING INSURER MUST AMEND ITS BYLAWS IF THE AMENDMENTS ARE PROVIDED FOR IN THE PLAN OF DIVISION.

(b) ON THE EFFECTIVE DATE OF A DIVISION PURSUANT TO SECTION
24 10-3-1710, IF THE DIVIDING INSURER DOES NOT SURVIVE, THE DIVIDING INSURER CEASES TO EXIST AND ANY RESULTING INSURER CREATED BY THE PLAN OF DIVISION COMES INTO EXISTENCE.

(c) EACH RESULTING INSURER HOLDS ANY CAPITAL, SURPLUS, AND OTHER ASSETS ALLOCATED TO THE RESULTING INSURER BY THE PLAN OF DIVISION AS A SUCCESSOR TO THE DIVIDING INSURER BY OPERATION OF LAW, AND NOT BY TRANSFER, WHETHER DIRECTLY OR INDIRECTLY. THE ARTICLES OF INCORPORATION AND BYLAWS, IF ANY, OF EACH RESULTING INSURER ARE EFFECTIVE WHEN THE RESULTING INSURER COMES INTO EXISTENCE.

(d) ALL CAPITAL, SURPLUS, AND OTHER ASSETS OF THE DIVIDING INSURER:

(I) THAT ARE ALLOCATED BY THE PLAN OF DIVISION VEST IN THE APPLICABLE RESULTING INSURER AS PROVIDED IN THE PLAN OF DIVISION OR REMAIN VESTED IN THE DIVIDING INSURER AS PROVIDED IN THE PLAN OF DIVISION;

(II) THAT ARE NOT ALLOCATED BY THE PLAN OF DIVISION REMAIN VESTED IN THE DIVIDING INSURER IF THE DIVIDING INSURER SURVIVES THE DIVISION AND ARE ALLOCATED TO, AND VEST PRO RATA IN, THE RESULTING INSURERS INDIVIDUALLY IF THE DIVIDING INSURER DOES NOT SURVIVE THE DIVISION; AND

(III) OTHERWISE VEST AS PROVIDED IN THIS SECTION WITHOUT TRANSFER, REVERSION, OR IMPAIRMENT.

(e) A RESULTING INSURER TO WHICH A CAUSE OF ACTION IS ALLOCATED MAY BE SUBSTITUTED OR ADDED IN ANY PENDING ACTION OR PROCEEDING TO WHICH THE DIVIDING INSURER IS A PARTY WHEN THE DIVISION BECOMES EFFECTIVE.

(f) ALL LIABILITIES, INCLUDING POLICY LIABILITIES, OF A DIVIDING INSURER ARE ALLOCATED BETWEEN OR AMONG ANY RESULTING INSURERS AS PROVIDED IN SECTION 10-3-1710, AND EACH RESULTING INSURER TO WHICH LIABILITIES ARE ALLOCATED IS LIABLE ONLY FOR THOSE LIABILITIES, INCLUDING POLICY LIABILITIES, ALLOCATED AS A SUCCESSOR TO THE DIVIDING INSURER BY OPERATION OF LAW, AND NOT BY TRANSFER OR ASSUMPTION, WHETHER DIRECTLY OR INDIRECTLY.

(g) ANY SHARES IN THE DIVIDING INSURER THAT ARE TO BE CONVERTED OR CANCELED IN THE DIVISION ARE CONVERTED OR CANCELED, AND THE SHAREHOLDERS OF THOSE SHARES ARE ENTITLED ONLY TO THE RIGHTS PROVIDED TO THE SHAREHOLDERS UNDER THE PLAN OF DIVISION AND ANY APPRAISAL RIGHTS THAT THE SHAREHOLDERS MAY HAVE PURSUANT TO SECTION 10-3-1713.

(2) EXCEPT AS PROVIDED IN THE DIVIDING INSURER'S ARTICLES OF INCORPORATION OR BYLAWS, A DIVISION DOES NOT GIVE RISE TO ANY RIGHTS THAT A SHAREHOLDER, DIRECTOR OF A DOMESTIC STOCK INSURER, OR THIRD PARTY WOULD HAVE UPON A DISSOLUTION, LIQUIDATION, OR WINDING UP OF THE DIVIDING INSURER.

(3) THE ALLOCATION TO A RESULTING INSURER OF CAPITAL, SURPLUS, OR OTHER ASSET THAT IS COLLATERAL COVERED BY AN EFFECTIVE FINANCING STATEMENT IS NOT EFFECTIVE UNTIL A NEW EFFECTIVE FINANCING STATEMENT NAMING THE RESULTING INSURER AS A DEBTOR IS EFFECTIVE UNDER THE "UNIFORM COMMERCIAL CODE", TITLE 4.

(4) UNLESS OTHERWISE PROVIDED IN THE PLAN OF DIVISION, THE SHARES IN, AND ANY SECURITIES OF, EACH RESULTING INSURER ARE DISTRIBUTED TO THE DIVIDING INSURER, IF IT SURVIVES THE DIVISION, OR ARE DISTRIBUTED PRO RATA TO THE SHAREHOLDERS OF THE DIVIDING INSURER THAT DO NOT ASSERT ANY APPRAISAL RIGHTS PURSUANT TO SECTION 10-3-1713.

(5) A DIVISION THAT BECOMES EFFECTIVE PURSUANT TO THIS PART 17 IS NOT AN ASSIGNMENT OF ANY INSURANCE POLICY, ANNUITY, REINSURANCE AGREEMENT, OR OTHER TYPE OF CONTRACT.

10-3-1712. Resulting insurers' liability for allocated assets and debts. (1) EXCEPT AS EXPRESSLY PROVIDED IN THIS SECTION, WHEN A DIVISION BECOMES EFFECTIVE, BY OPERATION OF LAW ALL OF THE FOLLOWING APPLY:

(a) A RESULTING INSURER IS INDIVIDUALLY LIABLE FOR THE LIABILITIES, INCLUDING POLICY LIABILITIES:

(I) THAT THE RESULTING INSURER ISSUES, UNDERTAKES, OR INCURS IN ITS OWN NAME AFTER THE DIVISION; AND

(II) OF THE DIVIDING INSURER THAT ARE ALLOCATED TO OR REMAIN THE LIABILITY OF THE RESULTING INSURER TO THE EXTENT SPECIFIED IN THE PLAN OF DIVISION;

(b) THE DIVIDING INSURER REMAINS RESPONSIBLE FOR THE LIABILITIES, INCLUDING POLICY LIABILITIES, OF THE DIVIDING INSURER THAT ARE NOT ALLOCATED BY THE PLAN OF DIVISION IF THE DIVIDING INSURER SURVIVES THE DIVISION; AND

(c) A RESULTING INSURER IS LIABLE PRO RATA INDIVIDUALLY FOR THE LIABILITIES, INCLUDING POLICY LIABILITIES, OF THE DIVIDING INSURER THAT ARE NOT ALLOCATED BY THE PLAN OF DIVISION IF THE DIVIDING INSURER DOES NOT SURVIVE THE DIVISION.

(2) EXCEPT AS OTHERWISE EXPRESSLY PROVIDED IN THIS SECTION, WHEN A DIVISION BECOMES EFFECTIVE, A RESULTING INSURER IS NOT RESPONSIBLE FOR AND DOES NOT HAVE LIABILITY FOR:

(a) ANY LIABILITIES, INCLUDING POLICY LIABILITIES, THAT ANOTHER RESULTING INSURER ISSUES, UNDERTAKES, OR INCURS IN THE RESULTING INSURER'S OWN NAME AFTER THE DIVISION; OR

(b) ANY LIABILITIES, INCLUDING POLICY LIABILITIES, OF THE DIVIDING INSURER THAT ARE ALLOCATED TO OR REMAIN THE LIABILITY OF ANOTHER RESULTING INSURER UNDER THE PLAN OF DIVISION.

(3) IF A PROVISION OF ANY EVIDENCE OF INDEBTEDNESS, WHETHER SECURED OR UNSECURED, OR A PROVISION OF ANY CONTRACT OTHER THAN AN INSURANCE POLICY, ANNUITY, OR REINSURANCE AGREEMENT THAT WAS ISSUED, INCURRED, OR EXECUTED BY THE DIVIDING INSURER BEFORE THE EFFECTIVE DATE OF THIS PART 17, REQUIRES THE CONSENT OF THE OBLIGEE TO A MERGER OF THE DIVIDING INSURER, OR TREATS SUCH A MERGER AS A DEFAULT, THE PROVISION APPLIES TO A DIVISION OF THE DIVIDING INSURER AS IF THE DIVISION WERE A MERGER.

(4) IF A DIVISION BREACHES A CONTRACTUAL OBLIGATION OF THE DIVIDING INSURER, ALL RESULTING INSURERS ARE JOINTLY AND SEVERALLY LIABLE FOR THE BREACH. THE VALIDITY AND EFFECTIVENESS OF THE DIVISION IS NOT AFFECTED BY THE BREACH.

(5) A DIRECT OR INDIRECT ALLOCATION OF CAPITAL, SURPLUS, ASSETS, OR LIABILITIES, INCLUDING POLICY LIABILITIES, OCCURS AUTOMATICALLY, BY OPERATION OF LAW, AND MAY NOT BE TREATED AS A DISTRIBUTION OR TRANSFER FOR ANY PURPOSE WITH RESPECT TO EITHER THE DIVIDING INSURER OR ANY RESULTING INSURER.

(6) LIENS, SECURITY INTERESTS, AND OTHER CHARGES ON THE CAPITAL, SURPLUS, OR OTHER ASSETS OF THE DIVIDING INSURER ARE NOT IMPAIRED BY

THE DIVISION, NOTWITHSTANDING ANY OTHERWISE ENFORCEABLE ALLOCATION OF LIABILITIES, INCLUDING POLICY LIABILITIES, OF THE DIVIDING INSURER.

(7) IF THE DIVIDING INSURER IS BOUND BY A SECURITY AGREEMENT GOVERNED BY ARTICLE 5 OR 9 OF TITLE 4, OR BY THE SUBSTANTIAL EQUIVALENT AS ENACTED IN ANY OTHER JURISDICTION, AND THE SECURITY AGREEMENT PROVIDES THAT THE SECURITY INTEREST ATTACHES TO AFTER-ACQUIRED COLLATERAL, A RESULTING INSURER IS BOUND BY THE SECURITY AGREEMENT.

(8) UNLESS OTHERWISE PROVIDED IN THE PLAN OF DIVISION AND SPECIFICALLY APPROVED BY THE COMMISSIONER, AN ALLOCATION OF A POLICY OR OTHER LIABILITY MAY NOT:

(a) AFFECT THE RIGHTS THAT A POLICYHOLDER OR CREDITOR HAS UNDER ANY OTHER LAW WITH RESPECT TO THE POLICY OR OTHER LIABILITY; EXCEPT THAT THE RIGHTS ARE AVAILABLE ONLY AGAINST A RESULTING INSURER RESPONSIBLE FOR THE POLICY OR LIABILITY UNDER THIS SECTION; OR

(b) RELEASE OR REDUCE THE OBLIGATION OF A REINSURER, SURETY, OR GUARANTOR OF THE POLICY OR LIABILITY.

(9) A RESULTING INSURER IS LIABLE ONLY FOR THE LIABILITIES ALLOCATED TO THE RESULTING INSURER IN ACCORDANCE WITH THE PLAN OF DIVISION AND THIS SECTION AND IS NOT LIABLE FOR ANY OTHER LIABILITIES UNDER THE COMMON LAW DOCTRINE OF SUCCESSOR LIABILITY OR ANY OTHER THEORY OF LIABILITY APPLICABLE TO TRANSFEREES OR ASSIGNEES OF ASSETS.

10-3-1713. Shareholder appraisal rights. IF A DIVIDING INSURER DOES NOT SURVIVE A DIVISION, A SHAREHOLDER OF THE DIVIDING INSURER IS ENTITLED TO APPRAISAL RIGHTS AND TO OBTAIN PAYMENT OF THE FAIR VALUE OF THE SHAREHOLDER'S SHARES IN THE SAME MANNER AND TO THE EXTENT PROVIDED FOR A CORPORATION AS A PARTY TO A MERGER PURSUANT TO SECTION 7-113-102.

10-3-1714. Rules. THE COMMISSIONER MAY ADOPT RULES TO ADMINISTER THIS PART 17.

10-3-1715. Enforcement by commissioner. THE COMMISSIONER MAY TAKE ANY ACTION WITHIN THE COMMISSIONER'S AUTHORITY TO ENFORCE COMPLIANCE WITH THIS PART 17.

10-3-1716. Merger or consolidation effective with division.

(1) TO FACILITATE THE MERGER OR CONSOLIDATION OF ANY RESULTING INSURER WITH AND INTO ANOTHER COMPANY SIMULTANEOUSLY WITH THE EFFECTIVENESS OF A DIVISION AUTHORIZED BY THIS PART 17, A DIVIDING INSURER, INCLUDING ITS OFFICERS, DIRECTORS, AND SHAREHOLDERS, MAY:

(a) ADOPT AND EXECUTE A PLAN OF MERGER OR CONSOLIDATION ON BEHALF OF A RESULTING INSURER;

(b) EXECUTE AND DELIVER DOCUMENTS, PLANS, CERTIFICATES, AND RESOLUTIONS; AND

(c) MAKE ANY FILINGS, IN EACH CASE, ON BEHALF OF THE RESULTING INSURER.

(2) IF SO PROVIDED IN A PLAN OF MERGER OR CONSOLIDATION DESCRIBED IN THIS SECTION, THE MERGER OR CONSOLIDATION IS EFFECTIVE SIMULTANEOUSLY WITH THE EFFECTIVENESS OF A DIVISION 19 AUTHORIZED BY THIS PART 17.

(3) ON REQUEST OF THE DIVIDING INSURER, THE COMMISSIONER MAY WAIVE THE OTHER REQUIREMENTS OF THIS SECTION WITH RESPECT TO ANY MERGER OR CONSOLIDATION INVOLVING ONLY DOMESTIC STOCK INSURERS AND MAY ISSUE THE COMMISSIONER'S FINAL APPROVAL OF THE MERGER OR CONSOLIDATION AS PART OF THE COMMISSIONER'S APPROVAL OF A PLAN OF DIVISION UNDER THIS PART 17.

SECTION 2. In Colorado Revised Statutes, 7-113-102**, amend as they will become effective July 1, 2020**, (1)(g), (1)(h), and (2) introductory portion; and add (1)(i) as follows:

7-113-102. Right to appraisal. (1) A shareholder is entitled to appraisal rights and to obtain payment of the fair value of that shareholder's shares in the event of any of the following corporate actions:

(g) Consummation of a conversion of the corporation to nonprofit status pursuant to section 7-90-201; ~~or~~

(h) Consummation of a conversion of the corporation to an unincorporated entity pursuant to section 7-90-206 (2) if the shareholder is entitled to vote on the conversion; OR

(i) CONSUMMATION OF A DIVISION, AS DEFINED IN SECTION 10-3-1701 (3), TO WHICH THE CORPORATION IS A PARTY IF THE CORPORATION DOES NOT SURVIVE THE DIVISION, SUBJECT TO THE LIMITATIONS SET FORTH IN SECTION 10-3-1713.

(2) Notwithstanding subsection (1) of this section, the availability of appraisal rights under subsections (1)(a), (1)(b), (1)(c), (1)(d), (1)(e), ~~and~~ (1)(h), AND (1)(i) of this section ~~are~~ IS limited in accordance with the following provisions:

SECTION 3. Act subject to petition - effective date. This act takes effect at 12:01 a.m. on the day following the expiration of the ninety-day period after final adjournment of the general assembly (August 5, 2020, if adjournment sine die is on May 6, 2020); except that, if a referendum petition is filed pursuant to section 1 (3) of article V of the state constitution against this act or an item, section, or part of this act within such period, then the act, item, section, or part will not take

effect unless approved by the people at the general election to be held in November 2020 and, in such case, will take effect on the date of the official declaration of the vote thereon by the governor.

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National Council of Insurance Legislators (NCOIL)

Distracted Driving Model Act

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

Draft as of November 9, 2020~~August 25, 2020~~

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

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Section 1. Title

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

Section 2. Purpose

This Model provides a structure to strengthen distracted driving laws across the country by establishing a comprehensive hands-free law to curb driver distraction, including manual, visual and cognitive distraction, to reduce highway fatalities, save lives, reduce auto crashes and make roads safer. The Model enables law enforcement to ticket drivers for holding a mobile device and limits use of a mounted or "hands-free" device while operating a motor vehicle, including texting, viewing videos or images, entering data, and talking or broadcasting content. Exceptions are provided for emergencies, for certain voice-activated technology, for navigation, and for "single swipe" activation as long as the device is not held by the driver or used to engage in viewing distracting content. The increased prevalence of smartphone technology and expansion of its capability and potential for use has exacerbated distraction behind the wheel.

Along with heightened public awareness, targeted research, and the development of technology to mitigate risks, the enactment of primary enforcement laws is an important part of the strategy to reduce traffic deaths and life altering crashes.

Section 3~~1~~ – Definitions

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

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

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

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

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

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

Section 4~~2~~ – Operation

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 5~~3~~ – Penalties

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 6. Effective Date

This Act shall become effective_____.

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National Council of Insurance Legislators (NCOIL)

Coronavirus Limited Immunity Model Act

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

Draft as of November 9, 2020.
To be introduced and discussed during the Property & Casualty Insurance Committee on December 12, 2020.

Section 1. Title

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

Section 2. Definitions

(A) "Coronavirus" means:

(1) Severe acute respiratory syndrome coronavirus 2;

(2) The disease caused by severe acute respiratory syndrome coronavirus 2; or

(3) Any subsequently identified mutation, modification, or strain of coronavirus if the transmission of said virus among humans rises to the level of an epidemic or pandemic and qualifies for an emergency declaration under applicable [State] law.

(B) "Person" means any entity recognized in this state and shall include but not be limited to an individual, corporation, limited liability company, partnership, trust, association, church or religious organization, city, county, school district, college, university or other institution of higher education, or other unit of local government. However, "person" shall not include any [State] public health district; the federal government or any of its agencies; the state of [State] or any of its agencies, except colleges, universities, and other institutions of higher education; nor any foreign government or foreign jurisdiction.

Section 3. Limited Immunity from Liability

(A) Subject to the other provisions of this section, a person is immune from civil liability for damages or an injury resulting from exposure of an individual to coronavirus.

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

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

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

Section 4. **Effective Date**

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

Section 5. Sunset Date

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

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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. Re-adopted by the Property & Casualty Insurance Committee on September 24, 2020 and Executive Committee on September 26, 2020.

Proposed Amendments sponsored by Asm. Ken Cooley (CA)

To be discussed during the Property & Casualty Insurance Committee on December 12, 2020.

Summary

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

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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.”

<u>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.)</u>

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

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

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

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

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

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

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

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

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

j. any claims for interest

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

3. Notwithstanding any other provision in this Act

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 4. Creation of the Association

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

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

Section 5. Board of Directors

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

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

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

Section 6. Powers and Duties of the Association

A. The Association shall:

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

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

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

c. an amount not exceeding $300,000 per claim for all other covered claims; provided, that for purposes of this limitation, all claims of any kind whatsoever arising out of, or related to, bodily injury or death to any one person shall constitute a single claim, regardless of the number of claims made, or the number of claimants

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

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

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

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

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

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

2. be deemed the insurer only to the extent of its obligation on the covered claims and to such extent, subject to the limitations provided in this article, shall have all rights, duties

and obligations of the insolvent insurer as if the insurer had not become insolvent, including but not limited to, the right to pursue and retain salvage and subrogation recoverable on paid covered claim obligations. The Association shall not be deemed the insolvent insurer for any purpose relating to the issue of whether the Association is amenable to the personal jurisdiction of the courts of any state.

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

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

4. investigate claims brought against the Association and adjust, compromise, settle, and pay covered claims to the extent of the Association's obligation and deny all other

claims. The Association shall have the right to appoint and to direct legal counsel retained under liability insurance policies for the defense of covered claims.

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

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

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

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

B. The Association may:

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

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

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

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

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

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

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

C. Suits Involving the Association

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

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

3. In any lawsuit contesting the applicability of Sections 3.I.2.d. and e. or 9.B.1. where the insured or claimant has declined to provide financial information under the procedure provided pursuant to Section 6 of this Act, the insured or claimant shall bear the burden of proof concerning its net worth at the relevant time. If the insured or claimant fails to

prove that its net worth at the relevant time was less than the applicable amount, the court shall award the Association its full costs, expenses, and reasonable attorneys' fees in contesting its claim.

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

Section 7. Plan of Operation

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

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

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

C. The plan of operation shall:

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

2. establish procedures for handling assets of the Association

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

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

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

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

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

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

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

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

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

Section 8. Duties and Powers of the Commissioner

A. The Commissioner shall:

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

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

B. The Commissioner may:

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

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

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

Section 9. Effect of Paid Claims

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

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

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

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

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

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

Section 10. Exhaustion of Other Coverage

A. Any person having a claim under an insurance policy, whether or not it is a policy issued by a member insurer, and the claim under such other policy arises from the same facts, injury, or loss

that gave rise to the covered claim against the Association, shall be required first to exhaust all coverage provided by any such policy. Any amount payable on a covered claim under this Act shall be reduced by the full applicable limits stated in such other insurance policy and the Association shall receive a full credit for such stated limits, or, where there are no applicable stated limits, the claim shall be reduced by the total recovery. Notwithstanding the foregoing, no person shall be required to exhaust any right under the policy of an insolvent insurer.

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

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

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

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

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

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

Section 11. Prevention of Insolvencies

To aid in the detection and prevention of insurer insolvencies:

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

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

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

Section 12. Examination of the Association

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

Section 13. Tax Exemption

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

Section 14. Recognition of Assessments in Rates

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

Section 15. Immunity

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

Section 16. Stay of Proceedings

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

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 26, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Hilton Alexandria Old Town Hotel on Saturday, September 26, 2020 at 9:00 A.M. (EST)

Representative Edmond Jordan of Louisiana, Chair of the Committee, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Sen. Matt Lesser (CT)*
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Jim Gooch (KY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Peggy Mayfield (IN)*
Rep. Derek Lewis (KY)
Rep. Bart Rowland (KY)
Rep. Dean Schamore (KY)
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

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

MINUTES

Upon a motion made by Asm. Cooley and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 8, 2020 meeting. Sen. Matt Lesser (CT) abstained.

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

Rep. Fischer thanked everyone for their work on the NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors (Model) and stated that he looks forward to the Committee proceeding with a vote on the Model today. The Model is fairly straightforward and represents a commonsense piece of model legislation and addresses an important issue. The Model would apply mostly to situations where minimal amounts are involved with settlements

involving minors, and the parties engaged want to settle without incurring additional costs for going into court and obtaining approval. It is similar to many laws in states that allow for settling small estates through affidavits. There are certain security measures in place to ensure that the settlement would be preserved for the minor. By settling through an affidavit, the Model would allow both parties in the matter to settle more quickly and allow the people who are injured to get their money faster.

Rep. Fischer stated that before proceeding with a vote he would like to point out one minor amendment both he and Rep. Tom Oliverson, M.D. (TX), co-sponsor of the Model, would like to make. In Section 3(3)(a) and (b), it is proposed that language be included to provide the settlement payor with flexibility in regard to the type of payment made - i.e. not requiring cash or direct deposit. Accordingly, those sections would include "by draft" among the methods available to make payment. Upon a Motion made by Rep. Fischer and seconded by Rep. Oliverson, the Committee voted to adopt the amendment without objection by way of a voice vote.

Rep. Oliverson stated that it has been a pleasure to work with Rep. Fischer. The Model represents a smart piece of legislation that removes unnecessary barriers, and he looks forward to the Committee adopting the Model.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that the Model represents the value of NCOIL. The Model is a good piece of consumer legislation that provides flexibility with consumer protections. The Model is in keeping with NCOIL's innovation agenda and it is a type of issue that only NCOIL, because of its expertise in insurance related matters, would focus on. APCIA thanks the sponsors and the Committee and looks forward to the Model being adopted.

Andrew Kirkner, Regional VP, Ohio/Mid-Atlantic Valley at the National Association of Mutual Insurance Companies (NAMIC), thanked Chair Jordan, the Committee and the sponsors for their work on the Model. NAMIC is supportive of the Model and believes that the Model will increase efficiency and provide a benefit to consumers and also protect those minors who enter into settlements. Mr. Kirkner also thanked the sponsors for the inclusion of the technical amendments to the Model and noted that NAMIC also submitted a written statement in support of the Model.

Asm. Cooley stated that he believes expanding the language through the amendment adopted provides flexibility and is an important safeguard to not be handcuffed to only having the options of cash or attorney trust funds. The amendment adds commercial realism which has practical benefits in terms of the manner of which the payout is made.

Rep. Jordan stated that as a practicing attorney who has dealt with minor settlements, not only can it be costly, but it can be time consuming getting on the judge's calendar. With the pandemic, it can be months before you can get into seeing a judge and getting somebody to sign off on a settlement. Rep. Jordan stated that he appreciates the work that has been done and supports the Model.

Returning to the original Motion made by Rep. Fischer and Rep. Oliverson, the Committee voted to adopt the Model as amended without objection by way of a voice vote.

INTRODUCTION AND DISCUSSION ON NCOIL INSURER DIVISION MODEL ACT

Sen. Lesser, sponsor of the NCOIL Insurer Division Model Act (Model), stated that NCOIL adopted an Insurance Business Transfer (IBT) Model Act this past March. Like the IBT Model Act, corporate division statutes address the significant limitations in the current methods available to insurers to transfer or assume blocks of insurance business in an efficient and cost-effective manner that provides needed legal finality. In 2017, Connecticut was the first state to enact an insurance-specific corporate division law. Since then, other states have followed including Illinois, Michigan, Iowa and Georgia. While IBTs and insurer divisions are similar in some respects, they are nonetheless distinct restructuring mechanisms with different functions. Accordingly, following NCOIL's adoption of its IBT Model Act, Sen. Lesser stated that he believes it makes sense that there should not be one Model without the other for states to consider adopting. Sen. Lesser stated that he is proud to sponsor the Model and looks forward to discussing and developing it throughout the next several months.

Jared Kosky, General Counsel at the Connecticut Insurance Department, stated that he would like to provide some background with regard to CT's insurance division Act that Sen. Lesser mentioned, provide a status update as to CT's Act, and note some differences between the Act and the Model. Mr. Kosky stated that a few years ago then Governor Dannel Malloy and his administration had requested legislative proposals as part of an initiative to enact business friendly laws in CT. Under that initiative, the insurance industry primarily, spearheaded by The Hartford, drafted and proposed a bill that sought to permit insurance company divisions. The particular bill was based on existing corporate division laws that had already existed in Arizona and Pennsylvania and the CT bill was specific to the insurance industry.

The purpose behind the proposal was that the U.S. insurance regulatory framework offered limited options to insurers that desired to achieve legal and economic finality when the insurer changed its business strategy, internally reorganized or exits or acquires a line or block of insurance business. So, the intent of the bill was to promote the efficient allocation of capital and better alignment of the insurance risks with an insurer's current business strategy and dedicated management. The bill ultimately passed and is now the CT insurance division Act and became effective in 2017.

As a general overview, the Act seeks to provide legal and economic finality to the reorganization and transfer of insurance risks in order to benefit, reinsurers and most importantly from CT's standpoint, policyholders, as the CT DOI's main charge is consumer protection. The Act does this by authorizing an insurer to divide into two or more insurers in a corporate level transaction that is in essence the reverse of a merger. Instead of two or more insurers being merged into one insurer as happens in a merger, what happens here is that you have one existing domestic insurer that is divided into two or more resulting insurers. As part of that division, the assets and obligations, including the insurance policies of the dividing insurer, are allocated to the resulting insurers as provided in the plan of division that is submitted. Those resulting insurers are deemed to be the legal successors of the dividing insurer and the assets and obligations are allocated to them as a result of succession and not by direct or indirect transfer.

From CT's standpoint, the insurance regulatory issues in a division are akin to those that we see in a merger and that is why the provisions of the Act regarding regulatory review of a division are similar to those that are applicable to a merger and that is also similar to what is contained in the Model. Further, if a division is part of a larger transaction that also involves a change of control of an insurer, that change of control will also require regulatory approval under CT's usual standards and procedures. In that case, it is the Form A procedures that govern which regulators have been doing for awhile and are very familiar with.

Mr. Kosky stated that although CT has received a number of inquiries from companies interested in making use of the division Act, an application has not yet been received and the regulatory process has not been engaged. CT DOI has heard from industry that the lack of activity comes down to two primary reasons. One is that CT has some very narrow language as to who can make use of the Act and who ultimately the resulting insurers are to be. That means that only domestic insurers may make use of it but the resulting insurers, under the CT Act, must also be domestic insurers. That is unique to CT and may be a reason why there has been a lack of activity. That language does not appear in the Model. The second reason is just the general uncertainty in the industry around the newness and ongoing review of restructuring mechanisms – both divisions and IBTs. The National Association of Insurance Commissioners (NAIC) has established a Working Group to review these mechanisms. There does seem to be a bit of a wait and see approach in the industry.

Mr. Kosky then highlighted some differences between the CT Act and the Model while noting that the Model does track very closely to the CT Act. One difference is the one noted earlier regarding the resulting insurer in CT needing to be a CT domestic company. The Model in Sections 3 and 12 talks about the ability of the resulting insurer allowed to be a domestic of another jurisdiction. Another key difference relates to the standards by which an Insurance Commissioner must approve a transaction. The Model has an additional standard that guaranty association coverage must be part of the standard for approval. The third major difference relates to the notice requirement. The CT Act has a notice and hearing requirement, but the notice requirement is sort of strictly related to the hearing itself. Mr. Kosky stated that he reads the Model language to be broader and allow for greater notice to policyholders and perhaps reinsurers.

Kathy Belfi, Director of Financial Regulation at the CT DOI, stated that she can provide a practical view as she is a regulator who would be looking at these types of transactions. Ms. Belfi thanked the Committee for its work introducing the Model and believes it was thoughtfully put together. CT feels good about the Model. Ms. Belfi stated that she would like to talk about two key issues that are in the Model and have been the subject of a lot of discussions among insurance regulators. The first issue relates to transparency through a public hearing. As Mr. Kosky mentioned, the CT Act is very similar to what CT already does and all of the change of controls in mergers are done for the most part through public hearings and that is very important to have as transparency is extremely important.

The other issue relates to the use of a contracted independent expert. In the CT Act, the Commissioner has the discretion to use a contracted expert and the key word is that the Commissioner "may" do so. There are some that feel that the Commissioner must use a contracted independent expert but CT DOI feels that it has decades of experience and it knows whether it has to use a contracted independent expert or not. Contracted experts are very good when needed. An example is that CT DOI has had many health mergers and CT DOI has had to use economic experts. However, Ms. Belfi stated there have been at least 50 transactions where she felt very comfortable that DOI staff could fully evaluate the transaction and either disapprove or approve. Accordingly, CT DOI believes that allowing for Commissioner discretion in this area is extremely important because ultimately contracted experts are expensive and not always are what is best for the consumer and quite often the use of them is not very efficient.

Asm. Cooley thanked Sen. Lesser for introducing the Model and stated that it is very important that there are mechanisms in place to allow insurance enterprises to evolve and manage their exposure in the marketplace, particularly during challenging times. Asm. Cooley stated that he believes it is important for NCOIL to go back and look at its guaranty association Model. The basic rule is to protect consumers through solvency protection and making sure carriers are

healthy. The second line of defense for consumers are guaranty funds so that if carriers sometimes run into trouble the consumer has coverage. Asm. Cooley stated that as we envision that a book of business may be transferred, it is important to ensure that guaranty fund protection follows the customer. It is important for NCOIL to speak with a common voice among the guaranty fund Model and measures like this current Model which Asm. Cooley stated he believes the industry needs.

Asm. Cooley stated that he is supportive of the Model but noted that it is important to review the guaranty fund Model and determine if any tweaks are needed so that the customer's expectancy is always met. Asm. Cooley stated that he believes that is a concern for insurance departments as well and does not believe it is a problem to make sure that the technical terminology in all Models harmonize seamlessly. Asm. Cooley thanked Sen. Lesser again for introducing the Model.

Bridget Dunn, Head of Gov't Affairs at Talcott Resolution (Talcott), stated that Talcott was formed in 2018 after the purchase of The Hartford's closed block of life and annuity insurance. Talcott is privately owned and has been working in the past two years to set up the company and to establish itself as a strategic risk partner for the insurance industry. This has been effective as earlier this week, The Hartford Courant named Talcott the number one mid-sized company in CT for the second year in a row. Talcott is poised for growth as it has built a platform where it wants to acquire other closed blocks of runoff business, primarily annuity insurer's insurance blocks, and one of the methods that it would like to use to acquire those policies is insurer divisions.

Ms. Dunn stated that like the IBT Model that NCOIL adopted earlier this year, insurer division statutes address the significant limitations to the current methods available to insurers to transfer or assume blocks of insurance business in an effective and cost effective manner that provides needed legal finality. As stated by the CT DOI, both IBTs and division are restructuring mechanisms but they go through different processes as to how an insurer can transfer or assume different policies. With divisions, it is a legal entity transaction that is like a reverse merger that must be approved by the state insurance regulator after a rigorous review process, a public hearing and a notice. The U.S. insurance regulatory framework offers limited options to provide the legal and economic finality of insurance risks when an insurer changes its business strategy or decides to internally reorganize, completely exit, or acquire new business. Divisions provide that legal and economic finality to insurers and allows for more efficient allocation of capital which can benefit policyholders. More efficient allocation of capital can lead to better product pricing. Policyholders also benefit when insurance businesses are aligned with an insurer's current business strategy and are the current focus of management, shareholders and regulators. Rather than being a distraction for an insurer who is focused on different lines of business under the current business strategy, policyholders can benefit when companies focus on that core business.

