30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL SPRING MEETING
MARCH 3 - 6, 2022

As of March 1, 2022, and Subject to Change

Harrah's Las Vegas
Las Vegas, Nevada

NCOIL SPRING MEETING
Las Vegas, Nevada
March 3 - 6, 2022
TENTATIVE SCHEDULE

THURSDAY, MARCH 3RD

Welcome Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, MARCH 4TH

Registration *Exhibits Open: 9:00 a.m. – 5:00 p.m.*	7:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
Networking Break	9:45 a.m.	-	10:00 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	10:00 a.m.	-	11:15 a.m.
Workers' Compensation Insurance Committee	11:15 a.m.	-	12:30 p.m.
The Institutes Griffith Foundation Legislator Luncheon Inflation: Implications for Insurers and Public Policymakers	12:30 p.m.	-	1:30 p.m.
NCOIL – NAIC Dialogue	1:30 p.m.	-	2:45 p.m.
General Session The Search for a Successful Public Option	2:45 p.m.	-	4:15 p.m.

Networking Break	4:15 p.m.	-	4:30 p.m.
Life Insurance & Financial Planning Committee	4:30 p.m.	-	5:45 p.m.
Adjournment	5:45 p.m.		
IEC Board Meeting	5:45 p.m.	-	6:30 p.m.
CIP Member & Sponsor Reception	6:15 p.m.	-	7:15 p.m.

SATURDAY, MARCH 5TH

Registration *Exhibits Open: 8:00 a.m. – 3:00 p.m.*	8:00 a.m.	-	3:00 p.m.
Property & Casualty Insurance Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
General Session The Interrelationship Between Climate Change and Insurance	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address *The Honorable Aaron D. Ford* *Nevada Attorney General*	12:00 p.m.	-	1:30 p.m.

Note: There will be a room available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

Financial Services & Multi-Lines Issues Committee	1:30 p.m.	-	3:00 p.m.
Adjournment	3:00 p.m.		

SUNDAY, MARCH 6TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	10:00 a.m.
Health Insurance & Long Term Care Issues Committee	9:00 a.m.	-	10:30 a.m.
Executive Committee	10:30 a.m.	-	11:30 a.m.

******Please note all speakers listed are scheduled to speak as of February 23, 2022. There will be modifications between now and the start of the Meeting.******
******Note: There will be a room available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.******

Thursday, March 3rd, 2022

Welcome Reception
Thursday, March 3, 2022
6:00 p.m. – 7:00 p.m.

Friday, March 4th, 2022

Welcome Breakfast
Friday, March 4, 2022
8:15 a.m. – 9:45 a.m.

1.) Welcome to Las Vegas
2.) ***Hon. Tom Considine***
    -Introductory Comments from NCOIL CEO
3.) ***Asm. Ken Cooley (CA)***
    a.) President's Welcome
    b.) New Member Welcome and Introduction
4.) ***Will Melofchik – NCOIL General Counsel***
    -Agenda Overview
5.) ***Rep. Tom Oliverson, M.D. (TX) – NCOIL Treasurer***
    -"NCOIL Open" Planning
6.) Any Other Business
7.) Adjournment

Networking Break
Friday, March 4, 2022
9:45 a.m. – 10:00 a.m.

Joint State-Federal Relations & International Insurance Issues Committee
Friday, March 4, 2022
10:00 a.m. – 11:15 a.m.

Chair: Sen. Paul Utke (MN)
Vice Chair: Rep. Brenda Carter (MI)

1.) Call to Order/Roll Call/Approval of November 20, 2021 Committee Meeting Minutes
2.) Update and Discussion on Implementation of New Federal Balance Billing Law – The "No Surprises Act"
Loren Adler, Associate Director - USC-Brookings Schaeffer Initiative for Health Policy
3.) Presentation on Status and Future of Social Security System
Andrew Biggs, Ph.D., Senior Fellow – American Enterprise Institute
4.) Introduction and Discussion of Resolution Supporting Independent Contractor Status for Insurance Agents and Other Licensed Financial Professions
Asm. Ken Cooley (CA) – NCOIL President – Sponsor
Maeghan Gale, Policy Director, Government Relations – National Association of Insurance & Financial Advisors (NAIFA)
5.) Any Other Business
6.) Adjournment

Workers' Compensation Insurance Committee
Friday, March 4, 2022
11:15 a.m.- 12:30 p.m.

Chair: Sen. Bob Hackett (OH)
Vice Chair: Rep. Hank Zuber (MS)

1.) Call to Order/Roll Call/Approval of November 18, 2021 Committee Meeting Minutes
2.) Workers' Compensation in the Post-COVID Era
Matthew Zender, SVP, WC Strategy - Amtrust North America
Monica Verduzco-Gutierrez, M.D., Professor and Chair, Department of Rehabilitation Medicine - University of Texas Health Science Center at San Antonio
3.) Consideration of Re-adoption of Model State Structured Settlement Protection Act - Supported 2/27/94; 7/22/06; 7/17/11; 11/20/16; 7/15/21; 11/20/21
4.) Any Other Business
5.) Adjournment

The Institutes Griffith Foundation Legislator Luncheon
Friday, March 4, 2022
12:30 p.m. – 1:30 p.m.
Inflation: Implications for Insurers and Public Policymakers

Michael Leonard, Ph.D., CBE
Vice President & Senior Economist, Insurance Information Institute (III)
Adjunct Faculty, Columbia University, Department of Statistics & Data Science Institute;
Adjunct Faculty, New York University, Department of Economics

*****Open Only to Public Policymakers and Staff*****

NCOIL – NAIC Dialogue
Friday, March 4, 2022
1:30 p.m. – 2:45 p.m.

Chair: Asm. Kevin Cahill (NY) – NCOIL Vice President
Vice Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Treasurer

1.) Call to Order/Roll Call/Approval of November 19, 2021 Committee Meeting Minutes
2.) Update on State Adoption of Credit for Reinsurance Models
3.) Update on Race and Insurance Issues
    a.) NCOIL Activities
    b.) NAIC Special Committee on Race and Insurance
4.) Update on Enhanced Cash Surrender Value Endorsements and their Interaction with Standard Nonforfeiture Law
5.) Discussion on Draft Proposed Changes to NAIC Climate Risk Disclosure Survey and Preview of NCOIL Climate-Focused General Session
6.) Discussion on NAIC Long-Term Care Insurance Multi-State Rate Review Framework
7.) Any Other Business
8.) Adjournment

General Session
The Search for a Successful Public Option
Friday, March 4, 2022
2:45 p.m. – 4:15 p.m.

Moderator: Asw. Maggie Carlton (NV)

Sally Pipes
President & CEO
Thomas W. Smith Fellow in Health Care Policy
Pacific Research Institute

Adam Fox
Deputy Director
Colorado Consumer Health Initiative

Liz Hagan
Director of Policy Solutions
United States of Care

Amber Stidham
VP of Gov't Affairs
Henderson Chamber of Commerce

Networking Break
Friday, March 4, 2022
4:15 p.m. – 4:30 p.m.

Life Insurance & Financial Planning Committee
Friday, March 4, 2022
4:30 p.m. – 5:45 p.m.

Chair: Asw. Maggie Carlton (NV)
Vice Chair: Sen. Walter Michel (MS)

1.) Call to Order/Roll Call/Approval of November 19, 2021 Committee Meeting Minutes
2.) Introduction and Discussion of Draft Paid Family Medical Leave (PFML) Insurance Model Act Proposal
    Karen Melchert, American Council of Life Insurers (ACLI)
3.) Life Insurer Perspectives on COVID-19 Developments
    a.) COVID-19 Vaccine Legislation
        ACLI Representative
        John Haley, AVP, Gov't Affairs - Unum
    b.) Underwriting Experiences
        Neal Halder, AVP & Chief Underwriter, Individual Life New Business & Underwriting – Principal
4.) Update on Interstate Insurance Product Regulation Commission (IIPRC) Developments
    Rep. Matt Lehman (IN) – NCOIL Immediate Past President
    Karen Schutter, Executive Director – IIPRC
5.) Consideration of Re-adoption of Model Laws
    a.) Secondary Addressee Model - Originally Adopted 11/20/96; Readopted 7/12/01, 2/27/04, 7/22/06, 2/26/12, 3/4/17; Amended Version Adopted 7/15/17
    b.) Insurance Compliance Self-Privilege Model - Originally Adopted 3/1/98; Readopted 7/13/01, 2/27/04, 7/22/06, 2/26/12, 3/4/17
6.) Any Other Business
7.) Adjournment

IEC Board Meeting
Friday, March 4, 2022
5:45 p.m. – 6:30 p.m.

CIP Member & Sponsor Reception
Friday, March 4, 2022
6:15 p.m. – 7:15 p.m.

Saturday, March 5th, 2022

Property & Casualty Insurance Committee
Saturday, March 5, 2022
9:00 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of November 19, 2021 and February 11, 2022 Committee Meeting Minutes
2.) Telematics: Turning Mobility and Driver Data into Meaningful Behavioral Insights
   Megan Klein, Director, Actuarial and Data Governance – Arity
   Tony LaMarca, Director of Product, Insurance Solutions – Arity
3.) Discussion on Development of NCOIL Delivery Network Company (DNC) Model Act
   Marty Young, Co-founder and CEO – Buckle
   Joe Messina, Legal Director, Insurance Law & Legislation – Uber
   Frank O'Brien, VP, State Gov't Relations – American Property Casualty Insurance Association (APCIA)
   National Association of Mutual Insurance Companies (NAMIC) Representative
4.) Discussion on NCOIL Insurance Underwriting Transparency Model Act
   Rep. Matt Lehman (IN), NCOIL Immediate Past President – Sponsor
   Frank O'Brien, VP, State Gov't Relations – APCIA
   NAMIC Representative
   Karen Melchert, Regional VP, State Relations - ACLI
5.) Continued Discussion on State Efforts to Lower the Uninsured Motorist Population and NCOIL Fairness for Responsible Drivers Model Act
   Sen. Shawn Vedaa (ND) – Sponsor
   NAMIC Representative
6.) Any Other Business
7.) Adjournment

Networking Break
Saturday, March 5, 2022
10:30 a.m. – 10:45 a.m.

General Session
The Interrelationship Between Climate Change and Insurance
Saturday, March 5, 2022
10:45 a.m. – 12:00 p.m.

Moderator: Rep. Wendi Thomas (PA)

Sean Kevelighan
CEO
Insurance Information Institute (III)

Stefan Holzberger
Senior Managing Director & Chief Rating Officer
AM Best

Rich Sorkin
Co-Founder & CEO
Jupiter Intelligence

The Honorable Andrew Mais
Connecticut Insurance Commissioner
NAIC Vice President

Dr. Joanne Leovy
NV State Medical Ass'n Delegate to Medical Society
Consortium on Climate and Health

Luncheon with Keynote Address
Saturday, March 5, 2022
12:00 p.m. – 1:30 p.m.

The Honorable Aaron D. Ford
Nevada Attorney General

Financial Services & Multi-Lines Issues Committee
Saturday, March 5, 2022
1:30 p.m. – 3:00 p.m.

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

1.) Call to Order/Roll Call/Approval of November 18, 2021 Committee Meeting Minutes
2.) AI-Enabled Underwriting Brings New Challenges for Insurance: Policy and Regulatory Considerations
    Azish Filabi, Executive Director, Maguire Center for Ethics, Associate Professor & Charles Lamont Post Chair of Business Ethics – The American College of Financial Services
    Sophia Duffy, J.D., CPA, Associate Professor of Business Planning - The American College of Financial Services
3.) Continued Discussion on NCOIL Insurance Regulatory Sandbox Model Act

Rep. Bart Rowland (KY) – Sponsor
Rep. Wendi Thomas (PA) – Co-Sponsor

4.) NCOIL Insurance Modernization Initiative Part II
Jeff Album, Vice President, Public and Government Affairs - Delta Dental of CA, NY, PA and Affiliates

5.) Any Other Business
6.) Adjournment

Sunday, March 6th, 2022

Health Insurance & Long Term Care Issues Committee
Sunday, March 6, 2022
9:00 a.m. – 10:30 a.m.