Ms. Dunn stated that the need for the legal and economic finality is reflected in the way that corporate and insurer division acts have been enacted or considered across the country. As previously mentioned, five states currently have insurance specific division laws, including CT, IL, MI, IA, and GA. A bill was introduced in CO and was being considered during the previous legislative session. The bill did not go the floor for a vote, but it is expected that it will be introduced during next session. There are also division laws in AZ and PA which apply to all industries. Delaware authorizes a division of limited liability companies and TX has a provision in its merger statute to allow a divisive merger where a single organization including an insurer can merge with the same effect as a division. Ms. Dunn stated that Talcott is thrilled that NCOIL

is considering the Model. Just like IBTs, mechanisms are needed to keep the insurance regulatory system modernizing.

Karen Melchert, Regional VP of State Relations of the American Council of Life Insurers (ACLI), thanked Sen. Lesser for introducing the Model and stated that ACLI would like to see a Model enacted by NCOIL that ACLI can support in states that wish to enact corporate division laws. That being said, Ms. Melchert stated that she would like to review some of ACLI's principles that it uses to evaluate restructuring mechanisms and reflect that there is some work to be done on the Model. First and foremost, ACLI's focus when evaluating these proposals is the protection of policyholders and for that to happen ACLI believes that impacted stakeholders and policyholders must have access to the process. That is one issue that ACLI spotted in its review of the Model - the hearing is not required unless the dividing insurer requests it. Access to the process and policyholder notification of a hearing is something that ACLI seeks to have as a requirement and not discretionary.

With regard to policyholder notification, the Model states that policyholder notification may be required by the Commissioner but there is no mandatory requirement. ACLI suggests that such notification be required in the Model. Also, ACLI believes that independent experts must be retained for protection of the policyholder. ACLI believes that the more people look at a division plan, the more likely it is to be viewed as good for the policyholders and good for the companies and it is actually something that is paid for by the dividing insurer so there is no cost to the DOI. The cost is something that ACLI believes is worthwhile and should be included in the Model.

Ms. Melchert stated that another issue centers around mandatory approval of a division plan which is similar to the language you see in mergers, but it doesn't give the Commissioner discretion to not approve a plan. Even if it meets all of the financial requirements and protections it doesn't give the Commissioner the opportunity to say "I am not comfortable for a certain reason." There are some transactions that the Commissioner may not want to approve for several reasons. Accordingly, there should be discretion involved there. Ms. Melchert further stated that there are also some technical edits that ACLI will suggest later.

Ms. Melchert noted then the CO bill that was referenced earlier, HB 1091. ACLI was engaged in that process and was successful in drafting amendments with the proponent of the bill and working with the CO DOI. Those amendments were adopted by the Committee but not adopted on the floor as that is the process in CO. If they were adopted into the legislation that would be something that ACLI would support. Accordingly, ACLI suggest the Committee look at the CO bill going forward. The CO bill was based on the IL statute which was based on the CT statute which reflects that there have been iterations of this type of legislation across the country.

Another issue that ACLI believes is important relates to guaranty association coverage. ACLI believes that the language in the Model needs to be stronger or at least more fleshed out so it is clear how it works. ACLI looks forward to working with the Committee to adopt a Model that ACLI can support and turn to when working on the issue in other states. ACLI recognizes that divisions are an important mechanism for the industry to have to be nimble and reactionary to the times at hand. Accordingly, ACLI requests that it works with the Committee to get it right. ACLI did have some issues with the IBT Model adopted earlier this year as ACLI was not successful in translating its principles into statutory language. However, ACLI believes it has done so in the CO bill and looks forward to using that experience to perfect the Model before the Committee that can be supported by ACLI.

Paul Martin, VP of State Relations at the Reinsurance Association of America (RAA), stated that from RAA's perspective there are four keys to ensuring that a division Model is most effective.

The first is notice to and opportunity to be heard for all parties – not just the dividing parties but also the policyholders and reinsurers. The second is confidentiality of sensitive financial information. As one can imagine in the middle of a transfer and division there is a lot of information and some of it is sensitive so it is important to make sure there are protections in the Model that are there to protect that information. The third is respect for contractual rights of parties. A division inherently involves an involuntary substitution of a party to which some parties to the contract don't necessarily have a say to unless there is notice and opportunity to be heard. Lastly, transparency of the proposed division plan is important. Everybody needs to know what is happening in the plan so there is transparency and no questions down the road.

Mr. Martin stated that with regard to the Model, there are some concerns. Similar to what Asm. Cooley mentioned, there needs to be more defined terms in the Model. RAA would also like to see beefed up adequate notice to all parties, not just reinsurers, including policyholders. RAA would also like to see a reasonable description of all the assets and liabilities that are going to be divided – RAA believes it can work on language for that. RAA also has some concerns about the asymmetrical treatment of creditors on one hand and policyholders, annuity holders and reinsures on the other hand. Lastly, RAA would like to see sufficient authority for the DOI to review or disapprove the plan. RAA would like for the Commissioner to have the authority to do that.

Mr. Martin stated that, as Ms. Melchert mentioned, there is an outstanding guide for the Committee to follow – the amended version of CO HB 1091. All of the stakeholders are happy with that bill and that is the best work product for the Committee to follow when drafting the Model going forward. RAA looks forward to working with the Committee going forward.

Bob Ridgeway, Senior Gov't Relations Counsel at America's Health Insurance Plans (AHIP), thanked the Committee for its work thus far and stated that AHIP agrees with most of the comments made by ACLI and RAA. Mr. Ridgeway stated that as he reads the Model, a transaction could be completed and approved without shareholder approval which he does not understand. Section 7(a) of the Model has provisions that he reads to say that the transaction could be approved without any hearing and that the hearing does not require policyholder consent in some circumstances and in some circumstances may not even require notice to policyholders.

Mr. Ridgeway stated that in Section 11(f)(1) of the Model, the policyholder's rights are probably only going to be applicable to the resulting insurer. As a practical matter, most of us know that when a consumer picks an insurance policy, they usually pick a particular insurer for a reason and often times it is because of a company's reputation or their financial standing and how strong they are. If we change the policyholder's contract without their consent and perhaps not even notice, that is not what the policyholder bargained for.

Mr. Ridgeway stated that his confidence is uplifted knowing that Ms. Belfi has looked at the Model and is supportive of it and he also sees some promising provisions in the Model relating to guaranty fund coverage. However, guaranty fund coverage does not always make all policyholders whole – sometimes they are left with only partial relief. Accordingly, there are some provisions that concern Mr. Ridgeway and he has spoken to people in the guaranty fund industry who have concerns about the Model and legislation like it in general for many of the reasons stated by Mr. Ridgeway. Having said that, Mr. Ridgeway stated that he looks forward to working with Sen. Lesser, industry, and the Committee going forward to improve the Model to a point where it can be supported by everyone.

Sen. Lesser stated that he appreciates all of the comments made today in an effort to improve the Model and he looks forward to working with everyone going forward.

Daniel Lewallen, Esq. at Faegre, Drinker, Biddle & Reath LLP, stated that he is speaking today on behalf of the National Organization of Life and Health Insurance Guaranty Associations (NOLGHA) and the National Conference of Insurance Guaranty Funds (NCIGF). Those are the coordinating bodies of the state insurance guaranty system and both organizations want to ensure that the Model will achieve what everyone agrees is a key objective to preserving guaranty association fund coverage for all affected policyholders following a division. NOLGHA and NCIGF are reviewing the Model and plan on submitting comments to that point in the future. Mr. Lewallen stated that he appreciates the comments made by Asm. Cooley and other speakers made earlier and he looks forward to working on the Model with the Committee going forward.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Rep. Lehman, the Committee adjourned at 10:00 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 25, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Hilton Alexandria Old Town Hotel on Friday, September 25, 2020 at 2:15 P.M. (EST)

Assemblyman Ken Cooley of California, Chair of the Committee and NCOIL Vice President, presided*.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Sen. David Livingston (AZ)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Sen. Neil Breslin (NY)*
Sen. Bob Hackett (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Jim Gooch (KY)
Sen. Kirk Talbot (LA)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a motion made by Sen. Travis Holdman (IN), NCOIL Immediate Past President, and seconded by Sen. Neil Breslin (NY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Breslin and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 6, 2020 meeting.

FORMATION OF NCOIL SPECIAL COMMITTEE ON RACE IN INSURANCE UNDERWRITING

Rep. Lehman mentioned the formation of the NCOIL Special Committee on Race in Insurance Underwriting which was just announced earlier this morning and will be Chaired by Sen. Breslin. Rep. Lehman stated that it is important to reiterate that the decisions made by the Committee will be guided by actuarial data. By its nature, insurance can be discriminatory which is why it is important to follow the data.

Sen. Breslin agreed with Rep. Lehman and stated that it is a slippery slope and difficult, but it is important to exhaust every possibility as to whether racism exists or not in the insurance

industry. Sometimes when you look at a pricing scenario in insurance, it might appear to be discriminatory against someone but in effect it is an insurance company doing its due diligence to come up with a fair and just pricing system. Sen. Breslin stated that he looks forward to inviting experts to testify on both sides of the aisle and at the very least sharing information with the NAIC. There could be a synergistic relationship between NCOIL and NAIC to come up with the proper conclusions. Asm. Cooley stated that the word synergistic is appropriate to use in this instance because the work of legislators and regulators is frequently intertwined.

UPDATE ON STATE ADOPTION OF AMENDED NAIC CREDIT FOR REINSURANCE MODELS

Asm. Cooley stated that after much hard work, the NAIC adopted amendments to its Credit for Reinsurance Model Law and Regulation in order to incorporate certain provisions of the Covered Agreement between the U.S. and European Union, and a similar Covered Agreement between the U.S. and United Kingdom. Since that time, both NCOIL and NAIC have been working hard to ensure that states adopt the Models so that there is no risk of federal preemption. NCOIL is committed to making sure there is no federal preemption in this area. NCOIL President, Rep. Matt Lehman, has made this a priority and he has had discussions with NAIC President, South Carolina Director Ray Farmer, to make sure both organizations dedicate their time and resources towards meeting the goal of state adoption of the Models.

Both NCOIL and NAIC have also been tracking each state's adoption of the Models, as well as listing all states' progress on each organization's website. Asm. Cooley noted that earlier this month, California adopted the amended Models which he sponsored in the Assembly. Asm. Cooley asked for an update as to how the NAIC's efforts have been progressing in terms of working with state legislatures to introduce and adopt this legislation.

The Hon. Scott White, Virginia Insurance Commissioner, stated that Asm. Cooley laid out the issue very well in terms of mentioning the Covered Agreement with the EU dating back to 2017. The NAIC looks at it as a reciprocal agreement and will agree to get rid of the reinsurance collateral requirements but in return the EU has agreed to recognize a state's approach to group supervision including group capital so that is a very important consideration to keep in mind. A component of that is a five-year timeline to have all states complete these changes through their laws to conform with the requirements of the Covered Agreement. That is a pretty tight timeline.

Cmsr. White stated that the NAIC first had to make changes to the Reinsurance Models and they were able to do that successfully in 2019. The Models then go to the states to have the Models passed in the legislature and to have the state insurance department amend certain regulations. In terms of numbers, there are about 14 states that have passed the Model Law – there may even be a few more as South Carolina adopted the Model law just yesterday. That is a number that the NAIC would like to see be higher. Only two states have adopted the amended Model regulation – California and Virginia. Cmsr. White stated that the NAIC is aware of a number of states that expect to adopt the Models soon so the NAIC is optimistic. The NAIC also made adoption of the Models an accreditation standard as well to really incentivize the states.

The Hon. Dean Cameron, Idaho Insurance Director and NAIC Vice President, thanked NCOIL for its help with this issue and noted that the NAIC is working very diligently to make sure there is no federal preemption. That is a goal of both NCOIL and NAIC.

Dir. Cameron then thanked Rep. Lehman and Sen. Breslin for their work regarding the Special Committee on Race in Insurance Underwriting. This is not the year anyone expected but it is

what it is and the NAIC is very serious about these issues going forward. Dir. Cameron stated that one of the first calls he made after the NAIC Officers met and decided to move forward on these issues was to Rep. Lehman in order to get his input and collaborate. The NAIC looks forward to working with NCOIL on these issues going forward in a collaborative manner. The NAIC's Race in Insurance Committee is being broken into five working groups and they are focused on determining whether there is discrimination – unintentional or otherwise – and looking at ways to improve access and improve the industry to be able to reach out to those who have not been involved in the industry and have not used the industry's products.

DISCUSSION ON PANDEMIC BUSINESS INTERRUPTION ISSUES

Asm. Cooley stated that business interruption insurance coverage issues arising from the global pandemic have undoubtedly been among the most important issues throughout the past several months regardless of one's involvement in the insurance industry. Both NCOIL and NAIC have taken positions on the issue in general, as well as the specific of issue "retroactive" business interruption insurance legislation. Additionally, the NAIC initiated a data call to collect data related to business interruption insurance and COVID-19. Asm. Cooley asked if a review and update on the NAIC's position statement, along with any information that can be shared regarding the results of the data call could be provided.

Dir. Cameron stated that this issue can be controversial, so it is important to lay a groundwork on the issue before discussions. Each state is dealing with the issue slightly differently and the story is probably not finished yet. COVID-19 really highlighted that many existing business interruption policies had exclusions for viruses and other diseases. In most cases – probably 99.9% of cases – coverage only triggered if there was actual physical damage to the property. Therefore, many of the policies were generally not designed to provide coverage arising out of COVID-19 – nor were they priced for a pandemic. That is not surprising because that is not how insurance works well as the only way insurance remains affordable is if risk is shared over a broad group. Therefore, the industry is not typically well-suited for a global pandemic or when virtually everyone suffers significant losses at the same time.

Historically, business interruption coverage for viral pandemics has been available on a separate endorsement or a policy form by certain carriers but few businesses have chosen to purchase it. The NAIC understands from the industry that only about 30% of small businesses and 40% of businesses overall have any type of business interruption coverage at all. In March, when the stay-at-home orders were first issued and many businesses were forced to close their doors and terminate their operations, the issue came to the forefront and began to receive significant media attention. Many businesses believed the pandemic would be covered and were surprised to learn that it was excluded from policies. Insurers have been taking the position that such claims were not covered because of no physical damage to the business from the virus or there was an explicit exclusion within the policy for viruses or communicable diseases. Often times that exclusion was contained within an overall pollution exclusion.

Dir. Cameron stated that several lawsuits have been filed by the business community. To date, these lawsuits have focused on whether the virus causes direct property damage to an insured's place of business such that business interruption or civil authority coverage is triggered. Businesses have also sought relief from Congress and state legislators. In March, the NAIC issued a statement to Congress opposing the federal legislative proposal to retroactively apply such coverage on the basis that it would pose a significant risk to the solvency of many insurance firms and would have a systematic impact on the industry as a whole and potentially the entire financial system. According to industry estimates, the exposure estimate ranged from $255 billion to $431 billion a month which would easily deplete any

industry's cash or capital surplus in a short period of time as well as dramatically impact the reinsurance market. Importantly, the NAIC raised concerns with respect to retroactivity of coverage of claims that were excluded and has encouraged policyholders to review their policies and carefully determine whether there may be coverage.

Since that time, the President and Members of Congress have weighed in on the issue. In April, the President made comments suggesting that insurers should cover business interruption claims regarding the pandemic that were not clearly excluded suggesting many insurance policies did not exclude such claims. Dir. Cameron stated that his home state of Idaho and many other states have taken a similar position. If the policy didn't specifically exclude coverage, then the carriers have been asked to pay. In most cases, the policies do specifically exclude. At the same time, Senator Scott from South Carolina along with several other Members of the Senate Banking Committee, including the Chairman, sent a letter to the President citing the NAIC's statement raising concerns about retroactive application to business interruption coverage and expressed skepticism about federal proposals for future pandemic coverage based on the Terrorism Risk Insurance Act (TRIA) or other models.

Dir. Cameron stated that the following week, several Republican House Financial Services Committee members raised similar concerns in a separate letter sent to the President, as did Members of the House Freedom Caucus. That letter was intended to get the attention of their former colleague and now White House Chief of Staff Mark Meadows. In addition, two pieces of federal legislation have been introduced to be retroactive in nature: The Business Interruption Coverage Act – H.R. 6494 from Congressman Thompson of California; and the Never Again Small Business Protection Act – H.R. 6497 by Congressman Fitzpatrick of Pennsylvania. Both proposals seek to require insurers to make business interruption pandemic coverage available. In the case of the Fitzpatrick proposal, the certification of the Secretary of Treasury and the establishment of a federal backup program. In the case of the Thompson proposal, upon the effective date of the legislation. Both plans nullify pandemic exclusions once those conditions are met. Those proposals raise a lot of questions for the NAIC – questions regarding the potential of consumers and businesses being priced out of coverage and whether policyholders would even be able to purchase it.

In May, the House Business Committee held a virtual forum titled "Business Interruption Coverage: Are Policyholders Being Left Behind?" The NAIC submitted a letter to the Committee largely tracking the NAIC's March statement and making clear that the expectation of insurance regulators is that insurers pay claims covered under the policies but continued to raise concerns related to the retroactive application of the coverage. Several witnesses and Members of the Committee, both Republicans and Democrats, acknowledged the issue of retroactive application of business interruption coverage for viruses. Instead, the hearing largely focused on the need for a future program to cover such claims. The House Financial Services Committee was planning a hearing in June titled "Insuring Against Pandemic Challenges and Solutions for Policyholders" but it was postponed due to the House floor schedule. Currently, the NAIC believes that federal activity related to retroactive business interruption coverage is low because many Members of Congress understand the solvency issues that the industry would have to face.

The Hon. Glen Mulready, Oklahoma Insurance Commissioner, then spoke to the NAIC's business interruption COVID-19 data call. Cmsr. Mulready stated that the regulators came together and developed a data call to look into and collect information on these business interruption coverage issues and what is happening with the exclusions and claims losses related to COVID-19. Some of the information has been obtained while some of it continues to be collected. Results thus far show that nearly 8 million policies include business interruption

coverage. Of that amount, 90% were for small businesses, defined as having 100 or fewer employees; 8% for medium businesses, defined as having 101 to 500 employees; and 2% for large businesses defined as having 500 or more employees. Of those policies, 83% of all policies included an exclusion for viral contamination, virus, disease or pandemic; 98% of the polices had a requirement for physical loss.

With regard to the claims, the latest estimates show nearly 200,000 have been reported by policyholders seeking lost income benefits under business interruption coverage. Less than 1% of the claims reported have been closed with a payment; 74% reported have closed without payment. The NAIC continues to collect data and that data collection will go through November of this year. Asm. Cooley thanked Dir. Cameron and Cmsr. Mulready and noted that it is extremely important to have the views of insurance experts heard on these issues, particularly on the federal level so that adverse long-term consequences are not felt by consumers. Cmsr. Mulready stated that 11 states have filed retroactive business interruption legislation. To date, none of the bills have moved forward or passed. At the federal level, the Pandemic Risk Insurance Act (PRIA), has been proposed. The American Property Casualty Insurance Association (APCIA), the National Association of Mutual Insurance Companies (NAMIC) and Independent Insurance Agents and Brokers of America (The Big I) also have a proposal, as do Chubb and Zurich. The only position NAIC has taken is to stand against retroactive coverage.

DISCUSSION ON PROPOSED CHANGES TO STATEMENT ON STATUTORY ACCOUNTING PRINCIPLE (SSAP) NO. 71

Asm. Cooley stated that an issue that has caught the attention of NCOIL is the NAIC's Statutory Accounting Principles Working Group's (WG) efforts to update SSAP No. 71 titled "Policy Acquisition Costs and Commissions." Without delving too deeply into the specifics of the principle itself, NCOIL has heard differing opinions as to whether the proposed changes are substantive as opposed to non-substantive. Asm. Cooley further stated that when NCOIL starts to hear of substantive changes being made via a handbook or manual, as legislators, their ears begin to burn, and they start to recall the debate surrounding incorporation by reference (IBR). Asm. Cooley noted that there is a constitutional provision in California that states no law shall be enacted except by statute and no statute except by bill.

Even if not substantive, there seems to be little debate that these changes could have a material and perhaps significant impact on insurers if adopted. If the impact is as large as some have told us, and we have heard impacts as high as 30% of risk based capital (RBC), which would place some companies below the regulatory action level, it strikes NCOIL as bad timing to implement such changes as the entire global economy is suffering during this global pandemic. Asm. Cooley asked if an update could be provided as to the status of the proposed changes, whether they are indeed substantive in nature, and what financial impact the NAIC believes they would have on the companies it regulates.

Cmsr. White stated that this is an accounting issue that has generated some discussion of late and it has to do with something that is called commission funding agreements that some insurance companies are entering into with third parties. The issue really is whether the arrangement should affect the commissions that insurers pay to their agents under statutory accounting principles really by deferring recognition of that liability. Before going any further, it will help to set the table to discuss some very core, basic statutory principles that the WG looked at with this issue. A basic rule of statutory accounting is that funds which have been spent or obligated as far as liabilities are no longer available to pay policyholder claims, and acquisition costs incurred with the issuance of a new policy must be expensed upfront. That is basically the core, statutory principles that are being dealt with.

With the issuance of an insurance policy, a liability to pay full commissions is required to be paid upfront and expensed at that time – that is SSAP No. 5. SSAP No. 71 requires expensing of policy acquisition costs and these include commission costs, and this is true if full repayment to the third party is not guaranteed. Cmsr. White stated that he looks at these as straightforward accounting concepts, but it has become an issue. The NAIC has learned that, and this is not believed to be widespread, there have been certain third party capital companies that have gone to insurance companies and said that they will take on the act of paying commissions to the agents and on behalf of that insurance company, the insurance company will then pay the third parties (sometimes called super-agents). The advantage for the insurance company is that they will no longer have to recognize those full acquisition costs at the inception of the policy.

Cmsr. White stated that the NAIC looks at that as a flawed arrangement because it assumes the third-party arrangements eliminates the insurance company's obligation that results from the issuance of the policy. As a reminder, acquisition costs such as commissions have to be expensed upfront – that is a core concept of statutory accounting. The idea of by inserting a third party into that arrangement through the structure or design of a contract could change that is not viewed by the NAIC as being consistent with core statutory concepts in terms of recognizing liabilities and expensing policy acquisitions.

Cmsr. White stated that this is important because if insurance companies can defer expense recognition through insertion of a third party it is really going to impact the comparability between entities when you are looking at their financial statements. Using third parties this way will create more favorable financial statements as it will make it appear that they have more assets available than they actually do because they are already obligated to pay commissions for previously sold policies. This came to the attention of the WG and they have been discussing the issue since August 2019. The WG has created an exposure to clarify the original intent of SSAP No. 71.

Cmsr. White then summarized what the NAIC believes are the core points that need to be made in SSAP No. 71. All policy expenses must be recognized upfront. Commission funding agreements cannot be used to defer recognition and that gets to the overall statutory accounting concepts of conservatism and comparability and requiring that financial statements reflect assets available for policyholder claims with comparable financial information. The NAIC does not believe contract designs should determine expense recognition. The proposed effective date for the change proposed by the WG is year-end 2020. The NAIC is recognizing for those insurance companies that have entered into these arrangements a correction of an error for entities that have used a third party to defer commission expenses. Comments on the current exposure were due on September 18. There is going to be full discussion on any comments that were submitted on a conference call either before the NAIC Fall National Meeting or at the Fall National Meeting itself.

Asm. Cooley thanked Cmsr. White for his statements stressing the importance of having a clear understanding of capital and its availability and when it's recognized. Nonetheless, some of the practices discussed probably emerged from companies trying to make sure they are financially strong. Asm. Cooley asked Cmsr. White how he views the change to SSAP No. 71 as it relates to the companies themselves. Cmsr. White stated that the NAIC did reach out to some of third party capital companies and tried to assess the scope and what the impact would be and the NAIC was told that there might be a material impact on some of the companies if they couldn't defer recognition of the commission costs. Cmsr. White stated that gets back to his earlier point in terms of it misrepresents the assets available to pay future policyholder claims and it misrepresents their overall financial condition. That is a concern, and it goes against core

principles of statutory accounting that have served the NAIC and served state regulators so well. That is why this issue itself is something that the NAIC has looked at very carefully and it is concerning.

It gets back to comparability – you can't have one state's regulator looking at a company's financial statement with a $1,500 commission fee and then looking at another company that has used a third party arrangement and they don't have the same assets available and they are not read comparably. That goes against core principles of statutory accounting and the NAIC believes clarification is needed with SSAP No. 71 to correct that, fully understanding the impact that it might have on companies that have entered into those third party agreements in good faith. The NAIC is not suggesting that anything improper was done and the NAIC has given them time until the end of the year to hopefully make that change and correct the recognition of the acquisition costs so they are done upfront consistent with the way it has always been done.

Sen. Holdman stated that there is an overarching issue here of IBR which was a key issue during his term as NCOIL President in 2016. Sen. Holdman stated that one of the concerns he has relates to corrections being made and having those corrections apply retroactively which means there is a pretty hefty adjustment to a financial statement for an insurance company to make. By saying that they are being given time to make the change sounds like it has already been decided that this is the way it is going to be.

Sen. Holdman stated that for those legislators in the room who may not be aware, back in 1996 there was something that needed to pass in legislatures called IBR which said that whatever the NAIC says and approves will become the law in that state. That is ok as long as it is a procedural matter but when it becomes a substantive matter, those are issues that call to mind what Asm. Cooley said earlier regarding only legislators can make the law. Sen. Holdman stated that legislators have given up the right to make law to the NAIC. That is not right but he is not sure that clock can get turned back. Sen. Holdman stated that he talked to a lobbyist in Indiana that was around when this legislation came to Indiana and she said she told legislators at the time "be careful what you vote for because one day you may regret doing this." Sen. Holdman stated that this is an example of when that day has arrived for legislators and there have been other examples throughout the past two decades of lawmaking being abdicated to the NAIC and in most instances the NAIC consists of unelected officials.

Sen. Holdman stated that discussing this issue with colleagues in the legislature is often difficult because they find it boring and don't understand what it means. Sen. Holdman stated that he and Rep. Lehman were successful a few years ago in getting legislation on IBR passed but the most that they could do was to require the Commissioner to report to the legislature on an annual basis all of the changes that were made to current procedure and process and what might be considered substantive changes to the NAIC manuals that impact Indiana process and procedure and substantive law. That is all that could be done because a point of no return has been reached because if a state doesn't make the changes that the NAIC has made, then the state doesn't receive accreditation and there is nobody in the insurance industry that wants a state to lose accreditation because then it becomes more work for them to have to get approval for every change they want to make instead of going through the NAIC clearinghouse to get that done. This is a complicated issue but it goes to the very heart of IBR because it looks like an accounting procedure but in fact it is going to have substantive changes and a substantive impact on the insurance industry and represents decisions that should be made by legislators, not the NAIC.

Cmsr. White stated that he understands and respects Sen. Holdman's points and understands that IBR has been an issue at NCOIL for years, but stated that this is not a new, substantive

rule. Rather, this is a clarification of several existing accounting procedures that have been in place since before 1998 and the NAIC believes that the clarification is needed because it was being mis-applied by insurance companies. The NAIC believes the language is clear and does not think a substantive change is being made. Cmsr. White further stated that this is not being done by the NAIC but rather the member states and the senior financial regulators are highly involved in the discussion of policy. The NAIC staff is relied upon for technical expertise but it is important to point out that it is almost necessary from a practical matter to address these new and emerging technical issues that arise from changes to state insurance laws in many cases.

The NAIC hopes that this dialogue around SSAP No. 71 is an open and transparent process that everyone can participate in and will make sure that it is done pursuant to documented procedures in order to get as much input as possible. It is different than the legislative process but the NAIC believes that when it comes to technical issues that arise – whether it be providing guidance to insurers on financial condition matters or on a handbook – it is something that NAIC has done for a long time and in Virginia that process is incorporated into its statutes while in other states there is a rulemaking procedure involved.

Rep. Lehman stated that if he is an insurance carrier and has been accounting for commissions in error, but he is solvent, and the proposed change to SSAP No. 71 threatens him to become insolvent, then is the proposed change really meeting its intent? Rep. Lehman further stated that the one thing about commissions is that there is no guarantee so if he writes a policy today and gets paid a certain amount and gets paid a certain amount of commission for the policy period, he doesn't get paid if the policy ends for whatever reason. So, how does a company actuarially account for renewal commissions? Rep. Lehman stated that he is a little confused as to how frontloading all of the potential expense is actually going to be possible, and noted that the conversation thus far sounds like substantive changes are being made to SSAP No. 71 that could threaten some insurer's solvency.

Cmsr. White stated that the concern is that expenses have to be recognized upfront. Even though there is a possibility that the policy could lapse and that would impact the commission, that is accounted for currently in terms of recognizing liability at that time – SSAP No. 5. It is a basic principle with the issuance of a policy – a liability to pay full commissions is required even if there is a possibility that the policy may lapse you have to recognize the liability upfront.

That has always been the rule. The NAIC is looking at by inserting a third party in the process and changing the design of the payment structure, that somehow should change the requirement that the acquisition costs have to be expensed up front and that is a dangerous road to go down because it doesn't take away from that insurance company's obligation to pay those commissions and to the extent that is hidden in the third party payment structure, it is not reflective of available assets and it misrepresents the financial condition of the company and it gets away from conservative principles of statutory accounting. Again, the situation should be avoided of having a company not using a third party having two different sets of books that the regulators can't look at and get an accurate picture of what their financial condition is. The NAIC is not doing anything other than clarifying existing statutory accounting principles based on conservatism and comparability.

Cmsr. Mulready stated that similar to the conversation regarding avoiding federal preemption in the area of reinsurance, having consistency here is a good thing. With that said, Oklahoma has its own concerns because it has heard from carriers saying that the change or clarification could be hurtful. Ongoing dialogue on this issue will be helpful.

Dir. Cameron thanked Cmsr, White for doing a good job explaining the issue and stated that he looks forward to bringing some of the concerns raised today back to the NAIC in an effort to circle back and have a continuing dialogue on the issue. The NAIC's goal is to treat all carriers the same and analyze books the same and understand and make sure that they have adequate resources to pay all of their claims including the potential paying commissions. If there is a mechanism or loophole that is allowing for some carriers to take advantage then that discussion should take place. It is certainly not the NAIC's intention to work around state legislators as the NAIC has consumer safety and insurer solvency as the top priority. Dir. Cameron suggested that another discussion on this issue take place after the NAIC has had time to further discuss the issue along with the topics raised today.

Cmsr. White stated that the NAIC has received letters from at least one Commissioner raising some of the concerns noted today. Cmsr. White stated that he agreed with Dir. Cameron that further discussion is warranted and the NAIC understands the concerns of the clarification having a material impact on certain carriers. One thing that the NAIC does not want is that if there are certain carriers utilizing this practice, and it is the NAIC's understanding that there are not many, it puts pressure on other carriers to go in that direction if they view it as being at a competitive disadvantage, especially if it is not an accurate reflection of the availability to pay future policyholder claims and it doesn't accurately reflect their financial condition. That is the concern of the WG and of the E Committee.

Asm. Cooley stated that when you boil down the entirety of insurance regulation, it is really focused upon the solvency of the companies. If the companies are solvent they will perform their promises and if they perform their promises the customer is taken care of. Guaranty funds are the second line of defense. If you don't have a solvent carrier you need a way to pay the claims and that is where guaranty funds come in. If we have something where it is felt that there is something in the marketplace that jeopardizes the solvency of carriers, then that is an issue to bring to the legislature because the expectancy is that the statutory laws of each state, not regulations, are the framework within which an insurance company should be able to operate safely and solvently whether in CA, VA or ID or OK or WA. Asm. Cooley stated that this is an important issue that warrants further discussion and it raises an issue of if you believe there is a solvency issue then we really need to be talking about how is the law setup and are adjustments necessary. That forces a broader conversation to weigh and evaluate what constitutes fairness in the practice of the insurance business and what may not.

DISCUSSION ON NAIC'S CASUALTY ACTUARIAL AND STATISTICAL TASK FORCE (CASTF)

Asm. Cooley stated that throughout the past several months, CASTF has been 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. The White Paper was actually just adopted by CASTF last week. Before adoption, NCOIL and NAIC discussed the White Paper at great length, culminating in NCOIL adopting a Resolution Urging the NAIC to Refrain from Intruding on the Constitutional Role of State Legislators – a Resolution which Asm. Cooley sponsored and which essentially opposes the White Paper.

However, while NCOIL did distribute the Resolution to NAIC leadership, NCOIL did not distribute it to all the Resolution's listed recipients – notably all state Insurance Commissioners, state legislative leaders, and members of the committees with jurisdiction over insurance public policy – because of assurances from NAIC leadership that language would be inserted into the White Paper clarifying that nothing in the White Paper is intended to, or could, change the

applicable legal and regulatory standards for approval of rating plans. Asm. Cooley, as sponsor of the Resolution, and on behalf of his fellow officers, thanked the NAIC for including that important language as it addresses NCOIL's concerns and therefore maintains the lack of a requirement to distribute the Resolution any further. Asm. Cooley asked if an update could be provided as to the road ahead for the White Paper

Cmsr. White stated that there has been a lot of work on the White Paper and the NAIC appreciates NCOIL's comments which were included in the latest version. The theme is that the White Paper is intended to provide best practices and guidance to regulators when they are interpreting very complex predictive models that underly rating plans. CASTF was first put together in 2018 and the White Paper has been exposed at least three times, the last time in June, and CASTF has met at each NAIC national meeting since then. The White Paper was adopted by CASTF on September 15 and it now goes to the Property and Casualty (C) Committee for consideration and adoption. Cmsr. White stated that the NAIC received a lot of comments on the White Paper from industry, regulators, and consumer representatives. There were about seven or eight different themes in the comments.