Chair: Asw. Pam Hunter (NY)
Vice Chair: Del. Steve Westfall (WV)

1.) Call to Order/Roll Call/Approval of November 18, 2021 Committee Meeting Minutes
2.) Continued Discussion on 340B Drug Pricing Program
Jeremy Crandall, Director, Federal and State Policy - National Association of Community Health Centers (NACHC)
Greg Doggett, Vice President, Legal and Policy Counsel - 340B Health
R. Logan Yoho, PharmD, RPh, BCACP, 340B ACE, Director of Pharmacy, Apexus Certified 340B Expert - Hopewell Health Centers
Abby Reale, MHA, Director of Advocacy - Mountain Health Network
3.) Lessons Learned from COVID-19 and Preparing for the Next Pandemic
Steve Landers, M.D., MPH, President & CEO - VNA Health Group
4.) The Unfunded Mandate of COVID-19 Testing
Brendan Peppard, Regional Director, State Affairs - America's Health Insurance Plans (AHIP)
5.) Value Based Care: Better Outcomes for All
Miranda Motter, Senior VP, State Affairs and Policy - AHIP
6.) Consideration of Re-adoption of Model Laws
a.) Model Act Regarding Air Ambulance Insurance Claims – Adopted 11/19/17
b.) Out-of-Network Balance Billing Transparency Model Act – Adopted 11/19/17
c.) Patient Safety Model Act – Adopted 11/19/05; Readopted 3/6/11, 3/5/17
d.) Rental Network Contract Arrangements Model Act – Adopted 11/23/08; Readopted 3/5/17
e.) Model Act Banning Fee Schedules for Uncovered Dental Services – Adopted 11/21/10; Readopted 3/5/17;
7.) Any Other Business
8.) Adjournment

Executive Committee
Sunday, March 6, 2022
10:30 a.m. – 11:30 a.m.

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

1.) Call to Order/Roll Call/approval of November 20, 2021 Committee Meeting Minutes
2.) Discussion and Consideration of Resolution in Honor of Past President
Representative George Keiser (ND)
3.) Future Meeting Locations
4.) Administration
    a.) Meeting Report
    b.) Receipt of Financials
5.) Consent Calendar
6.) Other Sessions
    a.) The Institutes Griffith Foundation Legislator Luncheon
    b.) Featured Speakers
7.) Any Other Business
8.) Adjournment

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATINOS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 20, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at The Westin Kierland Hotel in Scottsdale, Arizona on Saturday, November 20, 2021 at 10:30 a.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Sen. Keith Ingram (AR)
Asm. Ken Cooley (CA)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Hank Zuber (MS)
Asm. Kevin Cahill (NY)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Sen. Jim Guthrie (ID)
Rep. Craig Snow (IN)
Rep. Cherlynn Stevenson (KY)
Rep. Mary DuBuisson (LA)
Rep. Kyle Green (LA)
Rep. John Illg (LA)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Mike McLendon (MS)
Asm. Will Barclay (NY)
Asw. Pam Hunter (NY)
Sen. George Lang (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 Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Asm. Kevin Cahill (NY), NCOIL Treasurer, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Tom Oliverson, M.D. (TX), and seconded by Asm. Cooley, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2021 meeting in Boston, MA.

CONTINUED DISCUSSION AND CONSIDERATION OF NCOIL RESILIENT REVOLVING LOAN FUND MODEL ACT (Model)

Roderick Scott, Board Chair of the Flood Mitigation Industry Association (FMIA), thanked the Committee for the opportunity to speak and stated that we're really excited to be at this point. I'm the Board Chair of the FMIA and I work in the flood mitigation industry in the private sector. Unfortunately, Maryland Senator Katie Hester, the sponsor of the Model, could not attend today but she gives all of you her best and is hopeful that this will be passed out of committee today. I want to take this opportunity to thank NCOIL, the staff and the members, and this Committee for supporting this effort to create the world's first state resilience revolving loan program legislation. In less than a year, we have developed solid model legislation to provide states guidance in their efforts to craft their own resilience revolving loan programs. This is the third meeting in 2021 that we have presented this model legislation and we are very confident that we have a really good model going forward. We've collaborated with the earthquake risk folks, the fire risk folks, and the wind risk non-profit sector, and the industries that support those and they've all given it their blessing.

Natural hazard events and risks are increasing and causing increasing suffering and damages in the U.S. As a result, insurance rates are climbing to unaffordable levels to cover these risks. Millions of older and historic buildings in flood, wind, fire and earthquake zones need retrofit for hazard mitigation projects in order to reduce the risk, to be resilient and protect and preserve those property values that we invest in these buildings with the property tax revenues that fund our schools and our government operations. And so, we have to do this in order to be resilient to get that bounce back after the events. The events are going to keep happening, and they say they're going to happen more often and we need to be able to survive the events much better than we are now and be resilient and bounce back. In January, just to review the federal process so far, the Safeguarding Tomorrow through Ongoing Risk Mitigation (STORM) Act was signed by former President Trump. It became law after about a half a dozen years of our industry and several other industries working with Congress and the banks and two Administrations to provide a first ever, multi-hazard mitigation revolving loan program for the U.S.

The new infrastructure bill has provided $500 million dollars in initial appropriation and there's another $500 million currently in the Build Back Better legislation. We'll see what happens when it gets over to the Senate. Next, the Federal Emergency Management Agency (FEMA) will write the program administrative rules and launch the program. We're hoping by late 2023. So, while the rules are being written multiple natural hazard mitigation industry non-profits will be advocating for states to use this model legislation to create the state resilient revolving loan programs in order to be prepared for the STORM Act funding to come down to their states. States are going to have to borrow this money, and then the money will be sent to the taxing authorities to utilize as loans to these property owners. So, the revolving loans will be used by states and communities to match much larger federal projects. Match money is always one of the hardest things to find for communities and states for levy systems, for drainage projects, and things like that. And the other part of it is the private capital that's going to come from the financing institutions restricted from those other drainage projects just for buildings. Banks don't want to loan for anything but the buildings and it's their money. I encourage this committee to vote yes to move this model legislation out to the states and I'm ready to answer any questions. Thank you.

Hearing no comments or questions, upon a Motion made by Rep. Matt Lehman (IN), NCOIL President, and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice to adopt the Model.

PERSPECTIVES ON THE NATIONAL FLOOD INSURANCE PROGRAM'S (NFIP) NEW RATING METHODOLOGY: RISK RATING 2.0

The Honorable Andrew Garbarino (NY), Member of the U.S. House of Representatives, thanked the Committee for the opportunity to speak and stated that as some of you know I've been a part of NCOIL for several years beginning with my time as a member of the New York State Assembly, where I served on the insurance committee as the ranking member. Now, as a Member of Congress, I'm glad to be able to continue my involvement with this organization and with the many legislators working to advise on insurance policy. NCOIL is about idea sharing among current and future legislators and bringing forth insurance policy at a state and federal level that will benefit communities across the country. So, again I'm very pleased to be here. Now, today I was asked to briefly touch on an issue that always seems to be on the radar of Congress, especially for those Members who represent coastal area districts. I'm talking about the status of the NFIP and specifically, FEMA's implementation of Risk Rating 2.0.

As I'm sure many of you know, the NFIP will need to be reauthorized once again come December 3rd. In all likelihood another continuing resolution will provide reauthorization extension into the new year and stave off a program lapse. Unfortunately, it doesn't seem like my colleagues on the House Financial Services Committee and Chairwoman Maxine Waters have this on the top of their radar and her and Ranking Member are miles apart on this issue. So, I don't think we will see a long-term reauthorization happen for a while. Outside needing reauthorization in a couple weeks, the most concerning aspect of the NFIP is the ongoing implementation of Risk Rating 2.0. This is the first major update of the NFIP's pricing system in 50 years and FEMA has sold these new ratings as way to equitably distribute premiums across all policyholders based on home value and a property's unique flood risk.

What we're seeing since implementation began back in October is that many states are experiencing rate hikes as a result of Risk Rating 2.0. In my home state of New York, FEMA reports show 54% of New York residents enrolled in the program will see a rate increase. It's even worse for my constituents on Long Island, where 72% of Nassau County residents and 71% of Suffolk County residents on Long Island will see a significant rate increase. Needless to say, I'm extremely concerned about the untested methodology causing premium spikes for my constituents. Luckily, I have a few allies in Congress who see things the same way. I recently joined my friend Congressman Mario Diaz-Balart of Florida in co-sponsoring the NFIP Risk Rating 2.0 Delay Act which would temporarily limit the authority of the FEMA administrator to prescribe chargeable premium rates under the NFIP and pause the rate hike until September 30th of 2022.

This pause will allow lawmakers more time to develop sustainable reforms to the NFIP and above all else allow homeowners the time to better understand how their rates will be affected. I believe a pause is the responsible and right thing to do. We are in the middle of an economic crisis, highest inflation in 30 years, increased energy costs, rising food prices and now FEMA wants to increase the cost of flood insurance. Now is not the time to pile on, it is time to take a pause and give these hardworking families a break.

I'm also working with my colleague and fellow Long Islander Congresswoman Kathleen Rice to move forward with the NFIP reporting on Impact to Seaboards and Counties act of 2021. This bill which I'm proud to be the co-lead Republican on would require FEMA to report the potential impacts to changes to the risk rating methodology before implementation. Again, it comes down to what is best for homeowners and how they should be able to prepare for pending rate increases. Being a fresh Member of Congress you were kind of thrown into the deep end of the pool, but you're also given a unique opportunity to find your niche and concentrate on topics that are most interesting to you. Insurance has always been very interesting to me and I truly enjoy speaking with you all today. I look forward to your questions and discussion on this issue. Thank you.

Asm. Kevin Cahill (NY), NCOIL Treasurer, stated that to our colleagues here I can't tell you how important it was the nonpartisan approach that Congressman Garbarino took to all issues just like his predecessor on that committee, Asm. Will Barclay (NY). But when we dealt with subjects very early on in my term as Chair of the insurance committee the first thing we dealt with was Superstorm Sandy. And at that time there was a movement in Congress, I think it had already passed and then required a moratorium to redefine the zones and the rates and there was indeed a moratorium. And the logic behind that was that we can't just drop it on people, we have to let them know in advance what they have to do. We have to give the states an opportunity to derive a solution for those people, those homeowners and property owners who would otherwise be very negatively affected by it. And also, perhaps the science behind the redrawing of the lines and the rates was not perfect and needed to be examined. And I guess my question Congressman is it's a couple of years later, but it seems to me that those arguments are still valid today. Would you agree with that assessment?

Congressman Garbarino stated I would and I think the real issue right now is after Superstorm Sandy, that was my first campaign for the State Assembly, and a lot of my district was under water out in Suffolk County and since those years, FEMA came in and there was a lot of money put into raising homes and raising roads. And we all agreed that there had to be an update to the maps because places were flooded that had never been flooded before. The problem is, even under this new NFIP Risk Rating 2.0, homes that were raised due to Superstorm Sandy are seeing rate increases. They did everything they were supposed to do and now they're seeing that because of where they are they're still seeing their policies increased even though they have very little risk of actually having flood damage. So, it seems that there was a lot of talk about fixing everything after Superstorm Sandy and it hasn't been done yet and the fact that we can't get the Chair of the Financial Services Committee in Washington to really take a look at this and make the legislative changes that need to happen is just going to continue I think to delay and constituents, homeowners are really going to face the burden here and it's unfortunate.

Asm. Cahill thanked Congressman Garbarino for staying involved in NCOIL and coming back and visiting with us and giving us a federal perspective.