Cmsr. White stated that it is important to emphasize that the White Paper is not establishing rate filing requirements, nor is it usurping legislative authority. The NAIC looks at it from the standpoint that the best practices of states that were already looking at these issues were gathered and incorporated into the White Paper so that there is something all states can use. A lot of states just don't have the resources to properly analyze complex predictive models and they don't have an in-house actuary. The approach is to identify considerations to look at that might be helpful moving forward.

Cmsr. White stated that another issue that is important to address that he is often asked about is what the role of the NAIC is when it comes to assisting states in the review of complex predictive models. The role of the NAIC in that instance could be compared to the role of a consultant with two big exceptions, the first being that the NAIC will not override a recommendation but rather provide technical support to the extent needed and the NAIC will not work or communicate directly with insurance companies. The states are going to utilize the White Paper and Cmsr. White stated that his staff believes it will be very helpful and help speed to market because it lays out the information the modeling companies need to put in their filings. That will aid the process in getting the information to regulators and getting it reviewed that much more quickly.

Rep. Lehman stated that he would like to personally thank the NAIC, particularly Dir. Farmer and Dir. Cameron, for getting the White Paper to a place that eased NCOIL's concerns.

DISCUSSION ON NAIC CLIMATE AND RESILIENCY (EX) TASK FORCE

Asm. Cooley stated that he remembers when the NAIC used to meet quarterly and at those meetings everyone used to hear from global reinsurers who really put a spotlight on climate worries early on. It really is incredible what has happened in recent years with regard to the increased frequency of climate-related risk events such as hurricanes, flooding, and wildfires. California is battling unprecedented wildfires right now and it truly is shocking what has been going on; the smoke from the current CA wildfires had travelled via the jet stream to darken the northeastern skies last week. Asm. Cooley asked for an update as to what specifically the Task Force will be working on and what its timeline is. Asm. Cooley also noted the work of The Hon. Mike Kreidler, Washington Insurance Commissioner, in this area as Cmsr. Kreidler has scheduled a virtual Climate Summit on October 7 in order to highlight the latest climate science, private sector best practices, and regulatory environments related to climate change.

Cmsr. Kreidler stated that Washington has been severely impacted by the smoke and there were a number of days where the state was pretty much off the charts and had the worst air pollution in almost the entire world along with Oregon and many parts of California. It was a West coast phenomenon that all west coast states were contributing to because of the fires that were involved. Cmsr. Kreidler stated that he looks at this as a change that is taking place that the insurers must adapt to and he believes that is where the NAIC will end up as an association in terms of increasingly looking at what it can do to make sure that the kind of investments that are being made by insurance companies are ones that are going to be sustainable. We don't want to see stranded assets and insurance companies winding up with liabilities on their books that look good today but tomorrow are not. The NAIC needs to be on top of this.

Cmsr. Kreidler stated that the other part of it is going to be making sure everything is being done to make sure that insurance companies are kept in the market. California is also concerned about being able to keep homeowners insurance available in areas that are going to be more prone to fires. That is something that is unacceptable. We need to do a better of job of making sure that the kind of construction and where homes are being built are going to be ones that are sustainable and insurable. Cmsr. Kreidler stated that the last thing he wants to see is companies backing away from markets because of fires, tornadoes or hurricanes and not offering the public an opportunity to have insurance.

As a former state legislators and Member of Congress, Cmsr. Kriedler stated that policymakers must do everything they can to make sure insurers stay in the market but when you start dictating to companies to stay in markets that is kind of like saying to insurers in the midst of a pandemic that they have to retroactively go back and underwrite the fact that you didn't cover a virus and now you have to add the coverage. It is the same thing when telling insurance companies to go to certain markets as you will put them at risk financially and that is a huge part of the economy. This is going to be important to make sure to keep the industry fully engaged and competitive and offering good prices in the market regardless of where the risk is and also making sure that their investments are ones that will be sound and sustainable over time. It is not an easy task but it's not one that you can walk away from – change is happening. It is not worth arguing about what the cause of the change is as the bottom line is that change is happening, and we need to adapt to it.

Asm. Cooley stated that regarding the issue of insurer investment portfolios, there are a couple of ways to think about that. One is whether they are making investments in businesses that are going to be run aground and hard hit because of climate issues? Another aspect is in California, a small thing was done a few years ago where generally speaking, investments have to be a certain quality to be recognized by the regulator in the way financial accounting is established. In some cases, an investment might appear to have high utility which can be from a social standpoint on issues of justice and equality and fairness and that gets to the issue of where something might be very meritorious but it may not seem to meet the standard of an insurance company investment. But California also has issues of investments in "green" which is something that appears laudable and appropriate and of the character to move the nation forward and yet also it may not fall squarely within what is considered a traditional insurance company investment.

Asm. Cooley stated that he hopes that the NAIC Task Force on this issue will look at whether there is a way to recognize what can be seen as an appropriate investment whether on the justice or climate side of things. In California, dating back to the mid-1990s there is a program and statutory system that deals with that and it started initially in the wake of some of the civil unrest in California in the early 1990s and it was extended in the last 10 years to climate issues.

It gives the insurance regulator a little more flexibility to look at the type of investment the carrier might make and determining if it is a recognized and legitimate investment even though it is not exactly within the four corners of what has been traditionally looked at. It is about using the power of companies to invest to become change agents in a constructive way and a very good model to consider.

Rep. Lehman stated that he is concerned about the investment issue because as we go down that path, where is that line of controlling a company and their function and their solvency. If a company is totally solvent and has been for years and will be for years but it burns 100% coal and all of its adjusters drive in non eco-friendly trucks, is the department of insurance going to look at that company differently as not being environmentally sound? Rep. Lehman stated he is concerned about how deep regulators are getting into the philosophy of a company as opposed to the regulating of a company.

Cmsr. Kreidler stated that the NAIC has always been a very conservative place from the standpoint of what type of investments will be recognized. But the fear is what happens if you wind up making an investment, for example, as a big bet tied to municipal bonds tied to electrical power generation powered from coal. If you do that, right now because of the cheap rates of natural gas the price isn't there. What else is going to be tied to the future? Regulators will continue to be conservative in their investment recognition. The NAIC is looking at this issue from a standpoint of safety and soundness of the companies themselves in order to make sure they are making sound investments and the NAIC does not want to be an impediment for them. If a company sees a green investment out there, the NAIC does not want to be an impediment to them even if the investment is sound. The NAIC just wants to make sure they are making safe and sound investments and not tied to things that, just because historically municipal bonds from electrical coal generated power was a safe investment, to stay with it. If that status quo remains, we could be in trouble with the safety and soundness of some companies.

ANY OTHER BUSINESS

Sen. Bob Hackett (OH) stated that The Hon. Jillian Froment, recently resigned from her position as Ohio Insurance Commissioner. Sen. Hackett noted that Cmsr. Froment did a great job and is highly respected for the work she did.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Del. Steve Westfall (WV), the Committee adjourned at 3:30 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 24, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Hilton Alexandria Old Town Hotel on Thursday, September 24, 2020 at 4:30 P.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Joe Fischer (KY)
Rep. Dean Schamore (KY)
Del. Kris Valderrama (MD)*
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Asm. Kevin Cahill (NY)
Asw. Pam Hunter (NY)
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Jim Gooch (KY)
Rep. Derek Lewis (KY)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a motion made by Rep. Joe Fischer (KY), NCOIL Secretary, and seconded by Sen. Bob Hackett (OH), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Fischer and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 6, 2020 and July 24, 2020 meetings.

CONTINUED DISCUSSION ON NCOIL DISTRACTED DRIVING MODEL ACT

Sen. Bob Hackett (OH), co-sponsor of the NCOIL Distracted Driving Model Act (Model), stated that before we begin with hearing from our panel today, he would like to say thank you to everyone who has offered input on the Model thus far. Judging by the amount of comments received and the amount of conversations he and Asm. Cooley have had so far relating to the

Model, it is clear how this issue means so much to so many people across the entire country. Sen. Hackett stated that he knows Asm. Cooley, fellow Sponsor of the Model, who is participating via Zoom, agrees with him in saying that the current first draft of the Model is very strong, but they are certainly receptive to making some amendments to improve it. Some of those amendments have already been submitted.

Sen. Hackett stated that one amendment that both he and Asm. Cooley have already decided to include as a Sponsors' Amendment will be in the nature of making it clear that the Model is intended and was always intended to allow for primary enforcement. Distracted driving is blatant, observable behavior which makes primary enforcement the best way to enforce and make clear that such behavior is not acceptable. Accordingly, primary enforcement language will be included in the next draft. It likely that there will be other Sponsors' Amendments included as well. Sen. Hackett stated that the Model is still a work in progress and it will probably remain such at the next Meeting and perhaps the Meeting after that. Sen. Hackett stated that in Ohio, distracted driving legislation was passed a couple of years ago and at the last minute in the conference committee they switched from primary enforcement to secondary enforcement. Sen. Hackett noted that if you speak to law enforcement about secondary enforcement they will tell you that it does not work and it can't be done.

Sen. Hackett stated that distracted driving legislation is back in Ohio and opposition testimony was recently heard. A set of attorneys who are opposed to the bill agree that the bill should allow for primary enforcement. Accordingly, there is a lot of agreement with regard to primary enforcement but there are other issues that need to be cleaned up and they are being worked on.

Asm. Ken Cooley (CA), NCOIL Vice President and co-sponsor of the Model, stated that the issue of primary enforcement is very important. Going back to the days of when California passed proposition 103 which is supposed to regulate auto insurance rates; it was a time when costs had been rising as there was a 150% increase in auto insurance in a single decade. It changed the overall regulatory structure but it didn't actually address any cost drivers. That forced the California legislature to start going in search of things that would make for safer roads to bring down the cost of auto insurance. The legislature did a variety of things, one of which was starting with a seat belt requirement but it was secondary enforcement. Within just a couple of years, it was realized that it was a change that made people dramatically safer on the roads and therefore it was changed to primary enforcement. If you want affordability of auto insurance products for constituents, you need to impinge the hazards of driving. That is what the Model does and the primary enforcement will be a great asset. We have all had the experience of driving down the road and watching other drivers weaving and doing all sorts of crazy things including on the rare occasion, seeing someone watching a video while they are driving. The primary enforcement amendment is a little technical but it really will result in reduced loss of life, physical injury, and bring down costs of auto insurance.

The Hon. Nicole Nason, Administrator of the Federal Highway Administration (FHA), thanked the Committee for inviting her to speak and for taking measures to keep roads safe especially now. FHA appreciates the challenges that state legislatures and legislators are facing as FHA is facing many of the same challenges – the challenges of having the workforce largely working from home; the 52 different approaches that each state and each local leader have been taking to protect people; and revenue and budget impacts as a result of the national public health emergency. Given the financial limitations associated with gas tax revenues, and other budget shortfall areas, it is getting harder to safeguard the communities that we all serve.

Admin. Nason stated that in the past several months she has spoken to almost all of the secretaries of transportation in each state. Some state departments of transportation have had to take immediate action and have had to furlough staff and postpone highway projects and delay maintenance. Others are doing their best, at least initially, to accelerate and are now trying to hold steady. All state DOTs have expressed budget concerns in the next six to 12 months as revenue decreases will begin to clearly manifest in day to day operations. FHA understands the problems that many state DOTs face especially with the now expected extension of the Fixing America's Surface Transportation (FAST) Act which is the current service transportation reauthorization bill. Whatever the situation come October 1, FHA is ready to support states and all of its partners and stakeholders despite the fact that most of FHA's staff, 2,700 plus, are tele-working. FHA is here to support state and local and tribal partners and communities to deliver the federal highway program.

Admin. Nason stated that she truly believes that transportation – planning, construction, financing, safety – is a team sport and everyone needs to work together, perhaps now more than ever. Federal and state and local and industry leaders need to collaborate and that will be critical to the success in delivering transportation programs. Admin. Nason stated that she is very proud of the actions that the FHA has taken in the past few months to ensure the safety and efficiency of our roads. As just one example, when restaurants began to close or limit access, FHA issued a notice to temporarily allow states to permit food trucks at interstate rest areas. Commercial activity is normally prohibited in such areas but unusual times call for unusual solutions. We now find ourselves in the next phase as many communities have begun to return to normal. The return is slow but normal economic conditions are beginning to return as some schools are re-opening with small in-person classes and some businesses are re-opening and allowing more customers in. FHA is currently permitting states to use rights of way to social distant restaurant tables. Tables have been in roads and parking spaces – a blanket federal approval was issued for that. While we are far from being back to normal, we are definitely headed in the right direction.

Admin. Nason stated that we may soon even see increased pressure on our highways which is relevant to state legislators and the work they are doing. We know already that people feel comfortable in their cars. We know that aviation, transit and rail numbers are not close to being back to normal but from a low in April we are now back to almost 90% of where we were at this time in 2019 – people feel safe in their cars. That means that there will be more people on the roads as they are reluctant to use other options of transportation. The safety of the traveling public will always be the top priority at the DOT and it is the top priority of Secretary Elaine Chao and it is Admin. Nason's top priority. Despite improvements in roadway and intersection design and work zone management and traffic incident management and even more safety features on vehicles than ever before, we still lost more than 100 people per day on the roads – that is unacceptable. As everyone knows, there is much work left to be done to reduce fatalities and injuries on roads. Driver distraction remains a continuing problem and Admin. Nason stated that she is glad to have the opportunity to discuss that issue as NCOIL is one of the most influential groups to help address the issue.

Admin. Nason stated that over a decade ago, she led the National Highway and Traffic Safety Administration (NHTSA) – a sister agency to FHA. It has the primary responsibility within the DOT to reduce distracted driving and yet as with so many issues that we are facing right now it is too big of an issue for one agency to handle and it is too big of an issue for just the federal government to handle. It is a coast to coast problem so we need to partner with state legislators. FHA considers distracted driving as nothing short of a national epidemic. According to NHTSA's data, 23,000 people died in crashes involving a distracted driver between 2012 and 2018 which is the most official data that we have right now. Nearly 10% of all highway fatalities

involve a distracted driver and many people feel that the numbers are under-reported. Besides the work that NHTSA does with groups like NCOIL, it works closely with states, law enforcement agencies, the academic community, and the media to ensure that drivers focus on driving. We want them to concentrate on that and to resist talking on a phone or texting or any of the other unwanted distractions out there.

Distracted driving can take many forms: putting on makeup; playing with the radio; talking on a phone; talking with other people in the car. Texting has become one of the most common and pervasive forms of distracted driving. Too many drivers learn how dangerous it is too late and often at the expense of someone else's life. Everyone at DOT is fighting this problem and that includes all modes of transportation. For a host of great reasons, all federal employees are prohibited from texting while driving on official business while using government provided personal electronic devices or when using a government vehicle whether they are on duty or not. DOT also requires annual training for all U.S. DOT employees on the danger of distracted driving. Admin. Nason stated that she would like to thank anyone and everyone who have drafted or sponsored or worked to pass state bills on this issue as their commitment to safety is very much appreciated.

The use of a handheld cell phone while driving is illegal in 25 states as well as D.C. and Puerto Rico and Guam which means there are 25 other sates that do not have such a law. Accordingly, Admin. Nason stated that she appreciates NCOIL focusing on this continued problem. Admin. Nason stated that she is the daughter of a highway patrol officer and that is how she got into this field in the first-place and that is a big reason why she is a big supporter of traffic safety enforcement. We need our law enforcement partners. Admin. Nason stated that just yesterday she was dropping her son off at school and on the way back the car in front of her was moving very slowly in a 25 mph zone. The car gently swerved and eventually went up on the curb and came back. Upon driving next to the car, the driver was a young dad and had a child passenger seat in the back and he was on his cell phone. Admin. Nason stated that she thought he was probably working and he probably did not realize until he hit the curb how much danger he was in and how much danger everyone around him was in. The curb did its job by scaring him but it is very important to focus on education and engineering in addition to enforcement. There are important roles for each of those pieces to play when talking about messaging to the public as to how serious this issue is.

Admin. Nason stated that there were recently two girls outside Pennsylvania who were in a terrible crash and they rolled their vehicle twice and their first instinct was to take a tiktok video. They filmed themselves right after the crash and one girl held up her phone to survey the car and showed the windshield shattered and the car was on its side and her friend was pinned against the road. Their instinct was to film a video and they got a lot of attention for it. Admin. Nason stated that in an article she read about the crash, a commenter congratulated the girls because after his crash he was so nervous he could barely function and he said he respected them that they had the presence of mind to film a video. Accordingly, Admin. Nason stated that as the Committee works on the Model, it is imperative that everyone keeps on educating – we always need to continue to educate the public. At NHTSA, it was always said that educating parents on child safety was never finished because very day there is a new mother born when a new baby is born. With every new generation we need to educate the drivers. Accordingly, Admin. Nason stated that she hopes education is part of the Committee's discussions going forward, and thanked the Committee for the invitation to speak.

Andrew Kirkner, Regional VP, Ohio/Mid-Atlantic Valley at the National Association of Mutual Insurance Companies (NAMIC) stated that NAMIC members support the reduction of distracted driving and NAMIC is supportive of the Model, understanding that there are of course additional

language and amendments to be worked on. Mr. Kirkner stated that this effort is very timely and Admin. Nason just touched on something that he had not considered before which is that it is hard to pick up a newspaper or turn on the news without seeing a local city or municipality that is expanding the eating options for folks whether it be on previously open streets or sidewalks or whatever the case may be. Those municipalities are doing outreach and trying to help the restaurants in their area and accordingly there is not a more pertinent time to be talking about distracted driving with increased areas where pedestrians are more at risk of the dangers of distracted driving.

NAMIC believes that the Model contains some important provisions, specifically prohibitions on streaming videos as in the early days of some distracted driving legislation, bills focused on texting so folks could legally be watching YouTube videos. NAMIC also believes that the upcoming sponsor's amendment regarding primary enforcement is appropriate and will strengthen the Model. NAMIC is excited to work with NCOIL on the Model and hopefully once it is adopted, NAMIC looks forward to having states adopt the Model.

Jennifer Smith, CEO and co-founder of StopDistractions.org (organization), thanked the Committee for inviting her to speak and stated that the organization consists of victim's families and someone in their lives that has been impacted by a tragedy involving distracted driving. The organization builds relationships within communities with law enforcement and elected officials and tries to bring change to the deadly epidemic of distracted driving. Currently, 24 states plus D.C. have hands-free laws as well as Puerto Rico and Guam and the U.S. Virgin Islands. However, in the past two years there has been a huge groundswell in these types of laws passing – 9 states have passed such legislation in the past two years: GA, MN, AZ, TN, ME, MA, VA, IN, and ID. Also, in 2020 there was another groundswell of legislation filed. Out of the remaining 26 states, nearly all of them did have legislation filed and many of the bills have a good chance of passing. Three of the sates that did not have legislation were not even in session so that only left 5 states not currently working on such legislation and as you know COVID hit and everything stopped in its tracks so it is expected that next year will be a big year for this type of legislation.

Ms. Smith stated that there have been distracted driving laws on the books for several years but it continues to be a big problem because the big thing is the evolution of technology. How we use our phones changed so the way the laws were written in the beginning didn't really encompass everything. Texting is always talked about but when you talk to kids and others they say that they are not texting but they are on Instagram or TikTok or something else involving streaming and data. So everything that we are doing with our phones is casing a big increase in data transmission and that is where we need to get these types of laws to be more encompassing. The Insurance Institute for Highway Safety (IIHS) was also able to document this by looking at what drivers are doing behind the wheel and they showed that drivers are manipulating their phones more than they did in 2018 because of all of the new things with data. In general, we are also just on our phones more and there is a new group emerging called cell phone addicts who spend actively 28% of their time ignoring the road. That now accounts for about 8% of drivers and that group is doubling every year. Ms. Smith stated that she is afraid that with COVID and being locked in houses and on devices so much, that number may have been sped up and we could see a much bigger increase next year.

Ms. Smith stated that, speaking of COVID, distracted driving is another issue that we really need to address head on because even with less drivers on the road, drivers are on their phones a lot more. Zendrive, a telematics company, looked at this data comparing one month before and one month into lockdowns and they were showing there was a 38% increase of drivers phone use when behind the wheel. Another thing that is well known with regard to

insurance is that insurance rates have been constantly increasing across the country. Georgia had seen a 12.6% increase in their insurance rates in the years before passing their hands-free law. That is being seen across the country. As of a couple years ago, it was about a 16% increase since 2011. We are also seeing the public threat and the loss of life and the damage to communities and families and medical costs and property damage.

Ms. Smith stated that all of those things working together are really increasing the public support. Ms. Smith stated that when she first lost her Mom in a distracted driving crash in 2008, there weren't too many families out there who had lost someone. Now, everyone pretty much knows someone who has lost their life due to distracted driving. So, public support is growing. Using Tennessee as an example who recently passed a hands-free law, their polling came back at 91% support statewide therefore showing bipartisan support. Looking at Arizona, their situation is interesting because they could never even pass a texting law. They had been the first state in the nation to try and had tried for 13 sessions but recently they did pass a hands-free law with widespread support. Arizona also has, in a two year timespan, passed about 29 local ordinances passed in order to help boost that statewide law. Also, in Michigan there is polling indicating 88.3% in support of hands-free laws. Many states are showing support rates for these laws in the high 80's% and low 90s%.

Ms. Smith stated that it is important to have hands-free laws as opposed to just texting laws because with texting laws there are so many grey areas. People can provide many excuses such as saying they were just using GPS. There are always loopholes with those laws so cleaning those laws up and making it very clear that if a phone is in your hand you are in violation, that makes it much easier for law enforcement and easier to educate the public. The American Academy of Pediatrics just released a study concluding that bans on all handheld device use and texting bans for all drivers are associated with the greatest decrease in fatal motor vehicle crashes. If you look even further into the data, the Georgia study committee before passing their law analyzed data from the 15 states that currently had hands-free laws. Representative John Carson of Georgia compared the calculations from the years before and the years after implementation of the laws. He found that 12 of the 15 states did see a 20% decrease in fatalities within two years of passing their hands-free law. Looking even further into that, you can see in Georgia those results are happening in real-time. When looking at Georgia, it had seen a 34% increase in fatal crashes from 2014 to 2016 and a 12.6% insurance increase so they wanted to look at why fatalities and insurance rates were rising. They concluded in the study committee that there needed to be a hands-free law passed. The law passed with a vote of 144-18 in the House and 52-1 in the Senate and it went into effect on July 1, 2018.

The day the law went into effect, there was a 22% drop in use by drivers typing and swiping on their phones based on telematics data. There was also a 90 day grace period to give the public an opportunity to learn about the law and there is now a 98% awareness about the law. Within the first year, after having been in effect for six months, traffic fatalities were down 3.4%. There was a 15% reduction in commercial motor vehicle fatalities. The telematics data shows a reduction in phone use by drivers and there was a big drop when statewide enforcement of the law picked up. There are normal fluctuations for seasonal traveling but that used to not really go back up which is why you are seeing the reduction in fatalities and crashes. Looking at a smaller scale, if you look at one county in Georgia – in 2017, Cherokee county in Georgia investigated 34 fatal crashes. In 2018, when the law went into effect halfway through the year they investigated a total of 18 crashes that year and in 2019 with the law in effect all year they investigated only 9 fatal crashes. Overall, since 2018 Georgia is seeing even greater significant declines. As of 18 months into the law, fatalities are down 7% in the state (after a 34% increase). The state is also seeing vulnerable road users benefit as bicycle fatalities are down

30%; pedestrians 11%; ages 15-24 and 55-65 10% and 11%. Intersections and lane departure crashes are down 10% and 12%.

Georgia is not just a one-off. In Minnesota, their law went into effect on August 1, 2019. Comparing their driving fatalities for distracted driving, they were down 2% and overall down 4.6% within that first small period. All ages are also being cited in these statistics – not just the teens. Tennessee passed their hands-free law which went into effect on July 1, 2019. Looking at their data from this past February before COVID really hit, you can see distracted driving crashes year over year were down about 4% and as of February, fatalities were down 9.6% and crashes overall were down 4.1%. Ms. Smith stated that a common question that arises is whether these laws cost constituents any additional money to comply – they do not. With any smartphone, you can download an app to make the phone work with voice activation for free. If mounts are required for compliance, the mounts now cost about $1 to $5. The texting laws as they are, are pretty much unenforceable – you need a clear law saying if the phone is in your hand you are in violation.

Another question that arises is how will law enforcement enforce hands-free laws if they couldn't enforce texting laws. There is training developed for them – the International Association of Chiefs of Police just developed a specific training package as well as the traffic safety institute from DOT has some virtual training. These are laws that have been enforced the past decade so they are pretty much easily enforced if there are clear laws saying you are in violation if the phone is in your hand. There is not a lot of opposition to these types of laws as they have broad coalitions of support. Data is showing that the laws will save lives.

Bri Jesionek, P&C Product Development at Nationwide, thanked the Committee for inviting her to speak and thanked Sen. Hackett and Asm. Cooley for sponsoring the Model. Ms. Jesionek leads Nationwide's distracted driving efforts through their P&C product and telematics teams. As a mother of a high-schooler who is about to get his license, Ms. Jesionek wants to do everything in her power to make sure he is safe and protected when he gets behind the wheel without her. Ms. Jesionek stated that she worries that the combination of phone distractions and inexperienced driving will create a dangerous and potentially deadly recipe and without sitting in the passenger seat, will he make the right choice or will he feel pressure to respond to text messages and send snapchats to his friends? Will he have the help of local law enforcement when she cannot be there? In February of this year, Nationwide CEO Kurt Walker published an article "Hands-free Laws would make safer roads." That public call to action aligns with Nationwide's belief as a mutual insurance company that exists to serve and protect its members that now is the time to bring consistency to roadways across the country. Nationwide is committed to reducing distracted driving through heightened public awareness, development of technology to mitigate risks, continued targeted research, and the enactment and enforcement of hands-free laws that ban texting and handheld cell phone use while driving.

As Ms. Smith stated, we know that states that implemented hands-free legislation experienced on average 15.3% decrease in fatality rates within two years of their laws being enacted. That is a number Nationwide can support. As a leading provider of auto insurance in this country, Nationwide strongly supports and applauds NCOIL's work to adopt the Model. We need to create a mindset where distracted driving is viewed just as culturally unacceptable and undesirable as driving under the influence of drugs or alcohol. A combination of education, public awareness, and public policy will help bring about that mindset.

In addition to supporting efforts to curb distracted driving around the country, Nationwide is working to raise awareness by providing in-app distraction feedback and tips on how to become a safer driver through its telematics mobile program SmartRide. That program provides an

opportunity for Nationwide members to save money while becoming safer drivers. Operating system sensor data is captured to provide customers insights into their phone use behind the wheel. By doing so, the call to action can be elevated to eliminate active phone use and create safer roadways for drivers, passengers and pedestrians in all communities.

Ms. Jesionek stated that safety advocates will tell you that distracted driving fatalities and crashes are underreported. That is exactly what is being seen in Nationwide's partnership with Cambridge Mobile Telematics (CMT) who is currently the largest mobile telematics provider in the industry. While NHTSA estimates that 4.2% of drivers are distracted at any given time between 7 a.m. and 7 p.m., we know based on CMT's data that 41% of car trips between those hours in 2019 involved significant cell phone distraction. That figure was 26% in 2017, representing a substantial increase in just two years. You could also say that roughly four out of ten cars passing you, a family member or a friend was involved in a significant cell phone distraction. As we are all aware, all it takes is one vehicle to change someone's life forever. Additionally, CMTs analysis of crash data determined that 19% of crashes were attributable to phone based distraction. Reducing active distraction will have a significant impact on accidents and could help to save lives.

Starting in January, 2017 CMT has recorded and analyzed 54 million trips across the U.S. In 2019, that data showed 37% of all trips involve significant driver cell phone distraction and that number is trending upwards. In 2018, the national average was 35%. In some states, the analysis showed more than 50% of trips involved significant phone distraction. These numbers confirm what we all see on the road on a daily basis and it is only getting worse. The increased prevalence of smartphone technology has accompanied an increase in active distraction and all road users are impacted. A CMT analysis of roadway fatalities and injuries in the U.S. shows a direct correlation between the increase in owned smartphones and fatalities. The current pandemic has only increased society's reliance on technology and while vehicle miles driven have decreased in 2020, the national safety council announced that motor vehicle deaths were up 20% in the first six months of the year. We need to move swiftly to protect futures. Smartphone ownership and use in the U.S. are at a record high and the data analysis at CMT shows that by 2025, 4,000 people per year will lose their life from smartphone distraction-related crashes. By that time, 500,000 crashes will have been associated directly with smartphone distraction and we cannot allow that to happen.

Ms. Jesionek stated that in her home state of Ohio, the Governor called for passage of a distracted driving bill similar to the NCOIL Model after it was reported that July was the deadliest month on Ohio's roadways since 2007. Nationwide believes that drivers should have their eyes on the roadways instead of e-mailing, texting, shopping, posting, liking, viewing, watching or any other distraction caused by viewing a cell phone. As a company committed to protecting people, businesses and futures with extraordinary care, Nationwide looks forward to continuing to work with NCOIL and its members and officials across the country to raise awareness and to advocate for change to keep all eyes on the road and both hands on the wheel.

Annalia Michelman, Senior Legislative Attorney at the American Medical Association (AMA), thanked that Committee for inviting her to speak and thanked NCOIL for its work on distracted driving. The AMA takes the problem of distracted driving very seriously and it considers it to be a wholly preventable public health hazard. The use of a handheld wireless communication device is the leading source of distraction for drivers. The act of composing, sending, reading messages, photos or videos or anything else interrupts driver's cognitive attention and causes vision to be directed away from the road and compromises manual control of the vehicle. The AMA encourages its physicians to educate patients about the public health risks involved with using a handheld device while operating a motor vehicle and they advocate for such legislation

prohibiting such use while driving. The AMA in fact has its own model legislation on distracted driving which mirrors the NCOIL draft Model in many ways. The AMA supports NCOIL's Model and appreciates the work thus far. Legislation to prohibit use of a handheld wireless device while driving is absolutely vital to improving roadway safety for motor vehicle drivers as well as passengers, bicycles, pedestrians and other road users.

Ms. Michelman stated that the one suggestion AMA has is to encourage the Committee to include an exception for a physician or other healthcare professional acting within the course and scope of their employment. Those professionals do not necessarily fall within the definition of emergency medical service personnel which is included in the NCOIL draft Model. AMA's physician members often must use a handheld device to respond to an urgent medical matter remotely while they are in transit to a healthcare facility to respond in person. Of course, it is important that physicians and others take all safety measures available to avoid handheld use such as turning on hands-free mode but sometimes as is the case with other first responders, hand held use is simply unavoidable. Ms. Michelman reiterated AMA's support of the Model and stated that the AMA looks forward to working with NCOIL going forward.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated that NHTSA invited him to speak a few years ago regarding the drowsy driving issue as Arkansas had developed a law similar to Maggie's law in New Jersey. Sen. Rapert stated that he supports the concepts of the Model and supports the direction of the Committee. Sen. Rapert stated that with regard to GPS maps, he is not sure how much different it is when looking at a GPS map and looking at a video screen. Sen. Rapert also stated that a lot of the content that he likes to listen to is not on the radio and consists of old, archived video. Accordingly, he will turn that on when driving down the road but he is not watching the video but just listening to it. That raises interesting questions as to how that will be considered in terms of distracting driving laws, particularly in situations where after an accident law enforcement investigates the phone use.

Sen. Hackett stated that the equipment continues to get better to protect against this and one of the things to watch is that systems in cars are getting louder and people want to be told what to do without visually looking at things. Admin. Nason stated that these issues involving privacy and new technology are ones that we hear all the time at FHA especially as handheld devices become more and more sophisticated and the vehicle also becomes more sophisticated. That is one of the reasons why it is stressed that numerous steps are needed to combat this, including education. Enforcement and education and then the improvements in new technology can work against us but they can also work for us and that is something that FHA has looked at – how do we have the technology work with us; we don't' need to be at war with it. There can be places where it can help. There are ways to approach the industry to talk about some of these issues without only focusing on one leg of the stool.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that a number of statistics were cited and in some instances the entity that developed those statistics was also cited. What was not really developed was the methodology used to arrive at those statistics. Also, in drilling down into those statistics, Asm. Cahill asked if the methodology of distraction and the mode of distraction make a difference in terms of how much it puts the motoring public at risk. Further, Asm. Cahill stated that with regard to the AMA's request for an exemption, he has seen a lot of people who are exempt from current distracted driving laws in NY and they are not using exemptions for emergency purposes but rather using them because they don't have to pay attention to the law as the rest of us do and should and they are as distracted as any other driver. Asm. Cahill asked if the AMA would accept something more akin to an affirmative defense as opposed to an exemption so that if someone were to establish that they were in fact on an emergency call they could be forgiven for putting us all at risk. Asm. Cahill closed by stating that the Griffith Institute

several years ago conducted a distracted driving presentation for legislators and it was the most enlightening program he has participated in at NCOIL. It established firmly in his mind that humans are not actually capable of multi-tasking; we can only mono-task and we have a very easy tendency to lose our focus on what is before us if we allow something else to take over.

Ms. Smith stated that for the statistics she cited, they just looked at the fatality numbers of crashes and compared year to year and then within those numbers it was state DOTs that did analysis of their distracted driving crashes per se. Ms. Smith stated that she could get Asm. Cahill more information as to more detailed methodologies used.

Ms. Michelman stated that the idea of an affirmative defense makes sense. Physicians en route to a hospital are not identifiable as such when they are diving their cars they are not driving an ambulance so she thinks that they would be pulled over for being on their phone or whatever it may be so they would already sort of be in the situation where there would only be a citation. Ms. Michelman stated that she would be happy to discuss this issue further with her members but at first glance, the idea of an affirmative defense makes sense.

Ms. Jesionek stated that the statistics that she shared are all in direct correlation to phone use and crash data through CMTs analysis.

Rep. Tom Oliverson, M.D. (TX), stated that in Texas there is an app that has grown outside of Texas that is called Safe to Save. It is very popular with the high-school and college crowds and you basically put it on your phone and it uses telematics data to figure out when you are driving and as long as you are not touching your phone when driving you are earning points that can be used as discounts at restaurants and shops and an extensive network has been built. Rep. Oliverson stated that he brings that up because there is a carrot as well as a stick method of solving this problem that we need to think about as well.

Sen. Hackett stated that education is very important. At Ohio's last hearing on this issue, the public defenders testified and their big issue was what is the intent? When you talk to the people that have been in the crashes they will say "I would never have thought that." When you look at alcohol and DUI's, people who drink too much know that they are breaking the law so they choose to break the law and the intent is there. Accordingly, a combination is important. The NCOIL Model basically leaves it up to the individual states to create penalties. There are dollar penalties listed but whether it's a felony or misdemeanor is left up to the states. In Ohio, for a felony one, two or three you go to jail but there are always issues of intent such as what the public defenders raised. Therefore, education is extremely important but we also have to learn from the past such as with DUI's. The number of DUI's has decreased significantly but part of that is because of the stiff penalties. Every public defender will tell you that every case they have on distracted driving involves someone not knowing about any distracted driving law because they don't realize it because they have been doing it for such a long time, albeit with different phones. Education combined with a carrot and stick approach is a great idea.

Asm. Cooley stated that the testimony has made clear that we have an activity of driving in a motor vehicle that has been around for a long time. Technology has made it subject to a sort of creeping recklessness. Phones get smarter and there are more capabilities and people don't put them down. They are not designed to be reckless but that is the net effect. There is a dramatic amount of activity happening in the driver's seat beyond what was the case 5, 10, and 15 years ago. The technology is improving things. The map functions are excellent but most of the map functions will provide verbal audio directions once you program it – you don't necessarily have to hold the map or look at it. The virtue of the Model is that when NCOIL passes a Model and it gets introduced across the country, that gives clear signals to the

technology companies and designers of phones and lets them understand where they want to be designing their products to anticipate the state of the law during the service life of the product they are designing now. This is where a clear Model law that gains national support that is seen as saving lives will be a very clear signal to manufacturers. This issue is somewhat unique compared to other NCOIL models as other models show what the best path is but this Model can actually shape capital investment and innovation in a more safe manner and start to confront the creping recklessness. The conversation is extremely important on all sides to understand how to make this a transition people feel is constructive. It will transform into lower insurance premiums just like seat belt laws did across the country.

Admin. Nason thanked the Committee again for inviting her to speak and noted that although she could not comment on the Model specially, she hopes her remarks conveyed that FHA and DOT is committed to working with state legislatures and legislators on these important issues. Admin. Nason stated that she spent several years on the board of Mothers Against Drunk Driving (MADD) and she spoke at their 25th anniversary. When MADD first started, it was a joke as Jonny Carson told jokes about how drunk people were driving. So, it was a combination of passing laws, enforcing laws and educating the public combined with new technology such as breathalyzers.

Rep. Rowland noted there will be no vote on the Model today. The Model will be discussed again in December at the Annual Meeting and when the sponsors feel the time is right, a vote will be taken.

DISCUSSION ON THE FUTURE OF TRANSPORTATION AND IMPACTS ON THE P&C INDUSTRY

Robin Chase, Co-founder and former CEO of Zipcar and founder and former CEO of Buzzcar, thanked the Committee for the opportunity to speak and stated that every time she founded new mobility companies insurance has been a big issue and in some instances it took three years to obtain insurance before a company could be started. Ms. Chase stated that policy and insurance regulation needs to build on solid ground. In 2000, when Ms. Chase co-founded Zipcar, the questions for insurers was is this a fleet? But the users for the fleet are not employees so they could not think of it like that. From a state standpoint, questions arose like is it a car rental service? Boston, where the company had launched, had recently enacted a law that was a $10 surcharge on every car rental in order to pay for their new convention center. When they created the law they said “oh, well these are out-of-towners who are renting cars so it’s great.” But Zipcar and car-sharing is used by people in the neighborhood instead of owning their own car and it’s by the hour and by the day so if Zipcar was a car-rental service, a one hour transaction would then incur a $10 charge which would double the charge of that hour.

Then there is a whole issue regarding whether Zipcar cars should get commercial or personal plates. If commercial plates were obtained, would the cars then be allowed to park in loading zones? Then when the company moved to Washington D.C. another issue arose involving for every retail entity in the city there was a $300 fee and they questioned whether Zipcars were retail entities and another issue arose involving not being able to have Zipcars in residentially zoned areas because they are commercial vehicles. Yet, Zipcar is actually used by people everywhere around you instead of their own cars so they should exist and get the same treatment in all ways as personal cars. This all created a huge amount of anxiety for both Ms. Chase, the insurers, and policymakers at the state and local level.

Ms. Chase stated that in 2007, Velib, which is probably the first very large bike sharing company, started in Paris. When they went onto Paris streets, there was a huge issue with

people saying “why is the city giving so much space to this private company?” “Why are shared bikes being called public transportation when shared in public space but then owned by private companies?” “Is my personal bike as good as public transportation and are there age limits as to who gets to ride them even though there is no age limit for personal bikes?” “Who is responsible for liability?” Those are all questions that arose as shared bikes had never been seen before.

Then, in 2012, Uber and Lyft started to get going and they claimed they were not taxis when in reality they are taxi’s. And we still continue to argue over whether the drivers are employees and whether the vehicles, which are personal vehicles, need to undergo all of the laws applicable to taxi’s – should they have special types of inspection? With regard to insurance, when I am driving my car for my own purpose, my insurance controls but when I am using it for a commercial purpose, it now has to trigger over to a private commercial insurance policy. Ms. Chase stated that it drove her crazy that during the first few years that they operated, they completely lied stating that the insurance industry was covering them and whether a personal insurance policy would cover the driver. There was a car accident in San Francisco where the person who had been driving ran someone over at a crosswalk and the question was whether the app was turned on or not. Accordingly, there has been so much thought put into what the right policy recommendations should be for transportation evolution and insurance.

Fast forwarding to 2017, the rise of e-scooters started and questions arose as to whether they are safe and what rules govern them. Ms. Chase stated that she thought it was funny that there has been so much discussion around the safety of e-scooters but not around very large SUVs and their grills, particularly since 33% of motor-vehicle fatalities are people outside the vehicle. When you look at e-scooter accidents, very few are self-induced – it is cars that are hitting and killing these people. The rise in pedestrian and cyclist fatalities is enormous and a good piece is contributed to distracted driving and another good piece is contributed to the large number of SUVs on the roads such that when they hit pedestrians and cyclists there are fatalities. This is all to say that this entire brand new mobility service arrived and a lot of drama was experienced. Further, it is important to consider what will happen in the future when autonomous vehicles are introduced and we know that there is a very strong push to rent out a personal autonomous vehicle – is that going to be considered a taxi or will it be under a special new silo created for Uber and Lyft? Will it be considered public transportation if it is filled with four people? What about one person; is it still doing good things for the public? It is going to introduce new issues of commercial vs. personal use.

Ms. Chase stated that about two years ago as she traveled providing transportation policy recommendations, particularly urban transportation policy, and during conversations with several companies, she worked with NGO’s on shared mobility principles for livable cities. The idea was to get an alignment between all the stakeholders so city governments, service providers and individuals could agree on a joint vision as to where we should be moving forward. Under New Urban Mobility Alliance (NUMO), something was created coming to this assessment of new mobility and asking how to legislate for it and insure it. Ms. Chase stated that she realized that we need to get down to the foundation of risks and public benefit. The last 100 years have been spent creating silos for bicycles, taxis, personal cars and trucks. What we know is that those silos have been completely obliterated and are going to be increasingly obliterated. For Zipcar, it was very annoying having to debate over the personal vs. commercial vs. car rental issues. We cannot think in these silos and instead need to think in vehicle-type and risk-type silos such as weight, speed, footprint and emissions.

Ms. Chase’s colleague, Carlos Prado, stated that NUMO started with an analogy to the periodic table which we know from chemistry was the evolution of alchemy and we are currently involved

in the alchemy of transportation. The goal was to find a way to identify those attributes of vehicles and then find something that is much clearer in terms of distinguishing very minute differences. What is being worked on now is a much more detailed tool that can help identify certain characteristics. There are about 40 different vehicles on the platform being developed and you can choose based on the characteristics or attributes of a vehicle, even if it is something fantastic like a dragon and whether it is being used for commercial or personal purposes. Then you can start to generate an insurance risk assessment through a series of algorithms including what type of driver's license would be needed, what type of data requirements are needed and whether it needs a subsidy or not. A lot of work has been done getting into the details and weeds and work has begun to link the vehicle to see whether or not it could be used on a segment of a street such as near or far away from the curb and what the rules are associated with that.

Mr. Prado stated that there are currently 40 vehicles integrated into the platform and the algorithms are then linked to policy recommendations for licensing, space allocation, and fees/fines based on risk assessment. The way forward for the tool is to improve the usability of the platform and the reporting so that data can be obtained from cities and it can be linked to curbside management with service providers and legislators and companies with insurance expertise so that risk assessment can be improved. That way, we can start to understand and address these very siloed ways of learning and acting upon transportation. Mr. Prado stated that the initiative is completely open and free and urged anyone interested to reach out to him.

Ms. Chase stated that the bottom line is that legislators should recognize that we are moving and have been for the last 20 years, away from very siloed, defined vehicle types. There is so much technology now and so many different ways to share in many different ways that the industry is being transformed. Ms. Chase stated that her recommendation, especially from the perspective on trying to get insurance on new vehicles, is to have policy written on the basis of key risk figures such as weight, speed and emissions. That would make the future of transportation regulation much simpler.

RE-ADOPTION OF MODEL LAWS

Rep. Rowland stated that the following Models are scheduled for re-adoption: the Post Assessment Property and Liability Insurance Guaranty Association Model Act; the Model Act Regarding Medicaid Interception of Insurance Payments; the Storm Chaser Consumer Protection Act; the Model Act Regarding Use of Credit Information in Personal Insurance; and the Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers.

Rep. Rowland noted that the Models were on the agenda of the interim meeting of the Committee on July 24, 2020 and the opportunity for comments on the Models from legislators and interested parties was given during that Meeting so that the Models would be voted on today without further discussion.

Upon a Motion made by Rep. Tom Oliverson, M.D. (TX) and seconded by Rep. Dean Schamore (KY), the Committee voted without objection by way of a voice to re-adopt the Models.

ANY OTHER BUSINESS

Rep. Lehman stated that the Special Committee on Natural Disaster Recovery will now sunset since the Committee accomplished its goal – adopting the Private Primary Residential Flood Insurance Model Act. Rep. Lehman then appointed the Chair of that Committee, North Carolina

Senator Vickie Sawyer, to serve as Vice Chair of this Committee as that position is currently vacant.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Del. Westfall, the Committee adjourned at 6:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 25, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Hilton Alexandria Old Town Hotel on Friday, September 25, 2020 at 10:00 A.M. (EST)

Representative Tom Oliverson, M.D. of Texas, Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Edmond Jordan (LA)*
Sen. Jim Seward (NY)*
Del. Steve Westfall (WV)

Other legislators present were:

Sen. David Livingston (AZ)
Sen. Travis Holdman (IN)
Rep. Jim Gooch (KY)
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Rep. Brenda Carter (MI)
Asm. Kevin Cahill (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

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.

MINUTES

Upon a motion made by Rep. Deborah Ferguson (AR) and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 7, 2020 and May 29, 2020 meetings.

STATE OF THE LINE – AN UPDATE ON THE STATUS OF AND TRENDS IN THE WORKERS' COMPENSATION INSURANCE MARKETPLACE

Jeff Eddinger, Senior Division Executive – Regulatory Business Management at the National Council on Compensation Insurance (NCCI), stated that he will be discussing today somewhat of an overview of the past year in the workers' compensation insurance marketplace. Accordingly, while COVID-19 will certainly be a part of the discussion, more information specific

to COVID-19 and work comp can be found on the NCCI website. Mr. Eddinger stated that 2019 was another year of unprecedented results – a combined ratio of 85 meaning an underwriting profit of 15% and it is the fifth year in a row of underwriting gains and the third year in a row of underwriting combined ratios in the 80s. The theme here as we go along is that the workers' compensation industry is in a very strong position and has been for several years and is in a good position to address any claims that will come out of COVID now or in the near future.

Work comp investment gains on insurance transactions in 2019 show an 11% investment gain. That is very good – still below the long term average of 12.6% but is a very solid result given the low interest rate environment. Work comp pretax operating gain is basically combining underwriting profit of 15% and adding a gain on insurance transactions of 11% you get a pretax operating gain of 26% for the second year in a row. Those results from the recent two years are well above the long term average of 8% but also keep in mind that you can see the cyclical nature of work comp results so just 4, 5, and 6 years ago the operating gain was almost nothing so it is important to look at the long term results when you talk about how work comp has been doing over the long term. The work comp premium in the latest year has dropped a little bit – it had been increasing year over year since the great recession when a lot of the premium dropped precipitously due to large unemployment. The drop from 2018 to 2019 has nothing to do with the current situation. Obviously, premium is going to be one area where we are going to see a very big impact indirectly due to COVID and its impact on employment levels.

Mr. Eddinger stated that the residual market has been very stable and manageable at about $1 billion dollars. It began to increase after 9/11. We don't know yet what the impact on the residual market will be due to the pandemic but that is something NCCI is monitoring since there was an impact when it was realized that terrorism was a new work comp risk. Now, we realize that the pandemic could be a future work comp risk. That billion dollars in the residual market, to put it in perspective, is about 7% of the whole market. You can see that it has been very stable – anywhere between 7-8% over the last six or seven years. So, looking backwards the residual market has been very stable and manageable.

Mr. Eddinger noted that when speaking about the slight premium drop from 2018 to 2019, certain things drive that such as a payroll increase of about 5.5% but the loss cost that were being charged during that period have come down quite a bit mainly driven by NCCI and other bureau rate filing. Carrier pricing hasn't really impacted it that much – its more of just the base loss costs that have been coming down. Overall, the change in premium has been relatively small – about a 1.3% drop. Looking at payroll growth, it was driven by two things: wages have been up about 3-4% pretty much across the board and then employment levels vary a little bit more by the different sectors but overall during that period employment was up 1.5% and now obviously we are going to see things go in the opposite direction going forward.

When looking at the long term approved changes in bureau premium level for NCCI states, for the latest two years there have been pretty much decreases. For 2019, there was an overall 10% decrease so there are a lot of filings involving double digit rate decreases. 2020 has moderated a bit so that the overall impact so far on 2020 was a negative 7%. For the last year's rate filing season, the data clearly backs up the negative 7% figure. During last year's rate filing seasons, there were no filed increases. The largest decrease filed was a negative 13.7%. There were not as many double digit decreases last year versus two years ago but you can see that the average was a decrease but not as big as negative 10% - it averages out to about negative 7%.

On the loss side, improvements continue to be driven by improvements in work comp lost-time claim frequency. 2019 saw another decrease in claim frequency of 4% which is pretty much

consistent with the long term average of negative 3.8%. In 2018 there was a bit of a smaller decrease in -1.4% so some have questioned whether that was the year where frequency turns but so far it really did not turn out to be that and 2019 has continued on a long term pattern. There is one area that bucks the trend. Cumulative change in claim frequency from 2011 to 2018 shows a pretty large decrease during that time period – about 20%. One area that we've seen – probably the only area – claim frequency increase is in motor vehicle accidents. That is an area NCCI has been watching and has been posting studies on it during this period of time. From 2011 to 2018, smartphone ownership grew from 20% to 80% and NCCI has posited that the increase is really due to the increase in distracted driving so that is something that NCCI continues to look at. However, the data shows why NCCI has been filing decreases over this period of time.

Of course, on the loss side there is not just frequency but also severity which is the average cost of each claim. In 2019, the average indemnity claim cost or wage replacement increased by 4%; the year before that it increased by 3.4% - as we would expect since indemnity payments relate to wage levels. It has been pretty consistent over time as it is a long term 20 year history where it shows that the change in indemnity claim severity has pretty much tracked with the cumulative change in wage inflation during that time. There was a period between 1999 and 2008 where the indemnity claim severity was rising faster than wage replacement and we were seeing some larger claims during that period of time; but from 2008 to 2019 it has tracked more closely to wage inflation.

On the medical side, we see the medical claim severity is up 3% in 2019 versus 2.5% in 2018. It is a similar story although a little bit different when you compare medical claim severity to basically a medical cost index. The personal health care chain weighted price index is being used – it is not a medical CPI per se but that is pretty much a proxy for a medical cost index. Medical severity has risen much more than the medical cost index. However, between 1999 and 2008 it was very much out-pacing that cost index but from 2008 to 2018 it has been tracking much closer with the change in that cost index. What that really means for claim severity is that indemnity and medical claim severities have moderated so that they are pretty consistent with the wage and medical cost indexes. However, claim frequency continues to drop and that is really driving the improvement in the rates.

Going forward, it is difficult to project what will happen with several things but we can do our best. With employment, we continue to see large reductions in jobs in the leisure, hospitality and travel industries. Professional services may be staying the same as telecommuting helps to maintain current employment with a reduced risk of COVID-19 exposure. We have also seen an increase in jobs in the healthcare, grocery and direct delivery industries. There is definitely a very big downward pressure on premium and premium will be much lower going into the future. Unemployment is very high, people are working fewer hours and we don't know what is happening with wage adjustments yet. Even in 2020 there have been mid-term adjustments to premium because employment levels have changed so much just over this year and we are expecting negative audits meaning that payrolls are much lower than originally thought at the beginning of the policy being written. The only thing really holding things there is that some carriers have suspended or cancelled polices as well as penalties for late premium payments – due to laws being passed during the pandemic.

On the claims side, even in a normal year we would expect claim frequency to decrease but now maybe more so going forward due to a deferral in claim reporting or even a reduce in claim frequency because fewer people are doing their more dangerous jobs. There has also been a decrease in work-related driving. There could also be some upward pressure here since there

could be some coverage expansions for first responders, healthcare workers filing claims as well as for other essential workers or other occupations.

On claim severity, the use of telehealth could result in reduced medical costs. We know that telehealth has expanded during this time but we don't know yet exactly how much or if its resulted in savings. Things that could put upward pressure on claims severity are that things are taking longer and things may have been put on hold. Return to work and light duty programs may be used less often while these benefits continue. Those things could cause the current, open claims to be more expensive than they would have been if these things had not put a pause on the treatments that were occurring.

As we sit here today, the workers' compensation industry is strong and is in a very good position to handle any claims that would come out of this. However, there is uncertainty ahead as to what employment and premium will look like and what claims will look like in the future.

Rep. Matt Lehman (IN), NCOIL President, asked Mr. Eddinger from an NCCI standpoint as they have begun to see the compensatory mandatory compensation expansions how are those going to play into the rates and/or experience modifications. Mr. Eddinger stated that there has been a lot of activity in determining who is covered and there have been some expansions to the groups of workers with a presumption that they are covered. To the extent that those laws can clarify current state statutes, that can be a good thing as it could lead to claims being covered more quickly and denied less and less litigation. To the extent some of that legislation increases coverage over what it is today, those things need to be analyzed and it needs to be estimated what that means in terms of the change in system costs and California has attempted to do that. At this point in time, NCCI has not filed any COVID related changes to the rates as they feel they don't have enough information they don't know what the situation is going to look like in 2021 which is when rate filings that are currently being made now would be in effect.

As far as experience rating goes, NCCI did make a decision early on that COVID claims would be excluded from the experience rating calculation. The first thing to keep in mind is that the experience rating program is revenue neutral. That means that the program compares employer's experience and applies premium debits to some and credits to others overall not resulting in additional premium but applying those adjustments to employers and comparing them to see how safe they are. A pandemic is something that is a more rare event and not a very good predictor of how individual employers may be doing. The same decision was made when 9/11 happened – that terrorism would not be included because NCCI feels that even though you can argue that maybe some employers are doing things differently, there could be impacts on some employers for no fault of their own. It could simply be an area where there has been a COVID outbreak and a hospital sees many more patients. NCCI feels that COVID needs to be handled separately and not directly through the experience rating program.

SCENARIOS FOR THE 2030S: THREATS AND OPPORTUNITIES FOR WORKERS' COMPENSATION SYSTEMS

Dr. Richard Victor, Sedgwick Fellow at The Sedgwick Institute, stated that he recently published a book titled "Scenarios for the 2030s: Threats and Opportunities for Workers' Compensation Systems" that focuses on existential threats to the continuation of state workers' compensation systems. It is not a very uplifting story as Dr. Victor stated that upon finishing it, his wife asked if it comes bundled with anti-depressants. The question asked is if state workers' compensation systems were to disappear by 2030, what external forces might be the cause? Dr. Victor stated that by external he means outside the control of workers' compensation systems which makes it more difficult for the traditional workers' compensation reform processes to address

successfully. The book identifies a number of disruptors that are likely to challenge the state systems by as early as 2030. Since publication of the book 10 months ago, several other disruptors are likely to emerge from the pandemic and increased attention to economic and racial disparities. Dr. Victor stated that he spent 35 years doing research on workers' compensation; first at the RAND corporation in Santa Monica, California and then by founding the Workers' Compensation Research Institute (WCRI) in Cambridge, Massachusetts and lead it for about three decades. Dr. Victor stated that he retired about three years ago and decided he wanted to write a book and The Sedgwick Institute was kind enough to sponsor it and make it possible.

As background, over the past 100 years the state workers' compensation systems have been remarkably resilient and have persisted through periods of great change – through wars, economic gyrations, major demographic changes in the workplace, medical innovation, cultural shifts, political change, and more. These comp systems have been reasonably successful in meeting goals and being adaptable but that is not necessarily true for the next 100 years nor for the next decade. Dr. Victor stated that he would like to discuss three external disruptors that he believes create existential challenges for these systems. The first is historically large increases in work comp costs ahead of us, and that is a reversal of the trends stated by Mr. Eddinger. That is driven by forces outside the work comp system that are likely to produce dramatic increases in what we call soft tissue medical conditions that get shifted to work comp from other health insurance plans. These are medical conditions like back pain, knee pain, shoulder pain and wrist pain.

The second disruptor is political and fiscal realignments happening driven by millennials and post-millennials. That creates historic pressure on public officials. To reduce expenditures and regulatory compliance costs. It is not really more of the same pressures public officials have seen in the past and shaped public debates – it is really a paradigm shift driven by millennials and their priorities. The third disruptor is declining public support for employer-based health insurance. The pandemic has exposed a downside to linking health insurance to the workplace as millions of people have or will abruptly lose their jobs and lose their employer-based health insurance. It is inevitable that some public support for employer-based health insurance is likely to weaken.

Starting with an increase in soft tissue medical conditions shifted to work comp from other health insurance, Dr. Victor stated that his estimates show that work comp soft tissue cases could triple over the next decade. The engine for that is the shifting of cases to work from other health insurance programs whether it is private employer-based insurance or the individual market or government health insurance programs. It really only takes a small shift in these cases to work comp in order to produce a shock in work comp costs. For example, if there was just an 8% shift in soft tissue cases currently paid by employer-based health insurance that would be a tripling of work comp soft tissue cases and about a 150% increase in work comp costs. Dr. Victor stated that he focuses on soft tissue cases because such cases are often inherently uncertain about what is the true cost whether it is work related or not. To adjudicate the cases, work comp systems typically indulge in rules of thumb or necessary legal fictions but often the true cause is medically unknowable so patients and providers have substantial discretion in what they attribute the cause to – work related or not work related.

Dr. Victor posed the scenario of how state legislators' constituents would respond to sustained annual double digit increases in work comp costs for employers while at the same time there is no real increase in benefits to injured workers. Employers would howl for legislative and regulatory changes to contain costs. Labor would resist what they term "takeaways" reminding that workers got no benefit increases. As the key players got more and more dissatisfied with

the systems and if no timely and effective solutions came about, and remember the causes are external and substantially outside the control of the work comp reform process, the players will increasingly search for alternatives to state work comp systems as they get more and more frustrated. Dr. Victor posed the question of what could produce such a large increase in these soft tissue cases? Dr. Victor pointed out three forces. The first is workers shifting soft tissue cases to work comp from their health insurance as they face large and larger deductibles in their non-work comp health insurance - $3,000/$4,000/$5,000 is now common. Studies are now beginning to show exactly this behavior. Fifteen years ago, the average family deductible in a family health insurance plan was $1,000. Today, it is $3,000 and $5,000 in the high deductible health insurance plans. Fifteen years ago, only 4% of workers were in high deductible plans. Today, it's 30% and by 2030 it is likely to be the norm.

Dr. Victor stated that we have substantial evidence from decades of economists that patients respond to growing deductibles by forgoing care. Conservative consensus estimates of how much care that was forgone are that if a worker had a small deductible they would consume 25% more care than if they had a large deductible and remember, work comp has no deductible and no copays. So, for medical conditions where the true cause is inherently ambiguous, like these soft tissue cases, work comp becomes an increasingly attractive alternative for patients where work relatedness is ambiguous and workers have higher deductibles and they would but for the alternative of work comp forgo care for back or shoulder pain. This is not fraud but rather honest uncertainly about the true cause. What's changed is that the economic incentives to think outside the box about how I get reimbursed for care, not just my group health policy but maybe my work comp policy is an opportunity.

The second factor is healthcare providers shifting soft tissue to work comp from other health insurance plans as those plans abandon fee for service contracts with providers. Studies are also emerging that show this behavior. Traditionally, healthcare providers have been paid fee for service but today, health plans are moving away from fee for service and embracing provider contracts where providers bear some financial risk for meeting the financial targets for the insurer's patients. Common is an HMO where the provider is paid a fixed amount at the beginning of the policy year to provide all or most of care and doesn't get paid fee for service as they render care. So, if I go see a provider and I am covered by a capitated contract and my back pain is deemed not work related, the provider gets no payment for services for that care. But if the back pain is work related, the provider gets fee for services even though I am covered in my non-work comp healthcare under a capitated contract.

These capitated contracts are very common in some states and not common in others. In California, it is nearly half of enrollees in employer-based insurance. In other states like Michigan, North Dakota, Maryland, Nevada, Massachusetts it is 20%-30% of enrollees. And in a number of other states it is not very common – less than 10% in states like Texas, Minnesota, Kentucky, Ohio and Tennessee. But in those states the Medicaid populations are almost universally covered by capitated health plans and many of the Medicaid recipients are also workers and covered by work comp.

Another type of provider contract pays providers bonuses or levies penalties for providers hitting certain financial targets for the insurers group of patients. Currently, about 30% of employer plan enrollees are in these types of contracts and that has been growing rapidly. Providers can avoid their penalties or preserve their bonuses by classifying soft tissue injuries as work related and new studies are showing that this is beginning to happen as well. The third force is the pandemic itself. The pandemic is likely to result in significant permanent increases in remote work – especially sales or office work. The more remote work – the more soft tissue cases. Sofas are not as ergonomically correct as office chairs and it is also harder for an employer to

disprove whether back pain is work related when the worker has worked for the last two years at home. So, it is not hard to get to a tripling of work comp soft tissue cases which is 150% cost of work comp increases even if there is no real benefit increase to injured workers. The challenge to the work comp reform processes is that the causes are outside of work comp so the standard processes are not likely to be able to get the job done and then it is not hard to imagine growing interest by employers and regulators as they get more and more frustrated for alternatives to the state programs.

The second disruptor is that over the next decade we will see significant political and fiscal realignments in our public policy debates that have significant implications for the survival of state work comp systems. This is really a paradigm shift in the public policy debate driven by millennials and post-millennials voters who by 2030 will replace boomers as the largest group of voters and they will reframe the debate about government taxing and spending. Dr. Victor stated that about a decade ago his then teenage son bought him a book called Boomsday by Chris Buckley and the book has a scene that has stayed with him involving the Governor of Florida calling the National Guard to protect aging retired baby boomers on the golf courses in Florida who are being attacked by millennials because their taxes are so high because of all the spending and debt and unfunded liabilities that we have left them with. Since they will be the majority of voters, they will call the tune – not the Boomers. Their tune will be to cut spending big time and they will have an urgency that we haven't seen because we have run out of room to kick the can down the road. We have had a lot of room to kick the can down the road because we have had a labor force growing faster than the number of beneficiaries of the programs we have created but that has begun to turn around for Social Security, Medicare and public pensions in particular. It is also well known about the sorry state of our public infrastructure with lots of deferred payments that will come due.

So, if the debate is rational about cutting costs – and Dr. Victor stated that he firmly believes that it is not going to be the ideological small gov't vs. big gov't debate but rather a very pragmatic and immediate debate that really cuts across party lines and urban and rural lines and geography and socioeconomic status – the quest will be first about getting rid of unnecessary costs and the low lying fruit for unnecessary costs is found in program consolidation. Work comp is a prime candidate when you talk about program consolidation. So, what motivates the paradigm change and the urgency? Well, we boomers have left a fiscal mess for the millennials and post-millennials even before the pandemic and it has only gotten worse. With high government debt, massive unfunded liabilities, and substantial deferred maintenance on infrastructure, Dr. Victor stated that pre-pandemic he estimated that $100 trillion dollars and it is an easy calculation when you think of that as a mortgage and what you would have to do to pay it off over the next 50 years. That requires a doubling of all federal, state and local taxes and fees and clearly that is not something that any tax payer would stand for. It is really putting millennials and post-millennials in an untenable position and they have already had their earnings disrupted by the great recession and pandemic. So, it is not surprising that their fondness for baby boomers has already grown thin.

So, as taxes rise and bridges and water lines begin to crumble and millennials say "enough" and as we run out of time to continue deferring the problem and problem solving, the debate will be to cut costs and work comp is very vulnerable when you talk about program consolidation. It is an expensive way to deliver benefits with lots of overhead and there is an overlap with some safety net programs. The third disruptor is that the pandemic will weaken support for private health insurance. That will increase the odds of a public replacement. One of the arguments against Medicare for all is that we would lose our employer based health insurance and for those of us that have it that would add uncertainty to something that is very important and emotional with questions like whether to change doctors, whether we will have higher costs,

whether we will have to wait longer for our care. Dr. Victor stated that he recently saw estimates that 10 million workers either have lost or will lose their employer-based health insurance because of the pandemic. Many of these workers and their families probably used to feel that their jobs and their health insurance were secure but they now feel that is no longer as secure as they thought. Many of their colleagues that retain their insurance and jobs, or neighbors or relatives, still feel less secure about their employer based health insurance so it wouldn't be surprising if a number of those folks were less persuaded by the argument that employer based health insurance is secure when the debate arises again. Whether that debate arises in February, 2021 or later in the decade, it is inevitable.

What does that mean for the survival of state work comp systems? The larger the role the federal gov't plays in health insurance, that is really a potential disruptor for state work comp systems. Along with the growth of the federal role will be pressure to subsume medical care for work injuries into this expanded system. The broader the expansion the more pressure on work comp. The greater the need for funding sources for the expansion the more pressure on work comp. The faster work comp costs are growing, the greater the pressure on employers to include work comp in other plans. The greater the pressure for program consolidation from the millennials to save overhead costs, the greater the pressure. So, lets say the payment for work comp medical care gets subsumed into a larger healthcare system. That leaves income benefits as the revenue base for work comp insurers and many of the administrative costs will remain the same but now amortized over a base that is only about half its former size. So, the question arises: is that an economically sustainable line of insurance? When you put those three disruptors together, they are all external to the work comp systems and the picture is one of several potential threats to the existence of state work comp programs over the next decade or so.

UPDATE ON STATE COVID-19 WORKERS' COMPENSATION PRESUMPTION EXECUTIVE ORDERS/STATUTES/REGULATIONS

Jason Marcus, Esq. Legislative Chair of the Legislative Committee for the California Applicants Attorneys Association (CAAA), stated that CAAA is primarily a group of work comp attorneys that does applicant work or represent injured workers. California Governor Gavin Newsome issued a shutdown order on March 19 which basically said everyone needs to stay home except for essential workers and shortly after that CAAA along with various labor groups started engaging in an effort to either legislatively or through the Governor create a presumption for COVID-19 work comp claims, specifically for those workers that had been deemed essential and had to physically report back to work. Governor Newsome issued an Executive Order creating a work comp presumption for all workers who were working at their employer's location as opposed to those working from home in early May. That presumption was retroactive to the shutdown order on March 19 and lasted for 60 days from the day of the Order expiring on July 5.

Mr. Marcus stated that it was an interesting move in that California work comp is generally considered to be the sole province of the legislature so there were some questions about whether or not the Governor had the legal authority to issue the Executive Order. Nonetheless, he did and what CAAA found was that claims were being accepted under that presumption. CAAA continued to engage in efforts legislatively to both extend the presumption and expand it as necessary as probably was the case in legislatures across the country. It was anything but business as usually in California. The legislature was shut down for a number of months and even when it re-opened it was in a quite limited fashion so everything was being done via Zoom or phone calls. Those efforts continued right up until the end of California's legislative session

on August 31 and it culminated in primarily two pieces of legislation that related to work comp and COVID.

First is SB 1159 by Senator Jerry Hill which Governor Newsome signed into law shortly after the end of the session. That bill: a.) codified the Governor's Executive Order into statute which was a smart move and effectively prevents any legal challenges to the Governor's Order as exceeding his constitutional authority; b.) created a regular presumption for specified workers such as firefighters, police and other peace officers and certain healthcare workers. If those workers are at work and they contract COVID it is presumed to be work related. All of these presumptions both in the Order and in statute are rebuttable presumptions meaning that the employer or carrier has the ability to obtain and produce evidence to try and rebut the presumption and prove that the worker contracted COVID other than on the job; c.) created a triggered/threshold presumption that applies to all other workers – it applies only to employers with five or more employees and requires that the employer's premises be subject to an outbreak when a worker tests positive for COVID.