Rep. Matt Lehman (IN), NCOIL President, thanked Congressman Garbarino for being here and for your support of NCOIL. I guess one of the concerns having been here a while and you were in this seat as well is we're in a cycle of extend and try to fix, extend and try to fix, but those extensions have always been short term. So, if we're really trying to fix this, has there been any discussion of let's extend this for two years and in that two year period, we know there's now an end, right? We want to end these 30 day

extensions. We've got to find a solution and I think what's happening is the NFIP has shown no chance of ever surviving in the model they have now so something has to change.

This isn't a political issue by party, it's a political issue by region and I'm glad to see the Louisiana delegation is here. They have a stake in this. Indiana doesn't. We don't have the hurricanes that coastal states have. So, you have this issue of spreading the risk and it's odd that we're talking about how do we redraw these maps, how do we make them effective? And how do we pool our risk when at the same time the industry's moving away from pooling. The new adage is pay for what you use. If we take that approach, then the coastal areas would pay a lot more for their insurance than what someone would in the Midwest. We cover a lot of perils inside a standard ISO policy. The old adage is they've always been written in the north because we cover the weight of ice and snow and people in Key West, Florida are helping bear the burden of that risk. So, we have spread the risk in the past - how do we spread that risk across all policyholders? Maybe there is a little bit of a bump in the coastal regions but right now we seem to just kick the can down the road and we've accomplished nothing. And I really applaud you for stepping up and saying, we must find a solution, but what is it looking like long term? Isn't there a certain date that you could put out there and say let's do this the right way?

Congressman Garbarino stated that one thing I've learned in Washington is there has to be a fix at some point and when I was in the State Assembly in Albany, we always said the budget was due by April 1st, even when there wasn't agreement, we knew there was going to be an agreement at some point. We knew there had to be a budget passed. In Washington, they can just do these short-term fixes which is amazing to me and there's a comfort level with just kicking the can down the road there, just to keep the status quo and for legislators like myself and my friends from Louisiana, I've spoken with Congressman Scalise about this a lot and this is a huge concern because they know that it has to be addressed but unfortunately the leadership is not from areas that see the floods so they don't mind kicking the can down the road.

However, I do note that more and more Members are starting to pick up on it especially those from the midwestern states. Some are from the Great Lakes who've seen flooding from both the lakes and rivers running through. So, you're seeing a lot more legislators from middle America getting involved and getting interested in this. So, I think it is fair to say that the more and more people that face this flooding in their district, the more and more you'll get them to be able to realize that there has to be a fix to this. We can't just keep kicking the can down the road. Regarding pooling the risk, what FEMA's doing right now with Risk Rating is not working. I was just talking with one of the other witnesses before and I think we both agreed it seems like the administrator's doing this and it's more an ego push after they know it's not working, but he's still doing it. He just wants to do it, to say he did it and that's not good. So, we're hoping that the legislation that delays the Risk Rating passes and we're hoping that there is actual some real discussion with or without the Chairwoman of Financial Services. Insurance companies in D.C. and their lobbyists have been really starting to focus on this and realize that they want to get involved. It's frustrating and I would love to say I'd like to get this done in two years. The people in charge now don't seem to care that much but we're going to keep pushing it. We have a great coalition of Members, both Republican and Democrat, pushing this issue now. I hope it gets done, but I would not hold my breath that anything gets taken care of this year which is really unfortunate.

Rep. Lehman stated that I'd be remiss if I didn't say keep us at that table. I think sometimes D.C. gets in this vacuum of we'll solve the problem and you're not reaching out to the people with the boots on the ground that really live in these states and legislate in these states everyday. So, I know you get it, you've been here. But I would say, continue to keep NCOIL as a resource and I'll speak for Asm. Cooley, the incoming NCOIL President, that he'll go anywhere anytime to participate and I will too, and I think others would as well.

The next speaker was Chris Greene, Founder of Community First Agency, LLC. Before he spoke, Asm. Cahill asked Mr. Greene to remove props and hats that Mr. Greene had with him at the speaker's table. Mr. Greene refused to do so.

Mr. Greene thanked the Committee for the opportunity to speak and stated that the last three years, I have been traveling the country doing 1,000 videos in 1,000 days - strictly flood education, and I've talked to flood victims. I've addressed Risk Rating 2.0 for the last six months in every major city in the U.S. and what we've learned is that inland flooding is a major issue right now that people are completely uneducated on but with Risk Rating 2.0, not just insurance agents, property owners and real estate agents aren't really sure what to do. So, today I'm briefly going to talk about what I call the fingerprint of flood insurance and this is the thing that it addresses. Basically, if you think about Risk Rating 2.0 in an easy way, it's like going from Nintendo to Nintendo Switch overnight. So, think about no development in between and a lot of things are going to be broken. Briefly, let me talk about those things. We're talking about the rating system changing. So, flood zones no longer determine flood rates. Elevation certificates are no longer required which not being required may not be a bad thing, I just think that maybe the message that it's sending that while they're not required they're not needed and that's completely the opposite. Things that it's looking at now are distance to water, type of flooding, replacement cost of the building, and of course elevation and flooding frequency. And so those are things that are going to determine the rates in Risk Rating 2.0. Right now, I've been helping a property owner build a house in Louisiana. We help him mitigate it. FEMA had him at $600 a year when he was building his house. He elevated it 10 feet, he completed it with Risk Rating 2.0, and it was $3,000 a year.

So, it brings up the conversation of is mitigation dead with this new program? I have always had mitigation first and as great as flood insurance is, and it's going to help you recover financially, and emotionally quicker, at the end of the day, is it really doing anything to reduce the risks? So, with this new program, are people going to be motivated to raise their houses? We just got done helping someone raise their house who flooded in Nashville when they had 17 inches of rain in 24 hours. And in Birmingham, Alabama they had 13 inches of rain in four hours. These are some of things that are going to cause issues with Risk Rating 2.0. My office manager deals more with Risk rating 2.0 on a day to day basis but the struggles that she's seeing every day and other agents are seeing across the country is that the system is broken. You can't even finish a quote right now. Write-your-own carriers didn't even get the rating model until 30 days before they wanted them to issue policies. So, these are some of the things that are causing a lot of problems with Risk Rating 2.0. You've got phase one on October 1, 2021 for new policies. You've got phase two for renewal business on April 1, 2022. So, that's another point of confusion - when do I actually go into this program, or do I have to go in this program right away? A lot of people think that they have to wait

until the renewal, that they can't go into the program and they can so it's creating a lot of confusion.