The legislation tried its best to define outbreak. Ultimately, what it settled on was that if an employer has 100 or less employees, if four or more workers test positive within a rolling 14 day period that meets the definition of an outbreak; or if an employer has more than 100 employees at a specific location then you have to have 4% of the workforce test positive. Mr. Marcus stated that in his experience that is new when it comes to presumptions – having these kinds of triggers. CAAA is not a fan of that and pushed back on it but ultimately the objections weren't heard. One of the biggest objections CAAA had was how in the world is an employee supposed to prove that? How do you obtain data about other workers testing positive especially with HIPAA and healthcare privacy concerns. In order to address that there is a companion bill, AB 685 by Asw. Eloise Reyes which was also signed into law which creates additional enforcement standards and regulations for California Division of Occupational Safety and Health (CAOSHA) and requires employers to proactively report COVID infections so when an employee tests positive the employer is required to report that both to CAOSHA and to their work comp insurance carrier. It remains to be seen how that is going to work in practice as that law was only signed about less than 10 days ago. The presumption statutes did contain an urgency clause which in California means that rather than going into effect at the beginning of next year it goes into effect immediately so that is the state of the law in California but it remains to be seen how it will be applied in practice.

Mr. Marcus stated that in California one of the organizations that tracks data is the CA Work Comp Institute (CWCI). Mr. Marcus stated that he will post a link in the Zoom chat to their website which has put together an online tool where anyone can go and look at the overall claims in California and it is updated on a regular basis and is broken down into different data sets and is very helpful. Through September 21, there have been 42,544 COVID claims in California and the projections through the end of August were about 48,000 so California is slightly under those projections. Of those claims, just under 12,000 or about 28% have been denied and the remainder, just under 30,000, or about 71% either have been accepted or have not yet been denied. Mr. Marcus stated that in his own experience as a work comp attorney in California that represents injured workers, he has a handful of COVID claims all of which are either healthcare workers or peace officers and all of those claims have been accepted so far. The CWCI website breaks it down by employee group and far and away the largest group in California of COVID claims are healthcare workers. Over 15,000 claims or 38% of claims filed are healthcare workers. The next largest group with about 6,000, about 15%, are public workers which would include public officers, highway patrol, correction officers.

Interestingly, in California there has been a level of uncertainty with the CA Work Comp Insurance Rating Bureau (WCIRB). They have said that there is a whole lot of uncertainty in what COVID means for claim frequency, claim rates, and experience modification. California has had almost a decade of rate decreases. The WCIRB has recommended a slight increase this past Summer for this first time in about ten years but there is a lot of uncertainty about what it going to happen and how to incorporate what we are seeing now into future rate filings.

Erin Collins, VP of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that she would like to start by saying that we are all cognizant of the impact of the virus and mostly everyone has been impacted in some way by someone who has contracted the virus. So, when we talk about COVID-19 in the context of work comp, it is not to say that individuals who have contracted the virus shouldn't have access to care in order to recover – they absolutely should. This is about saying that shifting the onus of that recovery from a healthcare or government solution to the work comp system, which isn't built or designed for that, is going to imperil that system from completing the purpose that it is built for.

Work comp is meant to create a remedy for conditions that are specific and peculiar to a specific job meaning that there has to be a causal connection to the job function and the condition or the injury. In the existing system, if there is a casual link between the condition and job function for things such as black lung or if your job were to directly handle a virus and develop a vaccine, the system is already built to contemplate those kinds of fact patterns and handle it accordingly in the claims process. In fact, in most states there are statutes that say that a covered condition cant be an ordinary disease of life and that is ordinary only in the sense that it isn't specific to a function of work. The system is built that way so that there is a system with the scope available for those conditions that are peculiar to a job.

Ms. Collins stated that if a presumption of coverage for COVID is in place like the rebuttable presumption that Mr. Marcus mentioned, it shifts the onus onto the insurer to prove that someone didn't get the condition or injury through work. You can see where in a widespread disease of life, you can get the virus going to the grocery store or gas station and it would be nearly impossible to meet that standard and that is going to stress the system. Ms. Collins stated that we know there needs to be government based or healthcare solutions to help all of the people that contract the virus, but if we move that solution to work comp, the system is not going to be able to bear that level of long term effect and it will jeopardize the ability for the comp system to exist for those conditions and injuries for people that were underwritten and contemplated by what the product is built for.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) stated that as he sits here today he is thinking about this issue in the backdrop of Dr. Victor's presentation – particularly the last two points. Looking at what happened in terms of COVID and the legislative response, for many legislators there was a great deal of pressure to not just sit there but do something. Legislators legislate and they responded and took a look at this particular issue in a number of states and frankly the states are all over the place. Just look at the last two recent actions. In Virginia, the legislature just decided not to go with a presumption while in New Jersey they have.

One of the things that occurred here was that there was a presumption that the work comp system was somehow not dealing with these cases appropriately so there was a need to put the thumb on the scales in order to achieve a particular outcome. That has been and continues to be a growing trend in the work comp world whether it be various presumptions for public safety personnel, such as policemen and firefighters, certain conditions such as PTSD, and now with COVID-19 the legislature is making public policy decisions regarding who is going to be the

winners and losers. That is obviously the legislature's purpose and it's prerogative. The problem here is, at the 10,000 foot level, where does this end? Where does the work comp system ultimately end up? Do we end up with a system that is folded into perhaps a single payer system or something like that? Going back to the initial presentation from NCCI, the one thing that you can take away from that is one word – uncertainty, particularly when it comes to COVID. As we look ahead to this and where we will end up, states are pursuing different solutions. Some are going the presumption route; some are going another route. We don't know what ultimate costs are going to be but at then end of the day we do know that there are going to be costs and there are going to be public policy debates and issues that are going to have to be considered by legislators across the country and which will ultimately end up at NCOIL.

Rep. Oliverson stated that with his experience as a healthcare worker and as an essential employee since March 15, and he believes most of his colleagues feel the same where he works, it is interesting that he has yet to come across anyone in his line of work that has contracted the virus at work. That prompted him to do some digging and he visited with two fairly large employers, MD Anderson Cancer Center which has about 16,500 employees, as well as the UT Health System in Houston which has about 11,000 employees and about 6,000 students in various training programs. Although they showed a prevalence in terms of people contracting the virus as with employees and students it was between 2% and 5%, their contact tracing showed that less than 1% of them actually acquired the disease at work. That brings up some very interesting questions when talking about presumptions in various essential employee roles.

First, the question is there are many occupational diseases for which there are occupational safety guidelines as far as personal protective equipment (PPE) and so to what extent with regard to presumptions does the role of PPE and employers taking reasonable precautions play into effect? Secondly, is it not the case that contact tracing and the presence of a medical director are almost becoming necessities in the age of COVID in terms of employers figuring out how to navigate this? It becomes important, especially if we are going to treat this as an accepted claim, that contact tracing becomes vital because several studies are showing now that people are less likely to contract the virus at work than they are at home because when they are at work their employer mandates that they take certain precautions and when they are going out to eat or going to a protest or going to the beach or going to the nightclub they are not following those precautions. Accordingly, the issue of presumptions needs to be more carefully examined. Rep. Oliverson further stated that we talk about COVID as being a disease of life and he understands that but also in the setting of mandated shutdowns and forced isolation, there are certain employee groups which are considered essential who are mandatorily required not to follow recommended guidelines as far as social isolation so is it really a disease of life for groups that are required to be exposed to virus as part of their employment?

Ms. Collins stated that with regard to Rep. Oliverson's second point, in situations where there is a situation or set of conditions that makes it directly tied to the function of that job then it is not in that sense an ordinary disease of life. In that scenario, if your job function is directly tied to COVID, the current work comp system is built to contemplate that fact pattern and handle it appropriately in the claims process. The presumption on top of that is really where the problems Rep. Oliverson mentioned in his first point arise. Accordingly, that fact pattern raised by Rep. Oliverson is already handled by the work comp system and doesn't need a presumption on top of it.

Mr. O'Brien stated that regarding the PPE and safety guidelines issues, he was very much involved in a presumption bill in Vermont that had this issue in spades. Ultimately, the

legislature basically put in place a provision that stated that if the employer is able to show that they have been following all of the guidelines then the presumption shifts back to the employee and disappears in certain situations. So, there is a realization or expectation that there is a certain amount of rule following and responsibility on the part of the employer community and employee that has to be involved as well. But, that also runs headlong into an attitude and opinion that Mr. O'Brien and his colleagues have seen in a number of states that these poor people got sick and whether they are considered an essential employee or not favored with the title essential – somebody has to take care of these people and there was a feeling on the part of public policymakers that not everyone has health insurance so work comp steps into the fray. A lot of claims are going to be lost time claims of about two weeks and someone has to pay these people while they are out. At the 10,000 foot level, is that the appropriate role of a work comp system or is it what the work comp system has evolved to at this particular point in time? That is a public policy issue that all sides have to wrestle with – what is work comp going to look like down the road? Is it going to be a dystopian future similar to what Dr. Vitor described or is it going to be something else?

Mr. O'Brien stated that things have been relatively quiet in the work comp side of things over the last few years as the NCCI pointed out with double digit rate decreases. You can get away with a lot of things when rates are going down but we are getting to the point where rates are going to begin to climb because costs are climbing and we are not going to be able to get away with as much as we have with rates going up.

Mr. Marcus stated that everything that Mr. O'Brien just said was part of the conversations in California. In California, there were very strict lockdown orders in March that were lifted somewhat in May and June and then just now as California is starting to open up county by county. From the perspective of someone who represents claimants, Mr. Marcus stated that he wants to extend the coverage to as many people as he can but it really comes down to people getting sick and getting someone to pay. Either private health will pay, union healthcare plans will pay, or work comp – someone will have to pay and it is appropriate for the legislature to say that as a matter of public policy, especially for essential workers who are out working when other people don't have to be, those people should be covered.

One of the other things that was a big concern for the labor industry was paid time off. Most of these claims involve people that are off for a couple of weeks, they get a positive test so they have to quarantine and they are back at work in 14 to 30 days often with little to no long term health concerns which is fantastic. But, we don't have any type of universal paid sick leave so there is an issue of how to get people paid when they are missing that time. That was another big driving concern in all of this. Mr. Marcus acknowledged that he is biased as he represents injured workers but every day of the week he will say the employer or insurer should cover a cost rather than the worker. Not everyone will agree with that perspective but he is unashamed in having that position.

Rep. Oliverson asked Mr. Marcus about the scenario of a person who is an essential employee and their kid has a friend over or a relative is invited over for a BBQ and they expose you and you are in quarantine for 14 days. Is that an employer's responsibility to cover that when clearly that was not a work-related exposure? Where should the line be drawn because part of the issue is that we are not just talking about sick employees – we are taking about people who have potentially been exposed with workplace safety guidelines and mandatory quarantines.

Mr. Marcus stated that if there is evidence that the exposure was not at work it is reasonable to conclude that is not something that should be covered by a work comp system. In California, as a general rule when someone files a claim the employer has 90 days to do an investigation and

make a decision as to whether or not to accept the claim. Those rules have been changed slightly for COVID claims. The Governor's Executive Order shortened that to a 30 day period and the presumptions in statute now have a 30 day period for firefighters, peace officers and healthcare workers and a 45 day review period for all other workers. So, shorter than normal but still enough time to talk to the worker or have a contact tracer figure out where has someone possibly been exposed.

Mr. Marcus stated that, for him, if you cant tell where someone has been exposed and they have been going to work outside of their home, it is reasonable to conclude that work comp can handle the claim. But, if you have evidence such as what was given in Rep. Oliverson's example of where there was a party and someone came over and that person had or was known to be positive for COVID and you can show that is where the exposure is then that is reasonably not within the work comp coverage.

Rep. Lehman asked whether SB 1159 is strictly limited to COVID 19 or if it applies to future pandemics or illnesses. Mr. Marcus stated that it is strictly limited to COVID-19. There were discussions during negotiations about having the bill, especially for healthcare workers, be a broader presumption for other infectious diseases but that did not make it into the bill. Also, there are other existing presumptions in California for other bloodborne illnesses, MRSA for example, and Lyme Disease for park rangers. Rep. Lehman stated that is his main concern – going down a path of getting compensated for the 14 days I was off when I got COVID but I am not compensated for the days off I had when I got the flu and really the way I contracted that is going to be the same path in that nobody really knows. Healthcare workers are probably more exposed but the burden of proof on where that actually happened is going to be very difficult. Rep. Lehman stated that overall, he is concerned with presumptions in that they will lead to picking and choosing which diseases of ordinary life will be covered.

Mr. Marcus stated that in California, the basic premise before the presumption was that if someone contracted an ordinary disease of life the law required that person to show that they were at a higher level of exposure or higher risk of exposure than the general public. Ultimately, California made a public policy decision to put these claims in work comp. Obviously, not all states agree and that is a reasonable debate to have.

Rep. Oliverson stated that it is clear that people are far more reckless with this virus when they are at home than they are at work when their employer is requiring them to behave in a certain way and wear masks and then they go home and let their guard down. Rep. Oliverson stated that he read an article that stated you should wear a mask at home because that is where you are most likely to contact the virus – that is an unpopular view but true because we are much more cavalier about this at home then we were when our employers are watching. That is an issue that warrants further discussion going forward.

Sen. Jim Seward (NY), stated that in New York it has been interesting that the healthcare workers were contracting COVID at a much lower rate than the general population which was a great selling point for the PPE and precautions that were being taken in hospitals.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Del. Steve Westfall (WV), the Committee adjourned at 11:30 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS AND INTERNATIONAL INSURANCE ISSUES COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 24, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Hilton Alexandria Old Town Hotel on Thursday, September 24, 2020 at 3:00 P.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Sen. David Livingston (AZ)
Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Sen. Neil Breslin (NY)*
Asm. Kevin Cahill (NY)
Sen. Jim Seward (NY)*
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Jim Gooch (KY)
Rep. Derek Lewis (KY)
Rep. Edmond Jordan (LA)*
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Del. Steve Westfall (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a motion made by Rep. Joe Fischer (KY), NCOIL Secretary, and seconded by Sen. Jim Seward (NY), the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Rep. Fischer and seconded by Sen. Neil Breslin (NY), the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 6, 2020 meeting.

DISCUSSION ON EUROPE'S INSURANCE REGULATORY RESPONSE TO COVID-19

Sen. Hackett asked Matt Brewis, Director of General Insurance and Conduct Specialists at the Financial Conduct Authority (FCA) (who joined via Zoom in the UK), what role does the FCA play in regulating financial services firms in the UK, and how does that fit with the roles of the Prudential Regulation Authority (PRA) and the Bank of England (BoE)? Mr. Brewis stated that in the UK, the Treasury department of the UK government is the FCA's sponsor and sets the

rules and the framework by which the FCA, BoE, and PRA regulate firms in the UK. For insurance companies, the PRA is responsible for solvency and capital requirements and the FCA is responsible for their conduct and protecting consumers and ensuring the markets work well. Mr. Brewis stated that he is responsible in the UK for about 600 insurers; about 7,000 insurance brokers and that includes the Lloyds market as well as general retail selling to consumers directly.

Sen. Hackett asked Mr. Brewis how has the FCA addressed the challenges faced by the insurance industry and consumers during the coronavirus pandemic? Mr. Brewis stated that the biggest challenge that UK firms faced back in March was operational resilience. They had to move from their big tower blocks in the city to everyone working at home. For the most part, all firms did that quickly and safely and managed to continue to provide a high degree of service to the customers they service. That's not without some problems and some increase in risks were faced because of that such as IT issues. But on the whole, it was a strong test of business continuity plans that firms had and they have worked surprisingly well and the FCA has had a huge amount of engagement with the firms to make sure that they continue to treat their customers fairly and continue to provide the services that they need to.

Mr. Brewis stated that one of the obvious challenges faced by consumers in both the US and UK is that because of the economic conditions there have been many thousands if not millions of people who have lost their jobs and therefore struggled to continue to make their payments. The FCA implemented mortgage holidays or deferrals to allow people time to have the safety of having their houses but not having the concern about making payments during the pandemic. In the insurance industry, one of the rules that the FCA introduced early on was around deferral of payments. For many consumers in the UK, they pay on a monthly basis for their car or home insurance. The FCA required firms to either provide payment deferral to consumers or to help them with the issues they had. For some that may have been changing the contract that they had; for many people their cars were sitting and not being used and what the UK saw was that people just de-registered their cars so they no longer needed to pay car insurance. The FCA was trying to find ways to stop people needing to do that. People still need their cars – they just weren't able to afford them. Accordingly, the FCA took steps to assist with payment holidays and put the onus on firms to contact their customers who they understood to be in financial difficulty to assist them.

Linked to that, the FCA changed some rules around product value. Many people in the UK have insurance for their home boiler/heating. As part of that, insurance allows them an annual or bi-annual service of that under the insurance product. They were unable to make use of those because you couldn't have people in homes servicing the boilers. The FCA put the onus on the insurers to say if you cannot provide the product people have purchased, you need to find a way that the consumer can still get value. That might be extending the term of the policy; that may be providing a refund. That will differ between customers and products, but all firms have been required to take action to make sure their consumers get value. With regard to motor insurance for instance, the U.S. has experienced similar issues. Some firms have given $20 refunds to all customers for their car insurance, and some firms in the UK have done that. Mr. Brewis stated that for him, the challenge has been saying to insurers "$20 is great, but what are you doing for those young drivers whose car insurance is expensive and they have an old car and all they use the car for is going to work but they have lost their job? $20 is not going to help them so what are you going to do to make sure those vulnerable customers are still able to get value from the products that have been sold?" That is a tricky question and Mr. Brewis stated that it is different for him compared to the guy down the road – everyone is going to be different. Accordingly, the FCA has asked firms to think carefully about different customer

segments. Later this year, the firms will have to report to the FCA what they have done to provide value to their customers.

Mr. Brewis stated that perhaps the biggest issue that many may have heard about recently is that the FCA has taken eight insurers to court over business interruption insurance. In summary, similar to issues that the U.S. has experienced on the issue, the FCA has taken action because many contracts were unclear and did not clearly define whether they covered pandemics or not; they were silent on the issue and a reading of the policies, in the FCA's opinion, would seem to say that they did cover business interruption caused by COVID-19. Many insurers disagreed with that and as a result, the FCA took a court action to the high court in the UK. A verdict was issued last week. The verdict was mixed but the FCA feels that it won more than it lost. The action will affect 370,000 busines interruption policyholders and that represents thousands of small and medium-sized companies and the backbone of the economy – the restaurants and pubs that employ so many people across the UK. As a result of the action, it is hoped that it will result in some of those businesses being able to continue as others may not have.

Sen. Hackett stated that in Ohio, the first thing the carriers say is there is no premium there for pandemic business interruption coverage so how can you cause a carrier to pay for something that they have not paid a premium for. Mr. Brewis stated that in the UK there are two types of business interruption policies: property damage and non-property damage. For property damage policies, consider a car going through a restaurant's window. In that scenario, there is actual damage to the property and those policies don't work in the pandemic scenario as there is no physical damage to the property. There have been some attempts to say that the virus changes the building at a microscopic level but that argument was not raised in the FCA's case. Those policies represented about 90% of the business interruption policies in the UK. The FCA's case centered around the remaining 10% where there is no property damage so a restaurant will have coverage in the event the chef gets salmonella and they have to close the restaurant or a nursery has an outbreak of measles. Those policies are the ones that the FCA's case potentially helps in the UK. Mr. Brewis stated that he believes that layout is probably similar in the US as well.

Sen. Hackett stated that the US is a big and diverse area. In Ohio, the healthcare people did really strong healthcare modeling in terms of what would be faced and they projected and pretty much closed down hospitals. They projected that 35,000 people would be admitted to the hospital and now it is under 2,000. So, the healthcare modeling they did wasn't even close and that was assuming people wore masks and there was social distancing. Accordingly, Sen. Hackett asked how the modeling was done in UK and asked if the numbers have been as expected. Mr. Brewis stated that he is not an epidemiologist and that is one of the main issues in the FCA case and in general in terms of the prevalence of the disease. As he understands it, it is similar in the US in that the testing regime has picked up considerably recently. If you go back to March and April and May when all the businesses closed, there was not a significant testing regime. So, the question is how do you determine how prevalent the disease was. You can use hospital admissions as a measuring tool but in the more rural parts of the country it is much more difficult to determine. One of the challenges that the UK still faces is a question about how do you determine how widespread COVID-19 was in the UK at that time. There is lots of scientific evidence or conjecture and it is something that is still being worked on.

Rep. Matt Lehman (IN), NCOIL President, asked what process did the FCA go through when making the decision to take the business interruption case to court, and why did the FCA think that was the best route? Mr. Brewis stated that there were a number of things the FCA could have done. The FCA could have just made some rules to say "we think these policies should

pay out." What would have happened then is that the insurers would have taken the FCA to court and in the UK there is a concept of judicial review, which exists also in the US, where they would challenge whether or not the FCA had the power to do that. That would have taken quite a period of time. In the UK there is something called the Financial Ombudsman where individuals can take their complaints if they are unhappy by how they have been treated by their insurer or bank or any finance provider. The same issue would have been present in that scenario where if the insurers didn't like the outcome they could have judicially reviewed the outcome. Accordingly, the FCA figured it was best to skip to the last page knowing that the issue will end up in court anyway. So, what can we do as quickly as possible that will save a lot of work that would have ended up in court anyway and save many individual businesses quickly? For the UK regulatory and judicial system to go from launching the case in April and having a verdict in September that is frankly unheard of in terms of speed and the FCA felt that speed was of the essence due to all of the companies that could be helped. The FCA felt that was the best option to get a quick result.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that business interruption coverage is one of the most important issues of many of the people that reach out to state legislator's offices. Asm. Cahill asked Mr. Brewis to break down who won what issues in the FCA case; and also asked with regard to the very few cases that he has come across in New York involving someone who actually purchased pandemic business interruption insurance, and invariably it was Lloyds of London selling that, if there were any similar scenarios internationally. Mr. Brewis stated that the FCA asked its lawyers to review 600 policy types. Frustratingly, there isn't one common wording that is used. Every firm has multiple and in some cases hundreds of different wordings of business interruption insurance. Accordingly, the FCA looked at where the trends were and what the issues were. The FCA focused on the policies that they FCA believed the insurers decided incorrectly. There were some things the FCA thought the insurers were right on. The issues focused on were prevention of access – does the government saying "you have to close" mean that you are prevented from accessing your building. The insurers say no, you can still actually go to your building and get in but you just cant open for business. The FCA won on that issue. However, one of the issues that the FCA did not win was that involving when the government suggested that businesses close but didn't legally require them to. For example, in the UK it was suggested that dentists close but they were not required to do so.

Other issues included in the case centered around if you had to have the disease on the premises, and that forced you to close for a long period of time. The FCA lost on that issue because you can deep-clean the building so you might be covered for three days while cleaning but then afterwards, the coverage is gone. Another issue centered on policies requiring emergency local restrictions to be imposed; not a national restriction but rather something within a small vicinity. That is something that is now more prevalent in the UK – more localized lockdowns as opposed to national lockdowns.

With regard to Asm. Cahill's second question, Mr. Brewis stated that the FCA case covers policies written in the UK. It is possible that some of those policies were underwritten in the UK but wrote elsewhere. Mr. Brewis stated that he would be happy to look into the issue further and get in touch with Asm. Cahill afterwards. One of the issues discussed in the case was a famous judgment called the Orient Express. That dealt with a hotel in New Orleans that was damaged during Hurricane Katrina. The business tried to claim on its business interruption policy since the premises were damaged because of Katrina and therefore stated I should be paid under the policy. The insurers denied coverage and it went to court where the court ruled in favor of the insurer on the basis that Katrina was a widescale event and it didn't just impact the hotel. So, even if the hotel had not been damaged, it would not have had any customers because of how the area was so dramatically damaged. The corollary to the FCA case is that

people were not going out for dinner so even if you were open you would not have had any business anyway. The judges in the FCA case determined that the Orient Express case was probably incorrectly adjudicated by the previous court, so it leaves it open to further challenge in the future. That is something that insurers are immensely excited about going forward.

Rep. Lehman asked how the UK insurance industry has been affected by the coronavirus and Brexit, and what has that meant for the competitiveness of the UK market as a whole? Mr. Brewis stated that there is a huge amount we don't know about Brexit despite it having been going on for over four years now. It looks like it is going to happen in a few months one way or another. In the past few years, many insurers in the UK have gotten ready for Brexit by setting up European businesses and by moving their mainland Europe business out of the UK and into Europe, setting up new legal entities. It wont change how the FCA supervises in the UK. On Day 1, the rulebook will be exactly the same as it is today but there will be an opportunity for divergence in the future. So, COVID-19 hasn't changed the planning for Brexit and hasn't changed the approach and the rules that have been in place and expectations that the FCA has for firms. However, the double whammy of Brexit and COVID is going to make it an interesting period. But, the insurers, who the FCA has been talking to for years now, feel that they are ready for Brexit and have moved the business they need to and in some ways it shouldn't be as tricky and difficult as it may have been if this was a year or two previous.

Rep. Lehman asked where the business is being moved. Mr. Brewis stated that the business is being moved to different places. There are some insurers who are domiciled in other places in Europe and happen to have expanded into the UK – those insurers were already well equipped for Brexit. The big insurance hubs are in Paris, Amsterdam and Frankfurt – those are attractive places to move business. In industries other than insurance, we are seeing more onshoring into Europe as people split their businesses. For companies like Lloyds, the London market is a key part of the infrastructure and so FCA is working very closely with Lloyds as well as the whole London market in understanding the impacts and making sure they can continue to operate as well as they always have and have those constant conversations to make sure the UK remains a competitive place for businesses to operate.

Sen. Hackett asked if there has been any change to the Brexit advice for firms and consumers as a result of the pandemic? Mr. Brewis stated that most of the Brexit plans rely on the free trade agreements or any other agreements made by the government. All firms are prepared for various different types of Brexit depending on what deals are agreed upon with Europe. There have been three or four times where Brexit has been so close so firms are now well practiced in walking up the hill and being operationally ready. The COVID overlay is a difficult one to add into the mix but int terms of Brexit, those rules are pretty well set for most firms. The COVID response is in parallel and FCA's focus is on consumers and making sure that they have the services that they need and ensuring that they are protected. That continues to be the focus of Mr. Brewis and his team at the FCA.

Mr. Brewis closed by stating that if there are any follow-up questions, particularly with regard to business interruption, his e-mail address is part of the meeting info and he would be happy to answer any questions.

FEDERAL RESPONSE TO DYNAMEX: DISCUSSION ON U.S. DEPARTMENT OF LABOR EMPLOYEE CLASSIFCATION REGULATION

James A. Paretti, Jr., Shareholder at Littler Mendelson P.C., stated that he will be discussing the U.S. DOL's joint employer final rule under the Fair Labor Standards Act (FLSA). Before getting into that, Mr. Paretti stated that it is important to un-muddy the waters as there are two issues

that tend to get muddied together. One issue is whether a worker is properly classified as an employee or an independent contractor. There has been a lot of activity in states, most notably in California with AB 5, around that issue of whether a given worker is an employee and given the protection of wage and hour laws or an independent contractor. The issue is often put as one of misclassification. Something similar but distinct is the issue of joint employer status under the FLSA. The question here is whether someone is a joint employee meaning there is no question that the person is an employee to an employer – the question is whether there is a second or other employers to whom that employment relationship exists.

For years, there have been several tests varying from circuit to circuit. The DOL has set forth a final rule for determining whether an employee of one company may be held to also be employed by the second company - the joint employer. The DOL put forth a four-part test which is a balancing test and no single factor is dispositive of the equation. Essentially, the rule looks to a lot of what the common law states and clarifies and brings more certainty to it. In determining whether one employer is the joint employer of another entity's employee, they are going to look to see if the putative joint employer hires or fires the employee; supervises and controls the employee's work schedule or the terms and conditions of employment to a substantial degree; determines the employee's rate and method of payment; and maintains the employee's employment records.

The test makes very clear that no single factor is dispositive in determining joint-employer status. The DOL did state that if the fourth factor of maintaining employment records is the only box that is checked, that is on its face going to be insufficient but combined with other factors it may be sufficient. The final rule also clarifies that when you are looking at these factors, the joint employer must actually exercise direct or indirect one of the control factors. A significant issue over the years in litigation has been the issue of contractually reserving the right to fire subcontractors and employees but as a practical matter that right was never exercised. Some courts have said that under the common law rule that would be sufficient to get joint-employer status. The DOL mas made clear that is not the case and they are going to look into whether control is being exercised directly or indirectly.

The DOL rule also establishes that there are additional factors that may be relevant in terms of determining a joint-employer relationship. The rule also makes clear and identifies certain business models that do not make joint-employer status more or less likely. Mr. Paretti stated that he believes that was done to address the franchise model where we have increasingly seen a lot of cases of employees of a franchise restaurant are suing the owner of the franchise and also suing the national franchisor on the theory that it is a deeper pocket. The argument is that because franchises are such a structured relationship, that national franchisor at the top is really exerting control at the top. The DOL rule makes clear that franchising is not in and of itself indicative of or more likely to result in a joint employer finding.

Similarly, the rule states that if a contracting business requires certain terms and conditions relating to the employees of another company such as requiring that a subcontractor company institute sexual harassment policies, that does not increase the likelihood of the contracting company being deemed a joint employer. The rule also includes a number of examples illustrating the application of the four-factor test to certain business-to-business fact patterns. The examples are good, but as is usually the case with regulatory examples, they tend to be the easier cases rather than the hard cases, but the principles drawn from them can be distilled. Mr. Paretti stated that this past May, a coalition of State Attorneys General (mostly Democratic) sued the DOL to challenge the rule under the Administrative Procedures Act (APA) claiming that it was arbitrary and capricious, departed from prior precedent and is insufficiently grounded in the FLSA itself which has traditionally been read fairly protectively. The case is New York v.

Scalia, 2020 U.S. Dist. Lexis 163498, 1:20-cv-1689-GHW (S.D.N.Y. September 8, 2020). The District Court vacated the portion of the final rule applying "vertical" employment relationships. Mr. Paretti stated that his firm represents a group of trade associations who have intervened in the lawsuit to bring the interests of the business community to the table since the DOL is tasked with upholding their rule, not with representing any outside interests. As of today, the DOL has not made clear whether it intends to publish a new rule or appeal the District Court's decision or take another route. Accordingly, we are back to square one with this issue in terms of having to look at the common law in a particular circuit to answer these joint-employer questions.

Joe Capurro, Immediate Past President of the California Applicants Attorneys Association (CAAA), stated that he will talk about employee classification issues particularly in light of the California Supreme Court case *Dynamex* which is a fairly celebrated case in California along with the legislation that followed that case. Misclassification of employees as independent contractors is not a new problem but because of increasingly complex employee arrangements, it has become an issue of recent concern which ultimately led to the *Dynamex* decision. Before *Dynamex*, the standard for determining employment was called the control of work test – the right to control the manner and means of accomplishing the desired result of the activity. When making that determination, the CA SC in *Borello* stated that there were essentially nine subfactors that needed to be looked at such as the right to discharge the employee, what the pay arrangement was, who supplied tools, whether special skills were required and what the beliefs of the parties were with regard to the arrangement.

The standard was a factual standard and no one factor controlled. Decisions were hard to reconcile under that standard. In *Dynamex*, the case involved a day delivery service which had previously had its drivers as employees but at one point changed its policy and offered them all the opportunity to become independent contractors. The question became one of overtime and wage and hour issues which went to the CA SC. The case is Dynamex Operations W. v. Superior Court and Charles Lee, Real Party in Interest, the cite is 4 Cal.5th 903 (Cal. 2018). The court said with regard only to wage and hour issues (which is important as the SC said the case doesn't apply to other areas such as workers' compensation) they were shifting from the *Borello* test to a simple and more straightforward test referred to as the ABC test because there are three elements: whether the worker is free from control and direction of the hiring and performance of the work both under the contract and in fact; whether the worker performs work that is outside the usual course of the hiring entity's business; and whether the worker is customarily engaged in an independently established trade, occupation or business of the same nature of the work performed.

Following the case, there was a lot of commentary about what the actual decision was and whether the sky was falling for employment relationships in California or whether this was a wonderful decision which provided substantial new protections to the worker. There were follow-up cases, one involving a franchise janitorial service which applied *Dynamex* and found that they weren't truly franchisees but rather employees. Another case involved a taxi cab driver who drove for a company that controlled 90% of the taxi market in the area. That led to the introduction of several pieces of legislation in the CA legislature, some trying to undue the SC's decision and some trying to codify it and expand on it. The result was AB 5, legislation by Asw. Lorena Gonzalez which did in fact codify the decision and applied it to all labor issues, not just wage and hour issues. So, in CA, the ABC test is the standard test. However, within the legislation, a number of industries were exempted and still operate under the *Borello* test. There is likely to still be some confusion. One industry that did not participate in the legislative process seeking relief from the ABC test was the app-based ridesharing and delivery service industry – the gig economy. They have proposed proposition 22 which would for the first time create a presumption of independent contractor status within that industry.

Rep. Lehman asked if so many independent contractors now become employees, how will that affect workers' compensation, employment practices liability and professional employment organizations (PEOs) – what is the end result going to be for the employer? Mr. Capurro stated that he does not have a crystal ball but given the number of exceptions, many industries are going to continue to operate the same way. For instance, real estate brokers are exempted and that is an industry that typically identifies the broker as an independent contractor. Hairdressers and barbers are part of the exempted class. It is very typical in that industry to have the provider of service rent the chair from the owner of the salon. Thus far, the sky is not falling and businesses are going to go on. Also, the law makes clear that it does not prohibit an independent contractor relationship; it prohibits the mis-classification of an employee. So, if you are a hirer and you want to treat someone as if they are an employee, you cant call them an independent contractor. That is basically what the law provides.

Rep. Lehman stated that, using the janitorial example, if he goes out and contracts with ten people and pays them $15 per hour with no other payments such as workers' compensation, and now they become his employees, does that just set up the scenario to go and hire someone else. The sky may not be falling but it may be set up such that pieces of it may fall. Mr. Capurro stated that is a significant concern that was expressed during the process. The answer is that if your business is not set up as a janitorial service, you can hire a janitor as an independent contractor. Mr. Capurro stated that, as a lawyer, if he has a janitor come in to clean his office, he does not have to have that person be his employee – he can choose to do so but having his office cleaned is not an essential part of his work so that person does not have to be an employee under the AB 5 standard.

Mr. Paretti stated that to some extent he agrees with Mr. Capurro but does not on other issues. After the passage of AB 5, several people were concerned including freelance writers. In the last legislative session, further exceptions were included to AB 5. Mr. Paretti stated that he thinks the point Mr. Capurro is getting at is that of the three factors in the test, the second prong is difficult because the contractor is not in the normal course of your business. To use Mr. Capurro's example - a lawyer contracting with someone to clean their office – there is no argument that the lawyer is in the business of cleaning. But where it starts to get more difficult is when you bring in folks that are very closely related to what your enterprise is but are not necessarily the business you are in such as a bakery that wants to use delivery services – am I in the business of baking such that if I am contracting with a delivery company and an independent contractor to be my driver, I am free and clear? Or is a court going to look at it and say "no, you are in the business of delivered cakes and you don't really have a storefront" thus raising issues as to how integral they are to the business. Accordingly, that second prong is what has gotten the most attention.

Mr. Paretti stated that he suspects we will see additional legislation and certainly additional proposed fixes. In the immediate aftermath, there were reports of freelance writers having issues where there was a strict cap put in place such that if you submitted more than 35 pieces to a publisher, you are no longer a freelancer and you are an employee of that publisher. Well, entities such as Vox said they would not engage with freelancers from California anymore because they didn't want to run the risk of people mis-counting how many articles they submitted and therefore having an improper employee classification. That was somewhat addressed in AB 2357 which was the bill with a new set of amendments to AB 5 but there is still a lack of clarity in situations like those.

Mr. Capurro stated that there are going to be some close calls. In his industry, there is an issue with regard to interpreters. If I have a non-English speaking client and I need an interpreter, is

that an essential part of my business or is that an outside service? That is a question that will arise down the road.

Asm. Cooley stated that this issue became highly controversial in California as any profession that in any way has colleagues that they organize in some fashion got involved to raise the rancor of their political voice of being in or out. For example, truckers and journalists got involved and every imaginable group got involved. There are no ballot propositions on the current ballot – prop 22 relates to Uber and Lyft. It is the case that a law was passed with a series of cutouts which included insurance agents but the legislature keeps coming back with other bills and even calls to recall the Governor since he signed AB 5. There is quite an energy in this issue among different constituencies around CA. One of the reasons the insurance agent cutout was achieved is because the only reference to agency in the CA state Constitution concerns insurance agents. It is an obscure area of the law dealing with retaliatory taxation but nonetheless for the longest time there has been constitutional law addressing insurance agents. That fact became a helping effect to get the cutout for insurance agents in AB 5 because they did not want to run afoul somehow of constitutional law that might cause an infirmity. This is an issue that has really riled up a lot of organized employer groups. There was an information hearing done in the Capital in the Spring of 2019 and Asm. Cooley stated that it must have been six hours of non-stop testimony that you would characterize as highly vitriolic and people were very upset. Asm. Cooley stated that he was the only person besides the Chair to sit through the whole hearing to see how it unfolded.

Mr. Paretti stated that he agrees with Asm. Cooley and stated that like many issues involving labor and employment, this issue is very heated and moving quickly with a lot of strong arguments on both sides. It will be interesting to see what happens with the ballot proposition. Mr. Paretti thanked the Committee for the opportunity to speak. Mr. Capurro thanked the Committee for the opportunity to speak.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee adjourned at 4:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 26, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health insurance & Long Term Care Issues Committee met at the Hilton Alexandria Old Town Hotel on Saturday, September 26, 2020 at 11:30 A.M. (EST)

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

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Asm. Ken Cooley (CA)*
Rep. Martin Carbaugh (IN)*
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)*
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Dean Schamore (KY)
Rep. Brenda Carter (MI)
Rep. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Asm. Kevin Cahill (NY)
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)

Other legislators present were:

Rep. Edmond Jordan (LA)*
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a motion made by Asm. Kevin Cahill (NY), NCOIL Treasurer, and seconded by Sen. Paul Utke (MN) the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Sen. Jim Seward (NY) and seconded by Rep. Joe Fischer, NCOIL Secretary, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 7, 2020 and August 21, 2020 meetings.

CONSIDERATION OF NCOIL SHORT TERM LIMITED DURATION INSURANCE (STLDI) MODEL ACT

Rep. Martin Carbaugh (IN), sponsor of the NCOIL STLDI Model (Model), thanked everyone that has worked on this Model and noted that he greatly appreciates everyone's input. The

Committee has been discussing the Model since last July and it seems that the Committee is finally ready to put the Model forward for a vote. The Model can be viewed in the binders starting on page 258. Rep. Carbaugh stated that he believes very strongly that STLDI 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, 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. Rep. Carbaugh stated that he has seen in Indiana that plans have offered the minimum coverages required by the law and then some due to competition so that is exciting.

Rep. Carbaugh noted that as he has stated previously, 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 stated that he disagrees with those states but that doesn't mean that every state has to function the same and offer these plans. Rep. Carbaugh stated that he hopes that the states that have looked down on STLDI plans in the past could perhaps look to the Model and what has happened in Indiana to reconsider their position.

Rep. Carbaugh stated that the Committee had a great Zoom meeting about a month ago during which a final discussion was held on the Model. Rep. Carbaugh stated again that he greatly appreciates everyone's input.

Upon a Motion made by Rep. Dean Schamore (KY) and seconded by Rep. Matt Lehman (IN), NCOIL President, the Committee voted to adopt the Model by way of a voice vote. Asm. Kevin Cahill (NY), NCOIL Treasurer, was the only vote against adoption.

INTRODUCTION AND DISCUSSION ON NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (MODEL)

Asw. Pam Hunter, sponsor of the Model, stated that many of those here today, whether in-person or virtually, were most likely on the interim Zoom meeting this Committee had about a month ago during which this topic was introduced and it was indicated that the first draft of a Model would be forthcoming. The first draft of the Model is in the binders on page 265 and it is a good starting point for this Committee. This issue is a perfect opportunity for NCOIL to step in and provide guidance to states. The expansion of telemedicine has undoubtedly been one of the most significant issues the industry and consumers have faced throughout the past several months. New York faced issues surrounding in-person medical visits and reimbursement levels and people not having broadband internet to be able to be on a telemedicine visit with their provider.

It is clear that action is needed on the state level to make sure that the proper legislative framework is in place such that consumers are best protected. NCOIL is a perfect forum for us lawmakers to debate what should or should not be in model legislation for states to consider adopting. Asw. Hunter stated that she is proud to sponsor the Model and looks forward to discussing and developing it throughout the next several months. The Model is a good starting point but it is indeed a first draft and there is certainly much work to do. Asw. Hunter appreciates all of the comments already submitted.

The Hon. Dean Cameron, Director of the Idaho Department of Insurance (DOI) and National Association of Insurance Commissioners (NAIC) Vice President, applauded NCOIL for discussing this important issue. Idaho, like many other states and the federal government, moved to loosen restrictions and remove barriers for telemedicine during the pandemic. That causes us all to evaluate and reconsider those barriers that were there in the past. Idaho went from an average of 200 telemedicine visits per month to over 28,000 in April and it has dramatically moved forward. Idaho has five carriers and the ID DOI worked very closely with them to remove any barriers to allow them to expand networks and have the discussion and be able to use any provider who was willing to use the telemedicine platform. That has worked pretty successfully – all of the carriers even though they were not required to by law did pay providers at parity or at the same rate as if they were visiting in person. Dir. Cameron stated he does not know if that will stand that way forever but at least that is the way it is for the foreseeable future as they are trying to benefit consumers and give consumers choices.

Idaho has also seen where telemedicine has helped those with a mental illness and needed a mental health provider – it turned out to be in some cases a preferred methodology to receive treatment and have that discussion. Dir. Cameron then shared some data from what the NAIC has collected and noted that the NAIC is certainly willing to work with NCOIL as these discussions are had. There are some considerations at the federal level whether to continue to relax some privacy concerns and other concerns with telemedicine. Nearly 45 states have taken action since March to expand telehealth. 25 states issued orders to state regulated insurers. Nineteen states publicized requests to insurers and 10 ten states provided notice of relaxed enforcement. Idaho is not big on issuing orders but the DOI did remove barriers and probably would fall into the relaxed enforcement category. Idaho wanted to make sure consumers were protected. Many states provided state regulated insurers with similar flexibilities in Medicare providers including those related to other platforms and sites.

In addition to the 10 states with preexisting state laws on parity, about 11 states issued bulletins or emergency regulations on payment parity. Idaho worked with its carries to encourage payment parity during the pandemic but it also recognized that there is a potential unintended consequence of payment parity of carries moving to more out of state providers in the event that they are forced to do payment parity. Idaho has chosen to not get in the middle of those negotiated contracts between providers and the carriers.

Ann Mond Johnson, CEO of the American Telemedicine Association (ATA), stated that she is delighted to speak to the Committee about what ATA has seen in telehealth across the country and about ATA as well. The ATA is the longest standing organization focused exclusively on the expansion, dissemination, and adoption of telehealth. The vision of ATA is to ensure that Americans get care where and when they need it and when they do they know its safe, effective and appropriate while enabling clinicians to do more good for more people. ATA's membership includes a very wide range of organizations including delivery systems, payers, academic medical centers, pediatric facilities, and a range of solution providers including organizations like American Well and Teledoc Health as well as organizations like Zipnosis and BrightMD both of whom were at the forefront of providing support to delivery systems as they scaled their response during the pandemic.

ATA also includes in its memberships organizations like Babylon Health and Conversa that provide artificial intelligence (AI) driven solutions for consumers. ATA also has organizations that provide lifestyle and direct to consumer asynchronous support. And ATA also has members who provide remote monitoring to many of the hospitals in communities. ATA also includes in its membership a number of organizations like Microsoft, Sony, Verizon, HPintel

which are organizations that are really enabling telehealth and believe in the idea that high water floats all boats.

Ms. Johnson stated that she would be remiss if she did not acknowledge that many of the statistics in terms of the incredible growth of the number of telehealth visits. Telehealth is very broadly defined in our lexicon and includes synchronous communication like we are having now where we can see each other and go back and forth in real time. It includes asynchronous communication which could be text based and a delay in providing communication and it also includes remote monitoring which has been a lifeline for many Americans during the pandemic. The amount of activity that took place shows an incredible surge leading up to week 15 of this year in early April and now we are seeing it drop off. What we have seen is that the decline in telehealth visits has not been to the same levels as it was previously before the pandemic so it is safe to say that ATA is committed to ensuring that telehealth remains in place as long as it provides a safe and affordable and effective option for Americans.

The idea is that the ATA wants to serve as a resource to NCOIL as it examines the Model. ATA has a number of items on its website that Ms. Johnson urged the Committee to look at including terminology defining telehealth and terminology for states on medical practices and standardized terminology for states in terms of policy language on coverage and reimbursement. All of that emanates from the policy principles that were driven by the ATA and that is very much consistent with the idea that people should be able to get care where and when they need it.

Ms. Johnson noted that what has been relatively new to many of us is the growth of asynchronous communications in telehealth and it is important for us to remember that even if it is new to us it doesn't meant its unsafe. Asynchronous services are provided by companies who are committed to the good health and wellbeing of Americans just like our doctors and their offices. The topics the Committee will be dealing with will surely include reimbursement which ATA addresses in its policies. As stated by Dir. Cameron, it is very important that we really acknowledge that there is payment that needs to be made for these services. Another big issue relates to originating site. There were a number of barriers that were in place previously as it relates to originating site which were relieved with waivers and it is hoped that is continued going forward because it is very often the best way for people to get care. So, to have someone drive two or three hours from their home to see a clinician when in fact that service can be rendered virtually using technology is very important and should be maintained.

We also have seen that technology can be used to help people stay in nursing homes instead of getting transferred to a hospital and risks disruption of medication and disorientation. The ATA is very much supportive of using technology and encouraging laws to be adopted that acknowledge that technology has prompted safe and effective use of services by all Americans. One area that ATA is interested in working on deals with Medicaid. Only 4% of the Medicaid populations across the country have access to telehealth services and yet we all know that we can get services on our phones and 95% of Medicaid population have smartphones or access to them so ATA supports the idea that Medicaid adopt telehealth in a more expansive fashion recognizing that states are going to be under severe economic pressure and telehealth can be a very cost effective and affordable way to provide service in greater numbers. Lastly, Ms. Johnson stated that ATA does not believe it necessary to require an in-person visit in order to establish a physician-patient relationship. ATA encourages the Committee to consult its website and reach out throughout this process. Ms. Johnson thanked the Committee for the opportunity to speak on these issues.

Brendan Peppard, Regional Director of State Affairs at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak today and during the Committee's interim meeting in August. Since the interim meeting, AHIP has submitted a detailed comment letter and a red-lined version of the Model. Mr. Peppard stated that he would like to reiterate that insurance providers are and have been supportive of the use of telehealth to provide access and reduce costs. That is a good thing and AHIP is pleased to see the increase in use as noted in earlier testimony today. In order to move forward following the pandemic, there are a number of things that can cement the positive changes that we have seen. Mr. Peppard commended Asw. Hunter as sponsor of the Model for including a number of those things in the Model.

First, during the crisis, many states lifted restrictions on practicing across state lines. Physician's ability to work across state lines is determined by the state licensure boards under normal circumstances. Section 5 of the Model appears to address that situation and AHIP believes that is positive. Next, there have also been inconsistent state restrictions or mandates relating to types of technologies, services or specialties and originating sites that limit the ability of health insurers to design benefits that meet consumer's needs. The Model has several provisions allowing for flexibility including broad acceptance of various technologies and types of providers who can offer telehealth services – at least that is how AHIP reads the Model. However, there are some provisions that raise concerns. AHIP believes that health insurance providers should have the flexibility to design benefits and there is language in the Model that limits flexibility – mostly in Section 4 (A), (B), (C), and (E).

AHIP is concerned about requiring equivalent telehealth and in-person payment rates. That eliminates the cost saving potential of telehealth and can create inadvertent disincentives. While payment parity made sense during the pandemic as doctor's offices were closed and people could not go to their doctor and telehealth was the only way for them to receive care it made sense to provide a revenue stream for the providers and to allow access to networks. Even now, as has been stated, many individuals are still reluctant to go to their doctor in-person and some of those people have good reason not to if they are immunocompromised or have some other concern. However, post-pandemic it is important to look at what we are setting up as a structure going forward. Telehealth visits do not require the same level of intensity and same amount of time or the same amount of equipment as in-person visits and should not be required to be reimbursed equally. We have heard that providers cannot provide telehealth unless there is equivalent payment. However, it is important to point out that providers are not required to provide telehealth. They are encouraged to but they are not required to and there are providers that insurers have negotiated with who are willing and able to offer the services at negotiated rates. That is a benefit to AHIP's members.

AHIP also agrees that telehealth should not become a replacement for needed in-person visits. We don't want to create inappropriate incentives to substitute a telehealth visit for a necessary in person visit. There has been a drop in vaccination rates and that is a tremendous concern to the industry and to the provider community as well. We want to encourage people to go in and get their vaccines. That is just one example but we don't want to create any disincentives to have people go visit their doctor when they should. AHIP recommends to allow flexibility in negotiating appropriate payment rates for telehealth services – this is post-pandemic. The savings from negotiations can and do benefit consumers.

The explosion of telehealth under CVOID has provided opportunities and has raised new questions. Ultimately, the growth is good and health insurance providers have been providing telehealth coverage for a long time and they are pleased to see the growth. Mr. Peppard thanked the Committee again for the opportunity to speak.

Sen. Bob Hackett (OH) stated that when telehealth was brought to Ohio several years ago they were able to sell the business community by saying there would be a lower reimbursement rate. Sen. Hackett complemented the plans during this crisis in their efforts regarding reimbursement levels. Sen. Hackett stated that there has been a huge increase in the use of telehealth but there also has been a huge decrease in people going to the emergency room so there has been tremendous savings to the plans as they are not paying for those emergency room visits as they normally would. Sen. Hackett stated that he has supported telehealth but only at a lower reimbursement rate but noted that maybe he might change. What bothers him is that the providers say telehealth can be delivered at a cheaper price so what about the consumer – why don't they share in the savings? If they can do it at a lower price why should there be payment parity? During the pandemic is one thing and Sen. Hackett agrees with parity during the crisis but afterwards when we know the cost of telehealth is lower it raises interesting questions. Sen. Hackett stated that he has had numerous telehealth visits during the pandemic using his iPhone and it has worked tremendously.

Kim Horvath, Senior Legislative Attorney at the American Medical Association (AMA), thanked the Committee for the opportunity to speak and stated that this is an exceptionally important and timely issue and the AMA appreciates the Committee for introducing the Model which includes many of the key provisions to ensure expanded access to and coverage of telemedicine. Regarding coverage, the AMA supports the language in the Model expanding coverage of telemedicine. The AMA believes telemedicine can and should be integrated seamlessly into the delivery of healthcare and when clinically appropriate telemedicine is just one of the ways in which care can be provided to patients. Therefore, coverage of services provided via telemedicine should be on the same basis as comparable services provided in-person. The AMA has learned over the past six months that telemedicine cannot and should not be viewed as a separate and distinct service but rather a way in which physicians can provide care to their patients.

Likewise, the AMA believes patients should be able to access services via telemedicine from the same physicians who provide that care in-person and they should be able to do so without barriers or different cost sharing structures as other telemedicine providers. The AMA strongly encourages the Committee to include language in the Model to protect that construct. The AMA's letter to the Committee describes some specific parameters for consideration and the AMA believes they are important to ensure both protecting the patient-physician relationship and also continuity of care. Regarding payment, physician practices across the country have made and are continuing to make significant investments both in terms of time and money to adopt and promote access to telehealth service and telemedicine services for their patients particularly during the pandemic. Providers have ramped up in a very short period of time a number of physician practices that are providing telemedicine to their patients.

The AMA recognizes that it is not going away and many patients and providers alike don't want it to go away. The AMA will take efforts to make sure that does not happen but those practices should have certainty going forward that their investments are sustainable. We know that telemedicine has been instrumental in making sure patients have access to care during the pandemic and it has been vital for many patients during the pandemic including vulnerable populations. The AMA supports fair payments to further the advancement of telemedicine and believes services provided via two way audio visual telemedicine are commensurate with in-person services and the payment should be the same. With the increased use in telemedicine over the past six months we know that we have the ability and opportunity to collect data that will help inform potential savings associated with the appropriate use of telemedicine but also

fair payment. So, there is a lot more to come and a lot more to discuss on this and the AMA hopes that conversations with the Committee will continue.

Asw. Hunter asked if Mr. Peppard or Ms. Horvath could respond directly to Sen. Hackett's question as to why there should be payment parity if the costs are not the same. Ms. Horvath stated that when we are talking about audio visual telemedicine that is commensurate with what you would have with an in-person service. The AMA is working on collecting data to help inform those potential cost savings. The data is not ready yet but the AMA is working on it and will share it with the Committee when ready. The past six months have shown a huge increase in telemedicine and we have a unique opportunity now to gather that information and utilize it going forward.

Mr. Peppard stated that most carriers who design these benefits do in fact provide a reduced cost share for telemedicine use and so there is already a savings for the consumer immediately built in. Regarding decreased emergency room use, we always want to see that when it is not an appropriate emergency room visit and if this is a way to prevent that it is terrific. Providers are willing and able to negotiate with plans to provide these services so it is a benefit that is going to be available for AHIP members. Regarding data collection mentioned by AMA, Mr. Peppard stated that if you get more of something and pay more for it at the same time it is difficult to see how it reduces costs. Mr. Peppard challenged the AMA on that point.

Ms. Johnson stated that the ATA works closely with AHIP and AMA on many of these issues and the ATA in representing its broad, diverse membership supports fair payment that is commensurate with the investment required by telehealth providers recognizing that telehealth can be audio-only, and audio-visual but also provided remotely and there is a fair amount of costs and investment associated with that.

Rep. Deborah Ferguson (AR), Vice Chair of the Committee, stated that if you talk to your physician they will tell you that telemedicine actually takes them a little bit longer because of the video aspect taking longer to negotiate the visit so that supports payment parity. It is important to understand that telemedicine has evolved into sort of three separate things. You have your doctor to specialist which is like doctor to stroke specialist and which are great but in terms of the doctor to doctor of telemedicine that is also evolved into two separate things. You have your big-time telemedicine providers like Teledoc that contract with primarily ERISA's or big companies to provide telemedicine services to employees.

Then you have a separate telemedicine that has evolved during the pandemic which is setting up doctor's offices to do telemedicine with their own patients. Rep. Ferguson stated that she has a real concern that the big telemedicine companies who are contracting with ERISA's or insurance companies or employers are actually going to circumvent the patient's own provider and require the telemedicine visit to be with the big telemedicine company and not with the patient's own provider who may have telemedicine services available.

Rep. Ferguson stated that Arkansas looked at some problems where telemedicine was actually going to reduce access to rural healthcare because a telemedicine provider from a hospital was going to come into an area and provide services where the only doctor in the county was right across the street. That is a real concern. You should not circumvent the patient's own provider and it might actually reduce access to rural care if you driving patients to telemedicine away from the only rural provider.

Ms. Johnson stated that the ATA understands the concerns about telemedicine and believes that it is health - telehealth is health and telemedicine is medicine and the ATA views it as

another modality of care. In rural communities where organizations operate in the Dakota's and other states, what they have done is really support rural physicians who have not been able to sustain their practices otherwise without this technology so the ATA believes that when it is deployed in a reasonable fashion it really ends up supporting physician-patient relationships.

Mr. Peppard stated that AHIP believes that telehealth should not become a replacement for in-person visits when they are needed so that is a concern if telehealth was developed in a way described by Rep. Ferguson.

Ms. Horvath stated that often with telemedicine you don't always know, physicians or patients, at the beginning of the telemedicine visit whether that visit will necessitate an in-person care following that service. Not everything can or should be provided via telemedicine and not every patient should or can receive services telemedicine.

Asw. Hunter stated that everything is not created equal and not having some reliable access to broadband and Wifi has really hindered some people being able to have access to telehealth. While many people do have smartphones that have the capacity to do so that isn't always there. We see that with education now with remote learning in that its just not always available even though we think its so simple and everyone has a phone. Asw. Hunter stated that she has a concern about the requirement for an in-person meeting. You can see someone over the phone but you can't feel their heartbeat and feel their glands if they are swollen so it is important to make sure that care really is being given and recognize that everything is not equal and access isn't the same.

Dir. Cameron stated that the NAIC is also studying these issues and they don't have a firm position yet. Dir. Cameron stated that he has received telehealth services and it was quite the experience. Regarding parity, certainly there are additional costs associated with setting up telehealth services but there are savings that are also occurring when a physician is able to provide telehealth services. All of Idaho's carriers prior to the pandemic had telehealth services but they were with many of the companies such as WebMd and others mentioned earlier. Dir. Cameron stated that he does not believe we want to necessarily encourage to go back to just those options. We need to have a balance between encouraging the use of local doctors and helping local doctors set up their services but at the same time if there is not some commensurate savings for doing so it will naturally force the carriers to contract with those that are out of state and not with the across the street physician. Accordingly, Rep. Ferguson's concern is very valid and one that should be discussed going forward.

Asw. Hunter thanked everyone for their comments and stated that she looks forward to working with everyone on the Model going forward.

CONTINUED DISCUSSION ON NCOIL PATIENT DENTAL CARE BILL OF RIGHTS

Rep. Ferguson, sponsor of the NCOIL Patient Dental Care Bill of Rights Model Act (Model), stated that discussion on this Model started in December of last year and we have had a very productive dialogue since then. Since the last meeting in March, some changes to the Model have been made, which is in the binders starting on page 270. First, the title has changed from "Patient Dental Care Bill of Rights" to "Transparency in Dental Benefits Contracting Model Act." The main reason for that change is that the first draft of the Model started out with five separate substantive sections – each addressing a separate issue – but Rep. Ferguson stated that she decided to remove the sections dealing with retroactive denial and medical loss ratio as she believes those issues are complex enough such that they warrant their own separate discussions and perhaps separate Model Laws. Accordingly, given the removal of those

sections, the new title is more appropriate. The medical loss ratio and retroactive denial sections were not necessarily removed because of their substance, but rather in an effort to make the Model more concise and make it easier for the Committee to dedicate sufficient time to each topic. Three topics is already a lot to understand and digest, let alone five.

Rep. Ferguson stated that it is important to note the Sponsor's note that appears in the latest version of the Model at the top of page 1– it states that "this Model remains a significant working draft. Specific language for modification needs to be resolved and will continue to be discussed." That note is important because while Rep. Ferguson appreciates everyone's work and input on the Model thus far, there is still a lot of work do. Rep. Ferguson stated that she is confident that we will get there. Rep. Ferguson stated that she is proud to sponsor the Model and looks forward to working on it further with the Committee.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), stated that it is no secret that health insurance is confusing and dental insurance is no different. The ADA's feeling is that patients deserve a dental plan that protects them, removes rather than creates financial uncertainties, and is clear about what is covered and how to properly use that coverage. The ADA appreciates the changes made by Rep. Ferguson and noted that the ADA is working to develop further language that represents more of a cohesive stakeholder input version and looks forward to continuing that work.

The issues that remain in the Model are network leasing, prior authorization and virtual credit card payment, all under the umbrella of transparency. The first issue is to develop model language to establish fair and transparent network contracts. Insurance carriers occasionally lease or rent in network relationships that they have established with a provider to another entity such as another carrier or third party payer or administrator. This can be problematic when both the patients and providers don't know what's going on. If this approach is not done in a fair and transparent manner it can erode patient provider trust which can lead to wrong assumptions about the treatment plans and costs.

For example, the ADA had a New Jersey dentist who had signed into a network in the 1980s and reported that perhaps one or two subscribers had actually come through his office under that network umbrella. About five years ago that network relationship was rented to a very large carrier in the area and he found out about this because a patient said "thanks for joining the network." There was no notice given to the doctor and he found out later that a large portion of his patient base was now in network without his knowledge. He was not able to get out of the contract relationship for 90 days so he had to accept that discount for 90 days and then had to, because he chose not to be a part of it, inform all of his patients that he was removing himself the network. You can see that it ended up costing him almost $100,000 when all was said and done. That is a situation that a doctor and patient should not be put into and that is what the Model language does and tries to address.

Network leasing legislation like what is in the Model would expand transparency before networks are leased and provide an opportunity for providers to review the contracts and accept or refuse them. To that end, Mr. Olson stated that he would like to address some of the comments that were submitted stating that provider dentists should not have the right to opt out of rental networks if their carrier contracts indicate that the network relationship can be sold – similar to the 1980s scenario described earlier. The opt-out right of the dentists is an essential part of the Model and preserves an appropriate balance of power between the providers and carriers maintaining their networks. Without the ability to opt out, dentists will be at risk of signing into pretty much every network when they sign onto one network, particularly because carries frequently operate from a take it or leave it situation when they present the contracts –

there is not the ability to cross out some lines when signing a network contract with a dental carrier and say “I would like to sign into the network but not the leasing portion.”

As written, the Model makes a clear distinction between dental insurers and dental network leasing companies. If a dentist agrees to sign up with a dental network leasing company the dentist should reasonably expect that he or she is going to be leased. That said, a dental benefit insurer or carrier is a different kind of entity often wielding significant market strength in most states. To allow dental insurers to use a take it or leave it approach when they lease their networks they make it very difficult for a dentist to opt out particularly in areas when the carriers network strength is very strong because the provider would lose their in network status and perhaps put a significant portion of their patient base at risk.

With regard to prior authorization, as early as possible, patients and dentists should have a clear understanding of what coverage a patient has and what a patient will be financially responsible for as a result of healthcare services. Insurance carrier documentation issued prior to a service being provided, and often its called prior authorization, should accurately communicate the amount the carrier will pay. Doing so leads to a transparency for the patient and allowing better treatment planning for all involved. If an insurance carrier has issued a prior authorization the ADA’s view, which the Model reflects, is that state law should require the carrier to stand by its commitment to pay. Prior authorization is essentially a pre-submitted claim for treatment usually with diagnostic notes, x-rays or specific procedure codes reflecting prescribed care. State laws requiring carriers to honor prior authorization will prevent surprise billing which can lead to devastating effects on families and patients.

The third issue is virtual credit card payments. When reimbursing dentists on the claims they pay, some carriers send a series of numbers to the practice when entered into a credit card terminal or designated website it releases funds to the dentist as a payment for claim. Like any other credit card transaction, there is of course a processing fee associated with virtual credit card payments. They can range from 2.5% of the payment amount. This means that if you have a dentist’s office that is accepting $500,000 per year and virtual credit card is the only type of payment they are accepting the dentist office ends up paying $12,500 to $25,000 in fees for accepting that money. The Model says that can’t be the only option that the insurance carrier gives to the dentist to accept payment – there needs to be others such as direct reimbursement or a paper check. The Model would also ensure that a dentist is informed if there is a profit-sharing arrangement that has been set up between the virtual credit card company and the carrier. If the carrier is receiving a little percentage of the fee the credit card company is charging for cashing the payment this is information that would help the dentist decide whether or not to accept that form of payment. The Model is prescribing a simple notice of the arrangement - not a detailed accounting of what percentage the insurance company is collecting.

Mr. Olson thanked the Committee for the opportunity to speak. Having the Committee support these issues would be very beneficial as they have already passed in certain states.

Artur Bagyants, Associate Director of Gov’t Relations at the National Association of Dental Plans (NADP), stated that NADP continues to have concerns with the Model but appreciates the willingness of the Committee to be receptive of NADP’s feedback. NADP’s main point today is that the three issues should not be combined in one Model. Bills at the state level generally don’t do that for good reason. The three issues are very distinct with distinct characteristics and they do not have much in common. Each issue is complicated enough to allow for individual treatment. NADP has worked on the issues in multiple states and knows this from experience. For example, the network leasing issue in New Jersey was enacted in 2019 and it took over a

year of work. Earlier this year in Arizona there was a prior authorization bill similar to the Model and it had to be withdrawn and assigned to a study committee because of issues raised during the process. NADP believes that combining all of the issues into one piece of work product could cause problems.

That being said, network leasing is probably the primary issue so NADP would recommend that the Committee narrow the Model to only that issue which would be cleaner and more concise. NADP and AHIP and the American Council of Life Insurers (ACLI) submitted legislative language to the Committee that does that and it is based on recent laws passed in NJ and CA. Those laws are some of the most strict leasing laws in the country so it is believed that they should be looked at as a starting point. That does not mean the Model has to mirror that language but it could be used as a starting point. Mr. Bagyants stated that the other reason the NJ and CA laws were looked to is because those laws were very well-vetted and came about after a lot of deliberation and input from stakeholders. NADP was involved in that process and it came down to considering individual words and commas and that level of detail. For that reason, it is better to follow those laws as a base rather than something new. If the Committee does decide to move forward with the Model, NADP is committed to working with the Committee and helping it to make it a good final product. NADP routinely works with dental associations and legislators in states when these issues arise and there is usually a good dialogue.

Karen Melchert, Regional VP of State Relations at the ACLI, stated that the ACLI concurs with the NADP's comments on the need to break the Model up into three separate Models and work on them individually going forward. ACLI will continue to work with Rep. Ferguson, the ADA, and the Committee on perfecting the Model if that is the will of Rep. Ferguson. Ms. Melchert thanked Rep. Ferguson for the changes made thus far and looks forward to working on the Model going forward.

Mr. Peppard thanked Rep. Ferguson for the changes already made to the Model and echoed the comments made by Mr. Bagyants and Ms. Melchert with regard to there still being some concern over the remaining language. Focusing on the leasing component which seems to be getting the most attention is appropriate at this point. AHIP appreciates Rep. Ferguson's willingness to work on the Model going forward.

Rep. Ferguson stated that reducing the Model down to three issues has made it less contentious and with any Model legislation, states are going to take whatever part they want. Many of these issues have already been passed in Arkansas and other states so states can separate the issues themselves if they have already passed certain components. Regarding the virtual credit card issue, that was passed in Arkansas because most payers pay electronic fund transfers as it is really the smaller companies that send the credit card reimbursements and then they receive part of it and the provider has to take the percentage out just like running any other credit card. The Model doesn't prohibit that but makes clear that the dentist has the option to opt out. Regarding the leasing issue, Arkansas passed Medicaid expansion with private insurance particularly with BCBS as the biggest provider in the state. They were requiring dentists to participate in all products in other words Medicaid expansion under private insurance paid significantly less but you were required to participate in all products so it is a similar problem with leasing. You don't want to require a provider to accept low reimbursement if they are not contracted to do that. Rep. Ferguson believes that provision of the Model is reasonable and legislators can always take the Model and sperate however they would like.

Asw. Hunter thanked everyone for speaking and stated that hopefully the Model will be ready for a vote in December.

CONTINUED DISCUSSION ON NCOIL VISION CARE SERVICES MODEL ACT

Sen. Hackett, sponsor of the NCOIL Vision Care Services Model Act (Model), stated that Ohio is one of the few states that could not get the non-covered dental legislation passed no matter how hard the dentists pushed. Sen. Hackett stated that the Ohio optometrists saw this and they worked with the vision plans to get legislation similar to this Model passed in Ohio. Both sides gave and they met in the middle. NCOIL has not been able to get the support of the national optometrist association even though vision plans have agreed to allow the optometrists to stay in the network even though they did not offer discounts on non-covered items.

The national optometrist association will not support the Model and it really is because of one issue: when plans list on their website who is in the network they also want to list which providers will offer discounts on non-covered items. The question is should consumers know who is offering a discount and who is not? That is what the issue has come down to.