We've traveled the country and we tried to teach this, but there's so many moving parts with Risk Rating 2.0 and that's what I came today to discuss is really what we're actually seeing every day, how these rates are changing now. I'm a big believer that flood zones should never really determine rates because they're really more relevant from a regulatory standpoint. But I've also always been a big fan of setting up a standard rating system, almost like a home insurance product. Think about the fact that your house has a higher chance of flood then it does being broken into. That's something to go along with to help with financially with FEMA paying out these claims and taking a deeper look at some of these severe repetitive loss areas where these claims keep occurring.

Tim Murphy, Project Branch Manager at the Flood Control District of Maricopa County stated that I'll be speaking on behalf of the Association of State Floodplain Managers (ASFPM) and also informally for local Arizona communities involved in floodplain management. Risk rating 2.0 has been an important issue to ASFPM and our members since FEMA announced that they were going forward with it about two and a half years ago. ASFPM in its 38 state and regional chapters combined represent more than 20,000 local and state officials as well as private sector and other professionals engaged in all aspects of floodplain management and flood hazard mitigation. ASFPM and its members are concerned with reducing our nation's flood related losses as well as flood losses in their local areas and as mentioned earlier, floods are our nation's most frequent and costly natural disasters, and the trends are worsening. The NFIP is the nation's most widely used tool to reduce flood risk and we as an association and we as local floodplain managers have an interest in NFIP reform, NFIP reauthorization and things like that. I know that in July, Tony Hake with FEMA gave a presentation on Risk Rating 2.0, so I don't think there's any need to go into a great deal about that. ASFPM supports Risk Rating 2.0 and believes that the changes to the NFIP's rating system are long overdue.

The rating methods being used will be more in line with other current insurance rating approaches. The premiums determined using Risk Rating 2.0 will do a better job of communicating to homeowners, business owners and renters what their true flood risk is than the old legacy system did. We hope that this will encourage policyholders and communities to explore ways to lower the flood risk and also to lower their premiums. One concern from the beginning was to have smooth role out and have a rating tool that appropriately determines an individual building's flood risk and premium. Since we are in Arizona, I'd like to take a moment to provide some background on floodplain issues in Arizona. Over 100 communities in Arizona participate in the NFIP. There are around 27,000 NFIP policies and 15,000 in Maricopa County. The agency I work for, Flood Control District of Maricopa County, was created over 60 years ago and in 1984, the Arizona legislature changed state law and in Arizona now, each county is required to form a flood control district, and this has made it easier for Arizona counties and communities to develop the resources, particularly the funding and technical resources needed to better manage floods. The experiences in Arizona and around the nation with Risk Rating have been somewhat similar. Many communities were concerned that because the new approach made it possible to write a policy without having the elevation certificate that there might be less interest in them. Much to our surprise when, after October 1st when Risk Rating started being implemented for new policies, we started getting more requests for elevation certificates than we did in the past and many

of these requests were for areas outside of the floodplain, where an elevation certificate didn't exist and wasn't of any use because there's no base flood elevation determined.

Initially, many local floodplain managers felt like they didn't really have a good understanding of the various factors that were used in determining the premium under Risk Rating 2.0. and FEMA's training was focused on insurance agents. ASFPM was able to work with FEMA and have them offer training that was better suited to floodplain managers and covered the different rating factors that we're getting used to more in depth. Local floodplain managers since the announcement of Risk Rating 2.0 had been asking to have access to the rating tool. They don't feel like they know what their premiums might be in their communities, especially how they might vary from location to location within the community or how mitigation efforts might impact the premium. Or in some cases, from our standpoint as a local agency, when I'm working on a permit with somebody and saying if you elevate one foot or two feet, I used to be able to tell you what that was, what that premium might be. Right now, we just don't have that ability.

FEMA did release information that summarizes the changes by state and zip code and this is provided to us with some information and some understanding of the impacts. ASFPM did take that information and created an interactive map that shows graphically the impacts by state and zip code. That information can be accessed on ASFPM's website at floods.org. ASFPM encourages a holistic multiprong approach to strengthen the nation's overall resilience to flooding. Some of these approaches must include an insurance program that determines premiums based upon a building's specific risk and provides financial stability to the program. Second, we need to keep improving the quality of the existing 1.2 million miles of streams that have been mapped as well as map the 2.3 million miles of unmapped streams, rivers and coastlines. We'd like to see a national focus on mitigation efforts that reduce flood risk and ultimately flood insurance premiums for policyholders. On behalf of the ASFPM I thank you for providing this opportunity to participate on this panel and share our viewpoints with you. We look forward to working with you in the future.

Rep. Stephen Meskers (CT) stated that when I listen to the panelists in the conversation, we've heard testimony and we were talking about different risk pools and insurance premiums across the last couple of days and references were made to the fires in California. There's a climate component to the equation and the risk premiums. I don't know how we solve the issue because given what's going on in weather patterns and given what's going on with floods. We're back on the mitigation issue I think on infrastructure. We had the last Hurricane Ida that came up the Northeast, and in my town it was low tide and the shore line which was the FEMA regulated part of my equation didn't get touched but we had bottlenecks inland at a higher elevation and we had flooding we'd never had in 100 years. So, I don't know how we mitigate and cap the insurance premiums and figure out how to spread the risk pool when we're basically moving into new areas of risk and structural risks because of some climate components as well as the flooding. I think we've got a big challenge in figuring out how much of this is a reserve policy pooling of risk spread along our policyholders and how much of it is going to end up back at the federal government with pools of money that we're seeing on the infrastructure bill for coastal resiliency and storm mitigation. I think the shoreline is going to be problematic for the next 30 or 40 years with the rise in sea levels and I don't want to listen to the news reporting about one more 100 year or 500 year storm. So, I think the problem you're facing is real and accurate.