Robert Holden, State Gov't Relations Director at the National Association of Vision Care Plans (NAVCP), stated that the Model is based on consensus legislation was passed in Ohio and subsequently NAVCP has worked in Utah to pass similar language and is currently working in Arizona to do so as well as that bill passed the House but was not taken up in the Senate due to COVID. It is important that NCOIL consider the Model because there has been some confusion based on a previous Model that has passed at NCOIL referenced by Sen. Hackett – the Model Act Banning Fee Schedules for Uncovered Dental Services – and its application to the vision industry.

There are a number of differences between how vision benefits and dental benefits are offered. Unlike a dental plan, vision plans offer really only one healthcare service and that is an annual eye examination. It is routine and preventative care and is valuable care but there is really only one major health care service provided and it has many component parts but it is a relatively simple benefit from that perspective. The complexity comes in when we talk about coverage for the purchase of eyewear and in that way it really shows the difference between dental plan benefits and vision plan benefits. When a patient receives an annual eye examination, vision plans are based on the model of encouraging them to purchase eyewear from their provider as they get much better service from that perspective and it deepens the relationship.

However, there are complexities to that one of which is that there are a whole host of options available to the patient. One is from a non-medical side they have a number of frame options available to them to suit their preferences but also with respect to the actual lens there are a number of different medical options some of which are important for purposes of improving their vision and others are simply preferences as to the lens. For example, lens materials can be selected while vision plans typically cover single-vision bifocals or trifocals they may prefer progressive lenses and may want tinting or anti-reflective coating. Patients also have the option to not purchase from their provider as they can go elsewhere to other retailers.

Mr. Holden stated that the Model reflects some of those critical differences. One is that the Model defines vision care materials to distinguish materials from services. Also different in vision plans as opposed to dental plans there are two different provider types – one being optometrists and others ophthalmologists, medical doctors. Those are both equally treated in the Model as vision care providers. The Model also places requirements on plans. One which was a big compromise in Ohio is that vision plans will be prohibited from setting prices on non-covered services and materials as a condition of joining the network. This represents a compromise because essentially it made participation in any kind of plan pricing optional to the individual provider but allowed them to be a preferred provider within the network in every other

sense. While vision plans would have preferred to have a consistent benefit, a compromise was able to be reached. What that made critical is some of the patient protection provisions in the Model.

The Model also provides and guarantees that providers can prescribe all options to the patient with regard to services or eyewear so even if a particular eyewear type is not covered or is differentially priced there is no restriction on their ability to offer that through their own dispensary. The patient protection components of the Model are very critical because the patient needs to know that the pricing can differ if that provider has opted out of plan pricing and that comes up in two ways. One of the things that vision plans do is negotiate a discount on a second pair of frames. Once enrollees use up their benefit for the year they really have no reasons to continue to shop with a provider on price. Plans want to encourage them to continue to go to their doctor and purchase eyewear from them as a second touchpoint during the year or just to make sure that the second pair of frames properly suits their medical needs so they have negotiated discounts on that. Under the Model those discounts would be optional but the pans want to be able to tell the patient whether or not those standard price discounts are available.

The other component of this is something that is related to the lens options. All NAVCP plans cover a basic lens whether it's a single lens or bifocal lens and there are different options that can be provided on top of that. If a patient chooses any of those options, that is usually paid through a copay and that copay is offset by the cost of the lens but the remainder of that goes to the provider in addition to a dispensing fee. NAVCP is considered because during some discussions some providers considered that non-covered and then do not put a limit on that pricing. The concern there is that a patient thinks they are getting a covered lens and a covered option and before they know it there is a large increase in the out of pocket cost for them with their provider. Plans want to have the ability to provide them with information on that before they go to that provider and it needs to be reiterated at the point of service.

Mr. Holden stated that there is no doubt in the studies that NAVCP has run and with other studies that there is a tremendous value to patients going to see their optometrists or ophthalmologists and purchasing eyewear form them. They are far more likely to get that examination every year if they are going to purchase eyewear and even if they go specifically for the eye examination they are more likely to purchase that eyewear than if they don't have that benefit. So, NAVCP believes that combining those benefits provides a great deal of value to the patient and also to the provider and the Model is a great compromise in providing not only great flexibility to providers that are on the plan but also providing transparency to the individual consumer.

Mr. Peppard stated that AHIP agrees with the points made by Mr. Holden. Plans need to be able to provide information to their customers so they know what their benefit is and what they are looking at. This is a consumer protection and consumer interest Model. AHIP did submit one requested clarifying amendment as it believes the additional sentence at the end of Section (E) is not necessary and the provision reads more simply if that sentence is struck.

Daniel Carey, Senior Director of State Gov't Relations at the American Optometric Association (AOA), stated that the AOA appreciates the opportunity to be a part of this dialogue as it is a very important issue they have dealt with in almost 23 states. The AOA agrees that clear communication and notification to patients is critical to the care that they receive, to the benefits that they have and to the payments they may potentially make. The way that the Model is written and the way the AOA has seen it play out in states across the country is because ultimately when plans list out AOA's members, the result is a scarlet letter. Whether AOA's doctors are providing a full breadth of discounts or if they are offering singular discounts as it

relates to the plan they are held separately and problematically to the doctors who fully subscribe to the plans discounts that are being offered and those who fully sign onto the plan's contract.

The AOA has seen that happen in Ohio. In practical application, the AOA has seen its doctors held out and are not readily available to be viewed by patients when they do log into those portals. That is the concern. By no means does the AOA want to be disingenuous with what the protection or what the plan is offering. Ultimately, the AOA wants to make sure that patients are able to find the doctors that are most accessible and can provide the most comprehensive care to.

Another issue the AOA has relates to Section (D) and the non-covered services themselves. The non-covered services are discounts that the plans are marketing where they ultimately have no skin in the game because they are not fulfilling the costs as it relates to non-covered service materials. AOA is saying that as it relates to non-covered services it is important to make sure that the doctors are not being dictated to by the market power the plans have in place. NAVCP plans have roughly 180 million individuals across the country who are part of the plans. The issue is that they yield incredible market power within the states. One doctor Mr. Carey spoke to said that upwards of 70% of her patients come from the vision plan in her state. So, either she is in with the plan or not but she is not really able to opt out of the plan because 70% of her patient base comes from that. So, if she can't be found on the website as it relates to notification or if she weren't to take the discounts as outlined in the Model then she would essentially not be able to practice within her state.

Mr. Carey thanked the Committee for the opportunity to speak and stated that he looks forward to seeing a version of the Model ready by December that benefits providers, plans and most importantly consumers.

On behalf of the AOA, Dr. Rebecca Wartman, a practicing optometrist, stated that regarding the issue of informing patients of discounts the plans had a concern that providers were going to increase prices and charge a lot more to any plan member for anything that was not covered. There is a principle in usual and customary fees that is standard across everybody and is in most of the state laws already in place and is certainly a requirement in all federal programs that you charge what you charge across the board to everybody. There was a bit of scoffing when that was mentioned in a previous conversation. AOA's providers are doctors and they are not going to overcharge patients – their fees are what they are. That is a number one principle and should be sufficient to go by.

Plans as well should not be allowed to add covered items at nominal fees just to say that something is covered and pay a dollar or two dollars. That is not fair. Plans should be very clear on what is covered and what is not covered with patients. As a practicing provider, one of the common reasons is that a patient comes in assuming that they can get a free eye-exam and a free pair of glasses and then when they opt with education to go above what is standardly covered they get upset because the plans haven't informed them that there is going to be some things not covered.

Further, the AOA feels like if plans feel the need to educate their customers on what is covered and not covered and what fees exist for non covered services they should simply say there may or may not be discounts offered on non-covered services. That informs the patients that is a conversation they may need to have with their provider. Patients always have the choice on what they get. Patients are always educated on what their options are and why they may or may not want those options. Providers do a really good job because they are also

businesspeople and as such they want their patients to be happy. They want them to know exactly what to expect and the transparency when they come in. With plans leading patients to believe that their glasses are free or they are going to pay $10 or whatever their copay happens to be, that is as misleading as what the plans seem to think is misleading as the providers not being willing to have it published whether or not they are going to offer extra discounts on non-covered services. That needs to be an individual provider choice. As providers and businesspeople they know their markets and know what they need to do to make customers and patients happy. The AOA is hoping that it can move forward with the Model and fix this major issue.

Rep. Matt Lehman (IN), NCOIL President, stated that he is hearing multiple examples of where consensus was reached on this issue with state optometric associations but now there seems to be opposition to the Model. Rep. Lehman asked Sen. Hackett if that is correct. Sen. Hackett replied yes and stated that the issue also seems to come down to that Ohio was not able to pass the non-covered dental services legislation. Most states do not allow dental companies to do that.

Mr. Carey stated that optometric associations did support the legislation referenced earlier in AZ, UT and OH. Ultimately the bills were not what the AOA wanted and in OH for example the practical aspect of the bill has been problematic with the plans with not only listing out of doctors as they are listed on the websites but also lab choice in the ability of providers to be able to prescribe out to specific labs and that is ultimately what is best for the patient. Generally, the AOA tries its best to support its state associations and as the Committee knows legislation varies from state to state. The AOA is looking to have a national model on this issue be something that is the most comprehensive and best suits not only the plans and providers but the consumers. That is why AOA sent over to Sen. Hackett and NAVCP and NCOIL staff state legislation that was thought to not be completely one-sided such as that enacted in CO and AR. Perhaps if the Committee used those laws as a starting point that would be the better approach in developing a national Model. Mr. Carey stated that the AOA would enjoy the opportunity to have those conversations going forward.

Asw. Hunter stated that hopefully the Model can be ready for a vote in December.

Sen. Hackett stated that it is important to realize that getting in the network is a plus for the providers. With dental, if you don't offer the discounts you can't get in the network. NCOIL outlawed that but not all the states adopted that Model. Providers are getting a benefit of getting in the network so why can't consumers be protected to know which providers offer discounts and which don't. You can't blame the optometrists as some in Ohio don't like it because they don't want their patients to know that they don't give the discount. This is not an easy Model but work will continue to be conducted.

ADJOURNMENT

Upon a Motion made by Rep. Lehman and seconded by Rep. Carl Anderson (SC), the Committee adjourned at 1:00 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 26, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Hilton Alexandria Old Town Hotel on Saturday, September 26, 2020 at 10:00 A.M. (EST)

Representative Joe Fischer of Kentucky, NCOIL Secretary, Acting Chair of the Committee, presided.

Other members of the Committee present were (* indicates virtual attendance via Zoom):

Asm. Ken Cooley (CA)*
Rep. Matt Lehman (IN)
Rep. Jim Gooch (KY)
Rep. Bart Rowland (KY)
Rep. Michael Webber (MI)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Peggy Mayfield (IN)*
Rep. Dean Schamore (KY)
Sen. Kirk Talbot (LA)
Rep. Kevin Coleman (MI)
Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

Upon a motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Sen. Paul Utke (MN) the Committee waived the quorum requirement without objection by way of a voice vote.

MINUTES

Upon a motion made by Asw. Pam Hunter (NY) and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 6, 2020 meeting.

PRESENTATION ON LIFE INSURANCE SETTLEMENTS

Wes Bissett, representing the Life Insurance Settlements Association (LISA), stated that life settlements provide life insurance policyholders with a way to sell their policies that are no longer needed or wanted and at a value that typically far exceeds what they would receive for a cash surrender. Life settlements are essentially a way to unlock the market value that exists in a life policy and provide an alternative to lapse and surrender. LISA represents that market and has been in existence for about 25 years. When LISA was first established, life settlements

were somewhat of a new concept and regulation of the market was inconsistent. Much has changed in the last quarter century. The industry has matured significantly and it now has a comprehensive regulatory framework in place and a lot of credit for that goes to NCOIL. NCOIL first adopted a life settlement regulatory Model Act in 2000 and updated it in 2004 and 2007. Many of the state laws that exist today are based on that Model or a very similar National Association of Insurance Commissioners (NAIC) proposal. The goal today is to simply educate. Many often come to conferences saying there is no "ask" but this is one of the rare times when that is true.

The goal is to explain what life settlements are, what the market looks like in 2020 and how life settlements can potentially help seniors and provide much needed resources for seniors dealing with retirement, long term care and healthcare needs. Mr. Bissett then introduced his co-presenter, Michael Freedman. Mr. Freedman used to work at Coventry – the largest life settlement provider in the market. He worked there for 12 years and worked extensively on legislation across the country. He is now the CEO and co-founder of Lighthouse Life Solutions, LLC, a life settlement company that operates outside of Philadelphia. He is also an active LISA member and Chairs LISA's public policy council.

Mr. Freedman stated that this is a great opportunity to share with both those who are and are not familiar with life settlements what has gone on in the last several years and what the state of the market is and why it is particularly relevant and timely considering the aging of America and the healthcare crises that we face. A life settlement is simply the sale of an in-force life insurance policy. When that policy is sold, the policy owner receives in many instances a cash payment. The owner can also receive something called a retained death benefit option or some combination of the two.

Most policies are universal life but it can be for whole life and term life and under certain circumstances guaranteed universal life and other types of life insurance. People who sell their policies receive as a matter of law greater than they would get if they surrendered that policy and that policy had a cash surrender value. It has to exceed that or accelerated death benefits that might be available under the policy. But as a matter of practice, the average life settlement pays multiples more – it is a factor of the age and the health of the insured and the policy itself. So, there are a lot of factors but the average based on national studies is greater than four times more than surrendering the policy and as a practical matter, when somebody lapses their policy they get nothing so it is infinitely greater to sell the policy if facing a lapse and there is a value for it.

Mr. Freedman stated that the market is regulated by both having life settlement providers as the buyers of policies be licensed under state laws and by state insurance departments as well as the intermediary life settlement broker who represents the policy owner. The root of the sale of a life insurance policy is the fact that a life insurance policy is a form of property that the Supreme Court recognized over 100 years ago that it should have the same characteristics as ordinary property.

The Supreme Court stated that if you limited who could buy a policy - an asset that you own – and the Court was referring to people who have an insurable interest, then it would be worth less. If you could sell your house only back to the developer; if you could sell your car only back to the car dealership and there was only one buyer in the market, it would be worth less. So, everyone that owns a life insurance policy owns a piece of property that is as valuable an asset that they may own. By way of example, look at a $500,000 life insurance policy. If you lapse that policy, there is no return back to the policyowner of any value – they get nothing. But if the termination is through a surrender and it is a universal or whole life policy with a cash surrender

value, that surrender value is usually low. While it might have grown in prior years, by the time somebody is faced with whether to keep that policy or not, the premiums exceed whatever cash value is in the policy and often times that is the reason for surrendering the policy for whatever is left in the cash surrender value.

A life settlement is a demonstrably more valuable option for somebody who isn't going to keep their life insurance policy faced with a lapse or surrender and they will get on average four times more – in this case, with the $500,000 policy they could get $45,000 versus $7,500 if they surrendered it and $0 if they did nothing. As another brief example, people who are already in need of long term care or have entered long term care, their ability to maintain a life insurance policy is challenged by Medicaid eligibility which is the reality for most people who receive long term care having Medicaid pay for that, and also financial restraints make it hard. So, people who are in long term care or facing it often get rid of their life insurance policies. Selling that policy could generate real resources for somebody who can dedicate those resources towards long term care. As an example, a very average policy of $250,000 for somebody who needed long term care was able to sell their policy for $75,000. That is not going to change their life but it is money that goes towards their care and can help them get into the proper level and type of long term care whether it is nursing home care, assisted living, or skilled nursing. So, it is very good to be able to liquidate an asset rather than having to rely on government benefits all the time.

Mr. Freedman stated that the realty is that very few policies ever pay a death benefit. Based on data from the insurance industry, in 2018 there was $57 billion dollars in death benefits paid on individual life policies but more than $700 billion dollars worth of policies lapsed or surrendered in 2018. 92.5% of all death benefits that were terminated in 2018 were terminated without paying the policyowner anything or very little if there is a cash surrender. Nine times out of ten you are going to outlive your life insurance policy. What we do know based on research data is that seniors who have policies are more likely than the average policyowner to lapse or surrender their policy and that is at a rate of about 75% of term and universal life policies – it is just not affordable to keep the policy. Seniors terminate their policies because of the need for healthcare, specifically long term care, or really just meeting the cost of living in retirement. Most Americans don't have enough savings to cover their entire retirement and they do manage their assets by liquidating them and selling their home and using the equity and a life insurance policy is also capable of being sold and used in that same way.

Regarding the current state of the market, it is important to start with the available and in-force life insurance market. There is roughly $12 trillion dollars of in-force life insurance in the U.S. today of individual life insurance policies. About $700 billion in individual policy face value was lapsed or surrendered in 2018. With regard to life settlement activity, in 2019 there was only 2,800 life settlements done in the U.S. representing about $4.4 billion in death benefits. So, the idea that the life settlement market is a threat to the life insurance industry or to anything really is not really true given those numbers. The market is trending upward primarily because there is a greater focus on smaller face life insurance policies and there is more direct to consumer marketing that is taking place in the life settlement market where people who are in need of resources in retirement are searching the internet or being served ads on social media.

The market is still very much a deep end market as you can see from the 2019 numbers the average transaction for a life settlement at $4 billion dollars in life settlements and 3,000 transactions represents an average of $1.47 million dollars per transaction. Those are people that have $1.5 million dollars on average so the market is still very much focused on large faced policies because there are still a large number of intermediaries involved – insurance agents and financial advisors versus those who are on their own looking on the internet saying I don't

have an agent anymore or a financial advisor so what am I going to do with this life insurance policy. So, the market is starting to change but it is still very much in the large face market.

There is a great deal of regulation in this market as opposed to 15 or 20 years ago. 43 of the 50 states have laws on the books regulating the transaction. The regulations include licensing of providers and brokers. Interestingly and importantly, a life insurance agent can be a settlement broker by notifying the state in which they are licensed and they are transacting, if they have reciprocity of that license, that they are transacting as a broker and by doing so what is imposed on them is a fiduciary duty to represent the policyowner in the sale of that policy. They don't represent the buyer; they don't represent the insurance company – they represent the policyowner and that is very unique under insurance laws and regulations, particularly with life insurance.

There are numerous disclosure requirements throughout the transaction that at the outset tell the policyowner about the risk of selling their policy more generally and alternatives to selling their policy and that as the transaction goes on that the life settlement company advises the policyowner of how much they would get if they surrendered the policy, how much they would get for an accelerated death benefit and all sorts of disclosures. The compensation has to get disclosed if there is an intermediary involved. So, the level of disclosure in the transaction and the level of consumer protections in life settlements overall has really made this one of the hallmarks of insurance and financial services regulation. The result is that according to NAIC data in the past several years there has been one or two transactions that have been reported as a problem and one or two consumer complaints filed with the state insurance department in the past five years. Granted, the number of overall transactions is small but this is a senior financial service that doesn't have allegations of fraud or complaints and as a matter of fact there is virtually no legislation pending in the U.S. today for life settlements which is why there is no "ask" today. The fact is that this is a well regulated transaction and consumers are getting value for their life insurance policies and they are doing so with greater transparency and accountability than we find in any other insurance or financial services transaction. That is regulation that NCOIL led the way on.

Mr. Freedman stated that a number of states have adopted either the NCOIL Life Insurance Consumer Disclosure Model or some variation of it. There are disclosure requirements that when somebody is giving up their life insurance policy, in addition to what they can do once they give up the policy, the NCOIL model says that you have to tell them there are options that allow them to keep the policy if they can find a way to do it or if not then they can sell it or they can choose an accelerated death benefit so NCOIL went even further in establishing strong consumer protections by having the Model that has been adopted by several states.

Most important is the individual life insurance policy owner. Somebody who sells their policy does so for a variety of reasons, most often because they need the money in retirement either for healthcare or just cost of living in retirement and other things. A company led study in the life settlement industry found that most use their proceeds for their long term care and their healthcare – buying long term care insurance or a hybrid policy or to pay for direct healthcare, particularly long term care. Some use it just to supplement their income in retirement and that is often very much needed because we are in a time of a retirement crisis. We now have baby boomers turning 75 and we know there is a need for resources in retirement for seniors. We know specifically that there is a healthcare crisis for seniors and the majority of seniors are defaulting for long term care and moving on to Medicaid to pay for that long term care. The cost of nursing home care and other healthcare are rising and the out of pocket expenses that are not covered by Medicaid or Medicare can be very expensive and can be as much as $500,000 out of pocket for a couple starting at age 65 so it is very dramatic and here is an asset in a life

insurance policy that nine times out of ten will be gotten rid of for little or nothing in the form of a lapse of surrender. That life insurance policy in a folder in a drawer can have as much value as the equity in their own home so the ability for them to know about life settlements and the ability to sell the policy and use the money for whatever they need it for is the same as with any other asset owned and that is going back to the Supreme Court decision from over 100 years ago.

In 2017, the NAIC when looking at innovative ways to finance long term care included life settlements as one way for seniors to help finance their long term care needs and reported along with other options not only the value that policyowners can receive with over four times the cash surrender value but also among all the options that were innovative in the NAIC report, the life settlement option was the only one that the senior didn't have to shell out any money to benefit from to have money for long term care. It wasn't the purchase of a long term care insurance policy or the purchase of a health insurance policy with long term care benefits – it wasn't anything other than selling the policy which didn't cost them a penny and only made them some money. It was good to be included among those options to help seniors pay for long term care.

Mr. Freedman stated that there is a bill pending in Congress that would allow seniors to sell their life insurance policies and take the proceeds from the sale tax free if they were to roll the proceeds into what's called a senior health planning account that would be similar to a health savings account or other flexible spending account (FSAs) where you can defer taxes paid by dedicating the money into that account as long as they are used for qualified medical expenses. If you think about it, every other American and age group is incentivized to invest in healthcare except seniors who are the most expensive group of healthcare recipients in the U.S. So, they don't have any way to invest or plan for or pay for their costs of healthcare in a way that all other Americans can. The bill has bipartisan support and needs further vetting but it is an idea that is consistent with existing public policy at the federal level that allows for people who are dying to sell their policies tax free.

The bill is for people who don't have to be at that stage in life where they are diagnosed as terminally or chronically ill but who can sell their policy but dedicate those resources for long term care and get the tax free benefits of that transaction so it is very consistent with existent public policy. That is a sign that this market is becoming more and more accepted by public policymakers. NCOIL has led the way in this effort to put regulations in place and give the market the structure it needed to the point where now there are potential tax advantages to policy owners that are being considered in Congress on a bi-partisan basis. It is a long journey.

Sen. Bob Hackett (OH) stated that he appreciates all of the work that has been done to put regulations in place and noted that 15-20 years ago there were hundreds of complaints about life settlements in Ohio. Regulation was needed because it was like the Wild West. People needed to realize that the brokers were in between the people buying the policy and the people selling the policy and the commissions made were unbelievably high. There is a principle of follow the money and it was said that there was money there. It was said in Ohio that either the policyowner or investor was going to be disadvantaged until regulations were put in place.

Sen. Hackett stated that one of the problems that the life insurance industry has been experiencing for several years is that when universal life was sold years ago interest rates were so much higher and these policies are really going to blow up much earlier. Sen. Hackett asked if the life settlement industry is staying away from those policies because they are to expensive to keep in force. Sen. Hackett further stated that a problem is that you cannot really lower the death benefit too much in these policies due to existing regulations.

Mr. Freedman stated that is an interesting question because everything described by Sen. Hackett is why people are dropping their universal life insurance policies at a high rate, especially in older age when their premiums are doubling every year and the cash value is being depleted. Everything described by Sen. Hackett regarding interest rates being historically low is a consumer problem and it is also from a life settlement standpoint an investor in life settlement problem because what carriers are doing to address this in many instances is raising the cost of insurance (COI) which is within the rights of the policy and is contractually provided for but when those COI increases offset the costs inside the policy to the insurer and are passed onto the policyowner that is causing them to terminate their policies it also makes those policies less attractive to the life settlement market. It is a challenge for the life settlement industry in trying to help policyowners get the value if the life insurance company were to raise the premium to recoup their costs over those years and it hurts the consumers by not being able to keep their policy and not being able to sell it.

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 at McKinsey & Company, stated that she would like to spend some time discussing the impact of COVID-19 on life insurance and what some of the key trends are in talking to carriers across the country. The presentation will discuss: the impact of COVID-19 on life insurance in terms of broad trends; acceleration in digital and analytics; in such a record low interest rate environment, product innovation and what we can learn from Japan and Germany and elsewhere on capital light product innovation which we are likely to see a lot more of in this market; and in-force actions which we have seen over the years throughout the world but we will probably start to see more in the U.S..

If you index all the way back to the end of 2019 across all industries it is worth noting that insurance in particular has been impacted from an equity markets perspective much more than many other industries. Impacted more than insurance have been the travel and logistics industries as no one is staying at hotels and nobody flying; banking which has equally been hit with low interest rates and likely some of the small business and other failures in the market; and oil and gas which had a record drop in the price of oil globally. Those industries certainly have been hit harder than insurance but insurance overall has been harder than the overall world average and quite a bit harder than technology and pharma which for reasons related to COVID have been doing reasonably well.

There are a number of trends very specific to insurance disruptions that we are seeing. There have been operational disruptions – for the P&C industry there have been questions around what is covered in business interruption – and closer to home in life insurance there have been challenges in reduced appetite for higher value policies certainly in the term life side and for older policyholders. There has been a challenge of in-force blood draws and a highly paper based underwriting and application process. There have also been hundreds of thousands of call center representatives who have went home and we are also seeing much more higher cyber risk exposure than before and a lot more exploration of that area.

There have also been pricing, product and balance sheet challenges that insurers have faced. Low interest rates have been at a level that most carriers have never seen, certainly not in the U.S. P&C carriers have seen a lot fewer miles driven but certainly some back and forth in consumer pressure to give back some of those premiums. In the life insurance space we are seeing a lot more pressure on in force blocks and what to do with them as sources of value and revenue and funding are scarce. There are also broader balance sheet challenges as we see a bit more on the credit migration side and a risk of broader instability in the financial markets

linked to some of the variable annuity risk which we have seen over the years but is certainly present here as well. So, there have been a lots of operational and product pricing challenges.

In responding to those challenges there are seven broad trends that we have seen insurers react to or accelerate as they try to address some of those challenges. The first three are digital and analytics, innovate the product portfolio, and make in force management a strategic priority. The others include getting serious on cost as life insurers compared to many other industries like telecom have not really improved their cost structure much and when they do it often doesn't stick. Ms. Ellingrud said she is seeing across the industry a much stronger focus on improving expense ratios overall and trying to make some of that stick not necessarily to take it out and keep the cost structure low forever but to invest in digital and analytics efforts and find some of the growth initiatives that they are looking to have. In terms of exploiting strength, a lot of carriers are looking to M&A not just within insurance as there is certainly a bit of a look at smaller carriers with maybe less capital and comfortable carriers in terms of potential acquisitions at pretty attractive multiples. There is also a look at fintechs where they might have been partnering before but now some of them are struggling on both the revenue and funding side to do as well – there are some opportunistic views in the M&A space as well.

There is also an effort to upgrade talent and shift ways of working. Some of that is inevitable as almost all insurance carrier employees have gone home and are working remotely. This is a window of opportunity for carriers to re-think their operating model and how they work. A real thought of how to work in the future and how life claims will be handled how underwriting will be handled and how we avoid shifting employees from one situation and then shifting them again so we can look where the puck is going and shape some of that strategically in where we want it to go and in parallel shift the ways of working and upgrade talent as needed.

There have been a lot of smaller pilots in terms of re-skilling. Some carriers are taking call center representatives and shifting them over time to do very simple entry level IT training. We have also seen some financial reporting folks being trained to do entry level analytics. Most of those re-skilling efforts are on the pretty small scale so far and making that at scale to the hundreds is what we are starting to see carriers plan for as we shift to new ways of working. Finally, we have seen a pretty steady shift from a number of carriers to shifting to more fee-based earnings. We have seen this in Ameriprise over the decades but others as well and we will likely see the continuation of this as capital heavy products get less attractive in this interest rate environment and fee based earnings become a bit more attractive certainly from the valuation and equity markets valuation perspective but more broadly to balance the portfolio.

With regard to acceleration in digital and analytics, there have been three broad shifts. All life insurance executives that Ms. Ellingurd has spoken to have noted the really rapid acceleration of digital and analytics. Some of them have opted into that and really welcomed it in terms of more straight through processing and more online and automated underwriting. Others have felt like they had to jump into it for lack of any alternatives. By and large, the general consensus is that five or more years of progress has been made in the past six months since COVID started. Some of that is because policyholders who might not have opted in to self serve capabilities before and would have rather met with their agent in person are now forced into new channels and some of that is consumer and policyholder driven, some of that is agent driven and some of that is just the environment but carriers have been able to take advantage of that to further accelerate some of those shifts when they have wanted to.

The accelerated shift to digital is certainly a big trend and in that context we are seeing a lot more advanced analytics as well to identify needs to better match those needs with agents and to do better accelerated underwriting with less data for example. To support that, we have also

seen a shift in technology to more services in the cloud and more efficient technology use overall. McKinsey conducted a survey over the past few months with over 600 different agents in the U.S. and they were asked a number of questions. One was "what has been the biggest challenges working with customers during the COVID-19 pandemic?" Over half of them ranked building initial client relationships remotely as their number one challenge; second was generating leads.

Another question was "what portion of your time do you spend on the following activities in a typical week?" Pre-COVID responses were compared to post-COVID responses and by and large it is about equal with a pretty glaring exception of customers facing sales time. About 25% of time before COVID was spent with customers and now it is only about 16% of the time and you can imagine that is a more digital engagement model as some agents are piloting how to do a dinner conference call with a couple to talk through their financial situation and find their life insurance needs. Some are really liking that as they don't have to pay for dinner anymore and it is easier to get their undivided attention and some are finding the new lead generation easier but the vast majority of agents are finding it quite a bit harder.

Another question was "what can carriers do to best help you through this crisis?" About one in three said they need carriers to really provide more lead generation support and one in five said they need more digital tools and more self-service capabilities. So, there has been a real acceleration in e-signatures as well as better data to underwrite without in-person blood draws.

McKinsey also conducted a broad survey of over 1,000 companies with more than $1 billion in revenue and looked at those that really captured true at-scale value from analytics. Every company these days is doing analytics in some pocket of the organization but only about one in ten companies are truly capturing full at-scale value from analytics. The survey looked at what those companies are doing disproportionately compared to other companies. Those companies are twice as likely to use agile teams and cross-functional collaboration; 2.5 times more likely to have clear decision making rights and accountabilities; 1.5 times more likely to actually refine that as they put that in place more explicitly; 2.5 times more likely to invest deeply in analytics talent, especially in the analytics translator role which can take a business problem and the analytics science behind that and translate the two to speak the same language on both sides and connect those dots; and 4 times more likely to devote more analytics resources and dollars to last mile conversion. What we often find is that companies are creating really effective models especially with machine learning and other advanced analytics capabilities these days and the real difference in those that capture significant value is that last mile translation – how are you making that black box of analytics insights transparent and clear to the agent so that they can act on the next best conversation to have or next best step to take?

In terms of IT backbone and making IT both more flexible and more efficient we are seeing a number of trends – some of the same trends we have seen in terms of being dynamic, transparent and cross functions structure; more agile teams; a really strong backbone with cloud; and a really clear roadmap which applies to IT and equally to agility and analytics. The companies that have, for example, a clear analytics roadmap on the use cases that are going to drive the most business value and also where replicating those use cases for a different part of the business is going to give us additional impact. Those roadmaps are much more effective than the bottom up method of a thousand flowers bloom and having each different business unit innovate in its own way.

The second area that is thought to really accelerate, especially in the U.S. with low interest rates, is product innovation. A few overall trends have been seen. We have seen carriers, even if you ignore for a moment the low interest rate environment, in periods of high market volatility

there is much more market share gain and loss across the industry than typical. Even in a normal interest rate environment, we would expect a lot more market share shifts right now and over the next couple of years than typical. When you add to that a very low interest rate environment carriers are going to be looking hard under every single rock for potential sources of value. As we look globally for examples, Japan has had a low interest rate for decades and Germany for over a decade – they are innovating with capital light projects with fewer guarantees and that is a trend we are going to see deeply in the U.S. market as well. It is thought that lessons in agile product development can apply there thought in product innovation.

What we have seen in Japan is a very interesting separation of value from the 10 year indexed line and the life insurance index. They have been able to maintain and in some cases grow the value within life insurance despite lower bond yields and lower interest rates. The same thing is seen in Germany and Europe more broadly. A lot of that is driven by Allianz in a particular case in Germany but there are broader European trends as well. In the German market in particular, over the course of five years from 2013-2018, there was a really rapid shift to capital light products and unit linked hybrid products with a different type of guarantee and what we would call as a class capital efficient products. Proportionately, the traditional products have lessened their market share. Disability insurance in particular was growing at about 8% per year in the German market. Allianz has been a market leader in Germany for a long time but they have been really innovating in capital light products.

As we back up and look across carriers, 82% of senior leaders believe that product development is a core competency that they need. 25% of them don't really have a defined product development strategy. 12% of them actually thought that they did have a process that produced strong product innovation. So, it is a critical need and there is a gap more broadly and often times you will see carriers lump in product repricing with real de novo innovation so it might take them 6-9 months to reprice a UL policy while digging into underlying client needs and innovating in this new environment is put into the same team and unfortunately often times repricing of the UL policy will crowd out all of the other activity to do full scale de novo innovation and that is the challenge we are seeing in many of these product innovation teams.

The last trend to discuss is in force. Such blocks have been looked at for awhile partially as a potential source of a large reserve release but we have seen in the U.S. much less action than in the UK where there has been a lot of migration of closed blocks. There is typically on average simpler policies in many other markets but in the U.S. there hasn't been as much movement as expected over the last five to ten years on in force management. There are a lot of reasons why and one of them is that nobody typically owns it as much as they own the channel and the business and the growth side of things and the cross functional collaboration required to pull it off can be quite challenging. There is also a risk of backlash from customers so while many are closed blocks where you are not actively selling those policies, if they feel they are dealing with a different company that could be a frustrating customer policyholder experience. There is a lot to sort through and it can be highly technical so it is not necessarily the first thing carriers want to do dive into and terms and conditions can be set 50 years ago when the policies were first sold on that block so there are some really legal and other constraints that are important to keep in mind.

As we look at this, there are three broad buckets of levers that we have seen some cutting edge carries use as they look at in force management. The first would be transactional levers – do I want to change my reinsurance on this block? Do I want to sell this set of closed blocks completely? Above and beyond the deal value that you might get on a transactional lever, technical levels are an additional 20% of value and operational levers can actually be another 30-40% of that value. Technical levers would be things like capital and tax management,

reinsurance optimization, hedging, and better pricing. Operational levers would be expensive optimization, understanding the full life cycle of those customers, outsourcing certain pockets, data driven claims management, segmented service models and optimizing commissions. Overall, that can collectively add another 40-50% on the overall transaction lever. Typically, you would do this block by block as you look across the in force management blocks you are looking to optimize.

Ms. Ellingrud then discussed a map that some carriers have used to determine where they want to shift each block. On the X axis, operationally, you have keep as-is in the middle and options include wanting to insource more of the work and do it more yourself or outsource it. On the Y axis there is your balance sheet exposure and the appetite from a balance sheet perspective. Keeping as-is would be more of a operational light owner but you could also increase balance sheet exposure as a consolidation consortium for example or you could reduce it if you wanted to fully exit or insource and be more of a broad service provider. So, there are different actions or movements to take and you wouldn't have to do it across the entire portfolio – you could choose block by block and depending on the runoff, capital usage and profile of the block different decisions could be made.

Sen. Hackett stated that Mr. Freedman spoke about the in force business of universal life and the ability now that some Commissioners are taking to allow increases in COI. Sen. Hackett asked Ms. Ellingurd her thoughts on that. Ms. Ellingrud stated that she would separate the in force and often times closed blocks that are no longer being sold with how you are pricing new insurance and new business. Across the new business continuum there is term insurance on the one side and permanent insurance of which universal life and whole life and variable universal life are all different types of it. If you want the most cost competitive coverage, term insurance is certainly the way to go. Many are actually selling that at a below profit level. Life insurance as a whole really is not making much money at all and in fact it barely makes its cost of capital from year to year. So if you step back from the industry, overall pricing is about as low as it can go on some of those products. On universal life that may not be the case but on other product categories term life is a highly transparent and cost competitive market.

Sen. Hackett asked if that is the result of historically low interest rates. Ms. Ellingrud replied yes and stated it is a real challenge. As you look at life insurers contrasted with P&C insurers, they are holding policies on books for decades and they have to make that guarantee over that long period of time but if 10 years treasuries are at record lows you don't have the ability to do that and so where do you look for a lower risk return? It is a real challenge and that is why many carriers now are looking to lower capital usage products as discussed earlier and looking to cut costs wherever they can whether that is better managing in force books or selling closed books or reducing costs structure overall but it is a really challenging time as you look ahead with low interest rates and a lot of long duration commitments to policyholders. Interestingly, it is a challenging time during what was already a challenging industry. Even if you rewind a couple of years, the long term profitability over the cost of capital in life insurance was already about 0-1% and now you add to that really low interest rates and it is even more challenging so it is a particularly tough time for life carriers.

Rep. Fischer asked if an example could be provided of the movement from capital inefficient products to capital efficient products. Ms. Ellingurd stated that capital heavy products are traditional life insurance products with a guarantee where you have to keep a lot of that capital to be able to pay out the death benefit whenever that might happen. Term life, whole life, and universal life are all examples of capital heavy products. A capital light product would be some of the products for example in Japan – very targeted insurance like cancer insurance and pet insurance. There are other policies that are capital light and also there has been a broader shift

towards fee-based products. More on the wealth and investment side you start to see a lot of fee-based revenue there and there you don't have to hold any capital against somebody's investment portfolio and that is very capital light and capital efficient.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Rep. Lehman, the Committee adjourned at 11:00 a.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUSINESS PLANNING COMMITTEE AND EXECUTIVE COMMITTEE
ALEXANDRIA, VIRGINIA
SEPTEMBER 26, 2020
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning Committee and Executive Committee met at the Hilton Alexandria Old Town Hotel on Saturday, September 26, 2020 at 1:00 P.M. (EST)

Representative Matt Lehman of Indiana, NCOIL President and Chair of the Committees, presided.

Other members of the Committee present were (*indicates virtual attendance via Zoom):

Rep. Deborah Ferguson (AR)*
Asm. Ken Cooley (CA)*
Rep. Joe Fischer (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)*
Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)
Sen. Jim Seward (NY)*
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Michael Webber (MI)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel

QUORUM

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

MINUTES

Upon a motion made by Sen. Jim Seward (NY) and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted without objection by way of a voice vote to approve the minutes from the Committee's March 8, 2020 and July 1, 2020 meetings.

UPDATE ON DECEMBER ANNUAL MEETING IN TAMPA, FL

Commissioner Tom Considine, NCOIL CEO, stated that as we sit here today, we plan on going forward with the Annual Meeting in Tampa, FL. However, there is a hiccup as Florida has not paid NCOIL dues so the NCOIL Officers have instructed NCOIL staff to contact Marriott to see if the meeting could be moved to another Marriott location in a NCOIL Contributing Member state. Nonetheless, there remains optimism that Florida will pay its dues by the time of the Meeting.

The Annual meeting will also be the last NCOIL Annual Meeting in December, hopefully permanently as we have gone back to get NCOIL's traditional November dates and the National Association of Insurance Commissioner (NAIC) has been made aware of that.

2023 NCOIL SPRING MEETING LOCATION

Cmsr. Considine stated that at a prior NCOIL Executive Committee meeting, the location was focused on San Diego and the focus remains there. Oddly enough, there has been some trouble zeroing in on a hotel partly because of some government rate issues but there are three different options where progress can be made between the Gaslight district and the bay. Accordingly, the meeting will be in San Diego and the specific hotel will be decided soon.

ADMINISTRATION

Cmsr. Considine stated that there were 219 registrants for the Summer Meeting; 91 in-person, 128 virtual. There were 30 legislators from 16 states; 25 of which were in person. There was one first time legislator. Five Insurance Commissioners (or equivalent) participated, and 9 insurance departments were present.

Cmsr. Considine thanked everyone for all of their work and for participating. NCOIL was very forward-leaning in deciding to go forward with the hybrid meeting and that also required a lot of courage for all of the participants who came in person. Equally important were the people who attended via Zoom. Cmsr. Considine also thanked all NCOIL staff for all of their hard work.

Rep. Lehman thanked the hotel audio visual staff for making the hybrid meeting possible as they did a great job.

Cmsr. Considine stated that the 2020 unaudited financial report through August 31, 2020 show revenue of $1,021,853.51 and expenses of $651,785.96 for an excess of $370,067.55. All things considered, NCOIL is having a good year.

CONSIDERATION OF AUDIT

Asm. Ken Cooley (CA), NCOIL Vice President and Chair of the NCOIL Audit Committee (Committee), stated that the NCOIL audit was again performed by Jim Cunningham at Collins and Company. He went through NCOIL's financial statements and the ILF's financial statements. All was in order and it met current standards. It was noted that next year's audit will likely reveal some effects caused by COVID but it is not possible to predict what they will be now. Everything tracked properly and the Committee approved the audits.

Rep. Lehman stated that there was a positive change in net assets from last year of $95,115. That amount would have been $30,000 higher but a change was made in the middle of last year to shift administration expenses being borne by the ILF over to NCOIL to accurately reflect each organization's responsibilities.

Upon a Motion made by Rep. Joe Fischer (KY), NCOIL Secretary, and seconded by Sen. Bob Hackett (OH), the Committee voted to accept the administration report without objection by way of a voice vote.

Upon a Motion made by Sen. Jim Seward (NY) and seconded by Rep. Bart Rowland (KY), the Committee voted to adopt the audits without objection by way of a voice vote.

CONSENT CALENDAR

Rep. Lehman noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers in the time between Executive Committee meetings.

The Property & Casualty Insurance Committee re-adopted: a.) Post Assessment Property and Liability Insurance Guaranty Association Model; b.) Model Act Regarding Medicaid Interception of Insurance Payments; c.) Storm Chaser Consumer Protection Act; d.) Model Act Regarding Use of Credit Information in Personal Insurance; and e.) Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers.

The Special Committee on Natural Disaster Recovery adopted the NCOIL Private Primary Residential Flood Insurance Model Act.

The Financial Services & Multi-Lines Issues Committee adopted the NCOIL Model Act Concerning Statutory Thresholds for Settlements Involving Minors.

The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Short Term Limited Duration Insurance Model Act.

Rep. Lehman asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a Motion made by Rep. Rowland and seconded by Asm. Cooley the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Rep. Lehman thanked Virginia Insurance Commissioner Scott White for his remarks at the Welcome Breakfast.

Steve Livengood – Director of Public Programs and Chief Guide at the Capitol Historical Society – also delivered great remarks at the Welcome Breakfast.

Frank Donnatelli – who served in various positions in the Reagan administration including Assistant to the President for Political and Intergovernmental Affairs Deputy Assistant to the President for Public Liaison – delivered a great Keynote address during the luncheon.

Rep. Lehman thanked The Hon. Nicole Nason, Administrator of the Federal Highway Administration. After hearing her remarks, Rep. Lehman stated that he will never text while driving again.

Rep. Lehman thanked Robin Chase, the former CEO and co-founder of Buzzcar and Zipcar, who delivered a fascinating presentation on the current state and future of the transportation industry.

There were two interesting and timely general sessions: “COVID-19: Testing, Treatment, and Vaccination”; and “Future Pandemics: Approaches to Dealing with Business Interruption.”

OTHER BUSINESS

Rep. Lehman asked for a Motion to add Michigan Representative Michael Webber to the Executive Committee. Upon a Motion made by Rep. Rowland and seconded by Sen. Seward, the Committee voted without objection by way of a voice vote to do so.

Rep. Lehman asked Russell Harper, IEC Chair, if there were any recommendations by the IEC for topics that NCOIL should discuss at future meetings. Mr. Harper replied not at this time.

Rep. Lehman then announced that NCOIL will start the development of model legislation focused on business liability protections. Rep. Lehman stated that in this time of COVID-19, business liability protection has been one of the most frequently discussed issues and Rep. Lehman stated that he believes it is a good issue for NCOIL to take action on.

Rep. Lehman stated that the Property & Casualty Insurance Committee is the best place for this discussion to take place and in his discussions with the Committee Chair, Rep. Rowland, he is fully supportive and willing to sponsor the model legislation with Rep. Lehman serving as co-sponsor.

Rep. Rowland stated that this issue is very timely and one that NCOIL should consider. By the time 2021 starts, many states will be looking at legislation on this issue and some states have already passed such legislation. Some of the existing legislation is very short and concise and is sometimes less than one page. Rep. Rowland suggested perhaps having an interim meeting of the P&C Committee so that a model could be ready for adoption by December. Rep. Rowland thanked Rep. Lehman for co-sponsoring the Model.

Rep. Lehman stated that it might be a good idea to have an interim meeting as many states will be looking to adopt this type of legislation in 2021.

Rep. Lehman thanked NCOIL staff for all of their work since the Spring meeting as the organization had to navigate through some unprecedented times.

Cmsr. Considine stated that more than ever, the meeting surveys are very important given the unique nature of the meeting. Accordingly, Cmsr. Considine encouraged everyone to complete and submit a survey as there is now an electronic option for Zoom participants. This is also important because it is likely that the December meeting will be a hybrid format as well although there are no plans to make Zoom participation a regular option in all future meetings.

ADJOURNMENT

Upon a Motion made by Asm. Cooley and seconded by Sen. Seward, the Committee adjourned at 1:30 p.m.

The material below was either developed by NCOIL staff or submitted to NCOIL staff for consideration by the NCOIL Special Committee on Race in Insurance Underwriting.

The Committee welcomes and encourages additional submissions regarding both of its charges.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY/CASUALTY INSURANCE MODERNIZATION ACT

Adopted by the NCOIL Executive Committee on July 13, 2001.
Amended by the NCOIL Executive Committee on November 16, 2001, and March 1, 2002.
Reviewed and amended by the NCOIL Executive Committee on November 21, 2003.
Readopted by the NCOIL Executive Committee on July 22, 2006.
Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018

The amendments to this Model represent the NCOIL Staff Draft Strawman Proposed Language Defining Proxy Discrimination. It is intended as a discussion document. Proposed amendments are indicated in red font.*

Summary

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

Section 1. {Short Title}

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

Section 2. {Legislative Declaration}

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

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

B. To promote price competition among insurers

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

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

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

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

G. To prevent unfair discrimination, including proxy discrimination.

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

Section 3. {Definitions}

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

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

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

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

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

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

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

H. For the purpose of this Act, “Experience rating” means a rating procedure utilizing past insurance experience of the individual policyholder to forecast future losses by measuring the policyholder’s loss experience against the loss experience of

policyholders in the same classification to produce a prospective premium credit, debit, or unity modification.

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

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

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

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

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

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

M. For the purpose of this Act, “Non-competitive market” means a market, which is subject to a ruling pursuant to Section 5 that a reasonable degree of competition does not exist, and, for the purposes of this Act, residual markets, and pools are non-competitive markets.

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

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

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

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

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

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

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

~~T~~U. For the purpose of this Act, "Supplementary rate information" means any manual or plan of rates, classification, rating schedule, minimum premium, policy fee, rating rule, and any other similar information needed to determine an applicable rate in effect or to be in effect.

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

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

Section 4. {Scope}

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

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

1. Life insurance
2. Annuities
3. Accident and health insurance

4. Ocean marine insurance
5. Aircraft liability and aircraft hull insurance
6. Reinsurance
7. Surplus Lines
8. Workers Compensation Insurance

Section 5. {Competitive Market}

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

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

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

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

Section 6. {Rating Standards and Methods}

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

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

Drafting Note: Reflecting the well-accepted economic principle that costs and prices are driven downward by competition, insurance laws in seventeen (17) states do not allow a finding of

excessiveness in a competitive market. Those seventeen (17) states are: Arkansas, Connecticut, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Michigan, Missouri, Montana, Nevada, Oklahoma, Oregon, Vermont, Virginia, and Wyoming. Insurance laws in five (5) other states say that rates are "presumed" not to be excessive if there is a reasonable degree of competition. Those five (5) states are: Arizona, Kansas, Minnesota, New Mexico, and Wisconsin.

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

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

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

3. a. For the purpose of this Act, "Unfairly discriminatory" refers ***either*** to rates that cannot be actuarially justified***, or to rates that can be actuarially justified but are based on proxy discrimination.*** It does not refer to rates that produce differences in premiums for policyholders with like loss exposures, so long as the rate reflects such differences with reasonable accuracy. A rate is not unfairly discriminatory if it averages broadly among persons insured under a group, franchise or blanket policy, or a mass marketing plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Filings in Non-Competitive Markets.

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

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

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

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

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

Section 9. (Disapproval of Rates)

A. Bases for Disapproval

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

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

B. Procedures for Disapproval

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

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

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

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

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

Section 10. {Large Commercial Policyholder}

A. A policy of insurance sold to a "Large Commercial Policyholder," as defined in Section 3(J), shall not be subject to the requirements of this chapter, including but not limited to, Sections 5, 6, 7, 8, and 9. The forms and endorsements for any policy sold to a "Large Commercial Policyholder" shall not be subject to filing and approval requirements of (reference form filing and approval provisions plus other applicable provisions).

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

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

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

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

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

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

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

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

B. Regulation

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

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

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

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

Section 13. {Assigned Risks}

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

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

Section 14. {Examinations}

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

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

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

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

Section 15. {Exemptions}

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

Section 16. {Consumer Information}

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

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

Section 17. {Dividends}

Nothing in this Act shall be construed to prohibit or regulate the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers. A plan for the payment of dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members, or subscribers shall not be deemed a rating plan or system.

Section 18. {Penalties}

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

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

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

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

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

Section 19. {Judicial Review}

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

Section 20. {Notice and Hearing}

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

Section 21. {Severability}

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

Section 22. {Effective Date}

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

NAMIC
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NAMIC Statement in Support of NCOIL Race and Insurance Committee and Risk-Based Pricing in Insurance

The National Association of Mutual Insurance Companies(*1) is committed to continued participation in the ongoing dialogue among stakeholders to identify joint paths forward to ensure fairness and equity in property/casualty insurance. NAMIC and our member companies have a long and storied history of commitment to our policyholders and the communities they serve. Key to the success and survival of any insurer is a sound understanding of the responsibilities that accompany the promises made in policies: fair treatment and payment of covered claims when they come due. These things can only be accomplished when insurers are free to adequately spread their risk among policyholders.

In 2020, the United States has faced a unique and vast set of challenges. The economic strife resulting from well-intentioned pandemic response efforts by every level of government have amplified an even broader and fundamental conversation centered on our nation's continued journey to identify and eliminate racism. Racism has no place in today's world, and its elimination improves every aspect of our relationships, institutions and business communities. NAMIC stands with our fellow Americans against injustice and racism, and we commit to pooling our creativity and ingenuity to promote justice and equality under the law. To that end, we commend NCOIL for taking the initiative to develop a race and insurance committee to hold policymakers, regulators, and the entirety of the broader insurance community accountable for these efforts.

At NAMIC, we believe that at its very core insurance underwriting is a system predicated on and sustained by fair and equal treatment. A level playing field is achieved through applying equal, objective standards of risk assessment to everyone and it is still the best and only way to ensure that risk is spread appropriately and fairly across a book of business.

NCOIL's commitment to remaining data driven over the course of this initiative is a wise approach to these complex issues, as only through the data can we together be assured of the truth that property/casualty insurance does not contemplate an individual's race when assessing risk. A further commitment to risk-based pricing encourages the use of variables that make the most honest attempt by an insurance company to accurately measure the risk being purchased. We are confident that the data before NCOIL will continue to show the predictive value of these racially neutral factors as well as the inherent fairness to all policyholders in assessment based on risk presented.

To the extent that any conversations before NCOIL encourage drawing conclusions divorced from data or promote the use of new causation-based standards not contemplated by law, NAMIC issues strong caution and deep concern. A history of DUI does not cause a future loss or

crash, but it certainly highly correlates to the likelihood of a future loss. Parking a car on the street rather than in a garage does not cause it to be stolen, but it correlates to the likelihood of a future theft. On the homeowner's insurance front, the presence of a wood burning stove does not cause a future loss due to fire, but it highly correlates. Note that correlation also works in the opposite direction as a mitigation technique – a smoke detector or fire alarm system in a home does not prevent a future loss from a fire, but it makes it significantly less likely and less severe. A causation requirement is not only impractical and inconsistent with current law, but impossible to implement with certainty.

Mutual insurance companies are built on the notions of community and inclusivity; the mutual model has a long and proud history of service to minority communities. NAMIC and NAMIC's members are adamantly opposed to discrimination on the basis of race and any other form of unfair discrimination, and we support legislative and regulatory policies to prevent these practices.

Beyond that, our industry has an obligation to not just stand back and watch, but to lead the way by creating diverse, inclusive, and equitable workplaces – and many of our members are already tackling the issue head-on. An industry-wide effort is critical, and therefore we believe a good place to start is to understand the initiatives that are currently being pursued by insurers in the diversity and inclusion space. As of this writing,
our member companies are approaching these issues in myriad ways as part of a broad and wholistic effort.

Examples of just a few of the initiatives our members are undertaking in this space include:

- Signing on to the CEO ACT!ON pledge(*2) for diversity and inclusion
- Increasing efforts to recruit new associates from historically black colleges
- Establishing strategic partnerships with minority focused professional associations
- Establishing strategic partnerships with minority focused non-profits to promote grant, scholarship, and employee volunteer opportunities
- Establishing supplier diversity programs to provide opportunities for minority vendors
- Creating and promoting Employee Resource Groups (ERG's) to bring together employees of shared backgrounds for mentoring and development programs
- Providing financial literacy workshops in minority communities
- Purchasing and distributing diversity and inclusion training videos for associates
- Creating multicultural market strategy teams to focus on improving access to financial products
- Creating new feedback mechanisms to better assess existing diversity and inclusion efforts
- Signing on to the Credit Union DEI Collective Statement of Commitment and Solidarity with the African American and Black Community (*3)

NAMIC looks forward to NCOIL's forthcoming hearing on race and insurance as an opportunity to collectively reflect on the absolutely critical nature of risk-based pricing and its importance to ensure fairness and equity. Additionally, we hope to engage with legislators in identifying ways

in which the industry may play a role in fighting racial disparity in the United States. In addition to the above strategies already deployed by our
members, NAMIC seeks to discuss perhaps the greatest antidote to inequity in America: access.

Access to wide ranging, highly competitive, and affordable insurance is essential to American families and their financial success. Additionally, access to careers and education around the myriad opportunities to make a living in the insurance sector enrich underserved communities and the talent pipeline for the entire industry. Those goals are only achieved by thriving insurance markets, made stronger by accurate risk assessment, disbursement, and rating. NAMIC believes that the single greatest combatant the industry may deploy to fight racism is to be more accurate, more innovative, more competitive and thereby more beneficial to all consumers.

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(*1): The National Association of Mutual Insurance Companies is the largest property/casualty insurance trade group with a diverse membership of more than 1,400 local, regional, and national member companies, including seven of the top 10 property/casualty insurers in the United States. NAMIC members lead the personal lines sector representing 66 percent of the homeowner's insurance market and 53 percent of the auto market.

(*2): Pledge and list of signatories available at www.ceoaction.com/pledge

(*3): Statement and list of signatories available at www.cudeicollective.org/pledge

The definition of “proxy discrimination” listed below was submitted by Professor Daniel Schwarcz to the National Association of Insurance Commissioners (NAIC) during the NAIC’s deliberations regarding its Principles on Artificial Intelligence

Proxy discrimination occurs when insurers discriminate based on facially-neutral traits that (i) are correlated with membership in a protected groups, AND (ii) are predictive of losses for precisely that reason.

VIA ELECTRONIC MAIL

November 5, 2020

The Honorable Neil Breslin
c/o Mr. William Melofchik
General Counsel
NCOIL National Office
2317 Route 34 S, Suite 2B
Manasquan, New Jersey 08736

RE: The Role of "Proxy Theory" in the Unlawful Discrimination Landscape

Senator Breslin:

We write on behalf of the American Property Casualty Insurance Association (APCIA) as a follow-up to our October 22nd letter addressed to Mr. Tom Considine on the topic proxy discrimination. We understand the National Council of Insurance Legislators (NCOIL) is engaged in an effort to define that term and we hope what follows provides additional information that will be useful in the NCOIL effort.

Unlawful discrimination

"Unlawful discrimination" based on protected class characteristics has been the law for the 55 years since Congress enacted the Civil Rights Act in 1964. The definition of unlawful discrimination and the standard by which a defendant's policies or practices are judged have been worked out over that time largely in the employment context.[1] Regardless of context, the definition and the standard for imposing protected class liability on defendants have remained consistent. As for the business of insurance, statutory and regulatory rating standards universally prohibit rates that are "excessive, inadequate or unfairly discriminatory" and define "unfairly discriminatory" as treating policyholders or consumers with similar risk profiles differently. Most state insurance laws also make clear that failure to account for differences in expected losses constitutes prohibited "unfair discrimination."[2]

Protected class liability theories

There are various types of protected class liability theories. The two theories most applicable in the insurer/policyholder or consumer context are as follows:

1) *Intentional discrimination* in which "intent" is the sole focus and
2) *Disparate impact discrimination* where "intent" *plays no role at all*.

Disparate treatment discrimination, including proxy theory

Title VII of the Civil Rights Act of 1964 prohibits intentional discrimination and disparate treatment is a form of intentional discrimination.[3] In the insurer/policyholder or consumer context, disparate treatment occurs when a defendant insurer treats a policyholder or consumer less favorably than others *because of* the individual's membership in a protected class.[4] "Proxy theory" was adopted by the courts as an element of disparate treatment discrimination to recognize a policy should not be allowed to use a technically neutral classification as a proxy to evade Title VII's prohibition against intentional discrimination.[5] Because "intent" is a primary focus in disparate treatment cases, when relying on proxy theory, plaintiff must demonstrate that defendant *was motivated by a discriminatory purpose* in choosing the proxy about which plaintiff complains.[6]

As a form of intentional discrimination, disparate treatment challenges (including those that rely on proxy theory), ask one question – Has plaintiff put on sufficient evidence to establish that defendant either intended to discriminate against a protected class or was motivated by a discriminatory purpose in choosing the challenged proxy.[7] If the answer is "yes" then the challenged policy must be eliminated. Because defendant's bad act (either defendant's discriminatory intent or discriminatory motive in choosing the proxy) is an essential element of every disparate treatment challenge, plaintiff is entitled to equitable relief, attorneys fees, and monetary damages in the form of compensatory and punitive damages depending upon the underlying facts of the case.[8]

Disparate impact discrimination

Disparate impact discrimination did not exist until 1971 when the United States Supreme Court determined it constituted unlawful discrimination after which disparate impact discrimination became a basis for unlawful discrimination claims most frequently in the employment context.[9] Disparate impact discrimination was not codified into federal law until the Civil Rights Act of 1991 was enacted.[10] Disparate impact claims challenge practices that are not intended to discriminate, but in fact have a disproportionately adverse effect on a protected class and which are otherwise unjustified by a legitimate rationale.[11]

As a result, courts in disparate impact challenges ask a series of three questions consistent with the history of disparate impact jurisprudence in claims based on Title VII. They begin by asking: Does the challenged policy or practice have an adverse effect on a protected class? If the answer is "yes", then courts ask a second question: "Is there a valid interest served by the challenged policy?" And, if the answer is "yes", then the final question asked is whether there's an alternative policy or practice that serves the same valid interest with less disparate impact and less cost. If no such alternative policy exists, then the challenged policy stands, and the claim fails.[12] Because intent plays no role in disparate impact claims and proxy theory is associated exclusively with disparate

treatment discrimination, courts may award equitable relief and attorneys' fees to successful plaintiffs but not compensatory or punitive damages.[13]

Disparate Treatment Discrimination	Disparate Impact Discrimination
• Intent is the focus[14]	• Intent plays no role
• Proxy theory applies	• Proxy theory never applies
• A finding of intent (or discriminatory purpose in choosing the proxy) ends the inquiry	• A finding of adverse effect on a protected class does not end the inquiry • The inquiry continues with the question whether there is a valid interest served by the challenged policy or practice • The inquiry continues further with the question whether there is an equally effective alternative with less adverse effect on plaintiff and cost to defendant
• If the requisite intent or discriminatory purpose is found, depending upon the facts, plaintiff is entitled to – Equitable relief, – Attorneys' fees, – Compensatory damages and – Punitive damages	• If no valid interest exists or there is an equally effective alternative, the challenged policy or practice is enjoined and only attorneys' fees may be awarded • If a valid interest exits and there is no equally effective alternative, the challenged policy or practice stands, and the claim fails
• The goal is to eliminate the challenged policy or practice	• The goal is to mitigate the adverse effect of the challenged policy or practice where a valid interest is served

Summary

To define and apply "proxy theory" in the disparate impact context is to impose a legal concept on a body of law where it has been not applied to date either by the courts or legislatures.[xv] Doing so would unsettle the 55 years of jurisprudence and statutory law governing discrimination cases brought predominately under the Civil Rights Act, the Age Discrimination in Employment Act, the Rehabilitation Act, the Americans with Disabilities Act and the Fair Housing Act. Further, applying proxy theory to disparate impact claims is wholly inconsistent with the balancing of valid interests with equally effective alternatives and the mitigation goal of disparate impact jurisprudence generally.[xvi] Equally important is that application of proxy theory to disparate impact claims in the context of property and casualty insurance would conflict with current state law and regulations governing pricing and underwriting and would likely require an overhaul of both. This is true particularly as it relates to complying with state mandates prohibiting rates that are "excessive, inadequate or unfairly discriminatory".[xvii]

Proposed definition of the term "proxy" in the context of unlawful discrimination

A proxy is a policy, practice, factor, or equivalent that is technically neutral, but is otherwise used to evade statutory prohibitions against intentional discrimination regarding individuals or prohibitions against disparate treatment regarding a category of individuals because of their membership in a protected class. Unlawful discrimination by way of proxy (as defined herein) arises when a challenged policy, practice, factor or equivalent is directed at a category of individuals predominately composed of individuals in a protected class for the purpose of excluding or otherwise depriving them of a benefit available to others or where such is a motivating factor in choosing the proxy.

[1] The law in the area of unlawful discrimination has developed primarily in the employment context, including litigation arising out of the Civil Rights Act (1964), the Age Discrimination in Employment Act (1967), the Rehabilitation Act (1973), and the Americans with Disabilities Act (1990). Albeit fewer, unlawful discrimination has been the subject of claims brought under the Fair Housing Act (1968). *See*, *Community Services, Inc. v. Wind Gap Municipal Authority*, 421 F3d 170 (3d Cir. 2005) (a disparate treatment case) and more recently in *Texas Department of Housing and Community Affairs, et al. v. The Inclusive Communities Project, Inc.*, 576 U.S. 519 (2015) (a disparate impact case).

[2] For example, Utah law provides that "[a] rate is unfairly discriminatory if price differentials fail to equitably reflect the differences in expected losses and expenses after allowing for practical limitations." UTAH CODE ANN. § 31A-19a-201(4)(a); *see also, e.g.*, ARIZ. REV. STAT. ANN. § 20-383(D); COLO. REV. STAT. § 10-4-403(1)(c); MICH. COMP. LAWS ANN. § 500.2403(1)(d); MINN. STAT. ANN. § 70A.04(4); MO. ANN. STAT. § 379.318(4); NEV. REV. STAT. ANN. § 686B.050(4); N.H. REV. STAT. ANN. § 412:15(I)(d); N.M. STAT. ANN. § 59A-17-6(E); N.C. GEN. STAT. ANN. § 58-40- 20(e); TENN. CODE ANN. § 56-5-103(a) and (d), among other states.

[3] *McWright v. Alexander*, 982 F.2d 222, 227-228 (7th Cir. 1992).

[4] *Ricci et al. v. DeStefano, et al*, 557 U.S. 557, 577 (2009) quoting *Watson v. Fort Worth Bank and Trust*, 487 U.S. 977, 986 (1988). See also, *Community Services, Inc. v. Wind Gap Municipal Authority*, 421 F.3d 170, 178 (3d Cir. 2005).

[5] *McWright*, 982 F.2d at 228. Affirmed in *Community Services*, 421 F.3d 170 (3d Cir. 2005) and *Bowers v. National Collegiate Athletic Association*, 563 F. Supp. 2d 508 (D.N.J. 2008).

[6] "A disparate-treatment plaintiff must establish that the defendant had a discriminatory intent or motive [for taking adverse action against plaintiff]". *Watson*, 487 U.S. at 986.

[7] *Community Services*, 421 F.3d at 177.

[8] U.S. Equal Employment Opportunity Commission, "Remedies for Employment Discrimination" at https://www.eeoc.gov/remedies-employment-discrimination as of November 3, 2020.

[9] *Griggs v. Duke Power Co*., 401 U.S. 424 (1971).

[10] *Ricci*, 557 U.S. at 578.

[11] *Inclusive Communities*, 576 U.S. at 524-525. See also *Rizzo*, 557 U.S. at 577. When reviewing disparate impact claims under the Fair Housing Act (FAA) and Fair Housing Act as Amended (FHAA), courts have borrowed from the framework of Title VII of the Civil Rights Act of 1964. See, e.g., *Tsombanidis v. W. Haven Fire Dep't*, 352 F.3d 565 (2d Cir.2003) and *Lapid–Laurel, L.L.C. v. Zoning Bd. of Adjustment*, 284 F.3d 442 (3d Cir.2002).

[12] See the burden-shifting framework in *Inclusive Communities*, 576 U.S. 519 (2015).

[13] *Supra*, endnote 8.

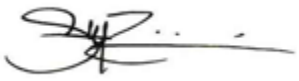
[14] In addition to intentional discrimination (including disparate treatment) and disparate impact discrimination, other discrimination claims in the Title VII context include pattern or practice, cat's paw, failure to accommodate, harassment, retaliation, and negligence. Except for disparate impact and negligence claims, all other listed claims require "intent" or discrimination as "a motivating factor".

[xv] This fact is acknowledged by advocates who argue in support of "making law" by applying proxy theory in the disparate impact context and, thereby, extending it beyond its long-standing and exclusive role in disparate treatment discrimination, a form of intentional discrimination . See, Anya E.R. Prince and Daniel Schwarcz, *Proxy Discrimination in the Age of Artificial Intelligence and Big Data*, 105 IOWA L. R. 1257, 1269-1270 (2020).

[xvi] *Supra*, endnotes 1 and 12.

[xvii] State insurance law affirmatively permits (and most require) risk-based pricing and underwriting in order to comply with the "excessive, inadequate, or unfairly discriminatory" rating standard. See examples, *supra*, endnote 2. As explained in the Casualty Actuarial Society Statement of Ratemaking Principles, "[a] rate is reasonable and not excessive, inadequate, or unfairly discriminatory if it is an actuarially sound estimate of the expected value of all future costs associated with an individual risk transfer." For purposes of state insurance law, rates are "unfairly discriminatory" if "premium differences . . . do not correspond to expected losses and average expenses or if there are expected average cost differences that are not reflected in the premium differences." *See*, Casualty Actuarial Society, *Statement of Principles Regarding Property and Casualty Insurance Ratemaking*, Principle 4 (May 1988), https://www.casact.org/professionalism/standards/princip/sppcrate.pdf.

Respectfully submitted,
AMERICAN PROPERTY CASUALTY INSURANCE ASSOCIATION



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