We have to be careful with legislation that caps premiums. The ability of the premiums to adequately provide for insurance payments is going to be compromised and then how do we spread that risk when we have inadequate policies? So, we're in a dilemma of letting people financially plan their future, own a home, make improvements, get a reduced rate for their insurance and then what happens when the model from the actuaries changes two years later? I'm interested to hear the policy measure we'd look at to smooth that risk factor. But I don't know where we think that would come through because the biggest complaint I heard was that subsequent to mitigation and meeting FEMA standards, policy rates still went up. I don't know how we deal with that. I don't know if you guys have thoughts on that and how do we smooth that issue out at the very best?

Mr. Scott stated that I'd like to address that from our industry's point of view. Flood mitigation is a proven method of reducing flood risk. My town is now 86% elevated since Hurricane Katrina. In Katrina we took 750 NFIP claims, this is all with a nine foot surge, for 25 million in Katrina. In Hurricane Isaac in 2012 we only had 250 claims for seven million. And for Ida we only documented 65 flooded buildings and they're all the old buildings sitting on the ground. Virtual sitting ducks. If we can just get this three or four million oldest of the buildings mitigated then these repetitive events are not going to have this catastrophic financial impact because it's all the old buildings getting repeatedly flooded. That's the problem. And FEMA tells us, "Oh we have a million of these old buildings that get flooded all the time, we got to fix them." Well, the problem is that we only insure 20% of our buildings in our flood zones or 30%. That's what all the floods are saying now. So, the banks and our industry estimate that we have three or four million of these buildings. The banks have told us it's $1.75 trillion in asset value and we have told them that it's $600 billion to retrofit in this generation and then we won't have the flooded buildings and it'll give my kids a chance to give us some breathing room.

Maybe we're going to move back from the coast. Maybe we're going to do other things and get our infrastructure raised. But right now, we've got to get this glut of our oldest historic buildings that have all this asset value and property tax value because our waterfront properties are our highest revenue producing buildings. We just got to get them so they don't flood. And we know how to do that. This whole thing with FEMA is that NFIP is not going to give us credit for mitigating these buildings which is $600 billion worth of investment and half a million in job creation. And they're not going to give us credit for this? We have to put a pause and a timeout on this deployment.

Mr. Murphy stated that although we're here in Arizona I'm not unsympathetic to coastal issues. I'm a South Jersey kid, I grew up just outside of Atlantic City. I have Aunts and Uncles and Cousins who live there and of course they know I work in floodplain management, and flood insurance and so I get questions sometimes about, "Hey what can I do about that FEMA thing of the flood insurance thing? Is there anything you can do to help me with that?" So, I do understand and I do get personally those kind of questions myself. But to Mr. Scott's point and some of the other things, a few years ago ASFPM had a mitigation conference up in Northern New Jersey. As part of that conference, we did go to Staten Island and there are homes being elevated in Staten Island. And they also, cleared out areas and retreated from some areas that were very vulnerable to flooding. So, those are two ways to kind of mitigate that and when people ask me about mitigation, things that I always think about, it's a little bit about like the old real estate joke. Location, location, location. But certainly, it's true. Location is

important. When we get to mitigation, elevation is definitely very important and one of the things we'd need to continue to have is an emphasis on better mapping, more accurate mapping, mapping that clearly shows the hazards, defines the hazards so that we can work on these mitigation projects.

ANY OTHER BUSINESS

Sen. Hackett stated that there are two pieces of work left. The first is consideration of the readoption of the NCOIL Company Licensing Modernization Model Act (Model). If you look in your binders it's on page 259. It was first adopted in 2002, and it's been readopted in 2004, 2006, 2011 and 2016. Hearing no questions or comments, upon a Motion made by Rep. Deborah Ferguson (AR) and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection by way of a voice vote to re-adopt the Model.

Sen. Hackett stated that he will turn things over to Rep. Lehman for the last item of business regarding technical changes to correct drafting oversights in the NCOIL Insurance Business Transfer (IBT) Model Act (Model). Rep. Lehman echoed Sen. Hackett's comments regarding the need to make technical corrections relating to reinsurers in the IBT Model and accordingly made a Motion to do so. Sen. Travis Holdman (IN), NCOIL Immediate Past President, seconded the Motion. Hearing no questions or comments, the Committee voted without objection by way of a voice vote to make technical changes to the Model.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson and seconded by Rep. Oliverson, the Committee adjourned at 12:00 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution Supporting Independent Contractor Status for Insurance Agents and Other Licensed Financial Professions

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

To be introduced and discussed during the Joint State-Federal Relations & International Insurance Issues Committee on March 4, 2022.

WHEREAS, there are over one million licensed insurance agents, financial advisors, and other financial professionals who operate as independent contractors in the United States, and

WHEREAS, these licensed, independent insurance agents and other financial professionals are often small business owners who have operated their own businesses for decades and have substantial relations with one or more insurance companies, broker-dealers, or registered investment advisors, and

WHEREAS, these independently contracted, licensed insurance agents and other financial professionals operate in highly regulated environments and provide vital financial services to consumers, and

WHEREAS the presence of an independent distribution model in the insurance and financial services industries benefits consumers by providing more choice, products, and services, and

WHEREAS, workers in insurance and other financial professions, unlike workers in other industries, have the choice to work as employees or as independent contractors, and

WHEREAS, many choose to be independent as it allows producers and other professionals the freedom to select the communities in which they will work, the products they will offer, and the kind of business they will build, and

WHEREAS, surveys, including research by the National Association of Insurance and Financial Advisors (NAIFA), show licensed independent agents and other financial services professionals are overwhelmingly satisfied with their status as independent

contractors and oppose policies that would take away their choice to work independently, and

WHEREAS, the future of independent work has been the subject of extended discussion nationwide as the Department of Labor (DOL) and other federal agencies, the United States Congress, and states legislatures have debated the topic of worker classification, and

WHEREAS, these debates are often centered on extending benefits and protections to workers in the so-called "gig economy" but resulting policies will have far-reaching consequences including in insurance and financial services, if not appropriately focused, and

WHEREAS, one policy under discussion in these debates is the use of a " ABC worker classification test" for determining whether a worker is an independent contractor or employee, and

WHEREAS, the "strict worker classification ABC test" is generally understood be a classification test in which a worker is deemed to be an employee unless: 1) the worker is free from the employer's control or direction in performing the work; 2) the work takes place outside the usual course of the business of the company and off the site of the business; *and* 3) the worker is customarily engaged in an independent trade, occupation, profession, or business;

WHEREAS, a strict ABC test, or other similarly worker classification laws, applied to licensed professionals in the insurance and financial services industries would be extremely disruptive as it could require licensed independent producers and other financial services professionals to be classified as employees of the companies whose products they sell, and

WHEREAS, reclassifying licensed, independent producers and other financial professionals to employees would disrupt nearly one million licensed professionals, thousands of Main Street businesses that are operated by licensed financial professionals across the United States, and

WHEREAS, reclassifying licensed, independent producers and other financial professionals to employees would disrupt established and well-functioning insurance distribution channels, and

WHEREAS, reclassifying independent, licensed financial professionals to employees would limit consumers' choices and access to products and advice, and

WHEREAS, multiple states have recognized the unique environment in which licensed insurance agents and other financial services professionals operate, as well as the disruption the ABC test or other similarly worker classification laws, would cause in insurance and financial services, and

WHEREAS, multiple states have seen it appropriate to exempt licensed insurance agents and other financial professionals from recent worker classification laws enacted in that state,

NOW, THEREFORE BE IT RESOLVED that NCOIL supports the continued presence of licensed, independent contractors in insurance and other regulated financial professions, and

BE IT ALSO RESOLVED that NCOIL will encourage states and federal entities that are debating worker classification policies and that are considering adopting a strict ABC test and or other similarly worker classification laws to continue issuing exemptions for, or exempting out, licensed insurance agents and other financial professionals, and

BE IT FURTHER RESOLVED that a copy of this Resolution be sent to state legislative leaders, governors, the Department of Labor and other federal agencies, and the Senate and House Labor Committees of the United States Congress.

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 18, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at The Westin Kierland Hotel in Scottsdale, Arizona on Thursday, November 18, 2021 at 3:15 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Sen. Mathew Pitsch (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Jonathan Carroll (IL)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Rachel Roberts (KY)
Sen. Paul Utke (MN)
Rep. Hank Zuber (MS)

Other legislators present were:

Rep. James Kaufman (AK)
Sen. David Livingston (AZ)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Susan Westrom (KY)
Sen. Lana Theis (MI)
Sen. Mike McLendon (MS)
Sen. Walter Michel (MS)
Sen. Charles Younger (MS)
Sen. Jim Burgin (NC)
Sen. Eric Neslon (WV)

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 Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Hank Zuber (MS), and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2021 meeting in Boston, MA.

PRESENTATION ON TEXAS OCCUPATIONAL INJURY MANAGEMENT

Amy Lee, President of Steadfast Policy Strategies, thanked the Committee for the opportunity to speak and stated that I'm also a recent retiree from the Texas Department of Insurance where I spent 27 years researching and providing policy assistance on the

workers compensation system in Texas. So, I'm going to talk to you today a little bit about the Texas workers compensation insurance market, give you an overview of the statistics involved with employer participation in the Texas workers compensation system, and then I'm going to turn it over to Lucinda Saxon of Texas Star Alliance on behalf of the Texas Alliance of Nonsubscribers, who will talk about occupational injury management programs from the employer perspective. So, a little bit about the Texas workers compensation insurance market - it's a very healthy insurance market. We have over 300 insurers actively writing coverage in Texas with direct written premiums at about $2.5 billion. The residual market is very small in Texas. It's less than 1%, and it's been that way essentially for the last 20 years. The projected accident year combined ratio is profitable for underwriting and it has been profitable for Texas insurers for the last decade. And insurance company average return on net worth is about 10% in Texas compared to the average nationally about 7.1%.

So, part of what you need to understand about the Texas workers compensation insurance market is that it wasn't always as healthy and profitable. We've had several legislative reforms just like other states have had. We had a major reform in 1989 which a lot of states had similar reforms in the late 1980, early 1990s. Then we had another reform in 2001 and 2005. And those last two reforms were mostly centered on medical costs - trying to decrease medical costs in Texas because according to the Workers Compensation Research Institute (WCRI), Texas had some of the highest medical costs per claim and some of the poorest outcomes in terms of return to work and patient satisfaction compared to other similarly situated injuries in other states. So, in 2005 there was a reform that passed that introduced managed care and introduced evidence based treatment guidelines and also required a lot additional data collection and reporting on the impact of those legislative reforms.

And so, part of that was a reduction in insurance rates that the Texas employers started to see, including a 73% reduction in the average premium per $100 of payroll. So, it is now cheaper to buy workers compensation in Texas than it's ever been essentially and the insurance rates have dropped also about 72% percent. So, the coverage requirements in Texas are kind of different compared to other states. For private sector employers we've had an optional system since the beginning, since 1913. And what that means is it's your decision as a private employer whether to purchase the insurance or not. If you want to purchase the insurance you have an option of purchasing a commercial policy, and if you meet certain requirements you can be a certified self-insured. Or you can have a group self-insurance as an option as well. Public sector employers in the state of Texas are required to have workers compensation coverage. Most of them are self-insured. Although, political subdivisions do have an option of buying a commercial policy if they so choose.

So, for those employers that choose the route of not having workers compensation insurance, and we refer to those employers often as non-subscribers in the workers compensation system, it doesn't mean that they don't have certain requirements that they need to meet. They do have to report their non-coverage status not only to them – but to their employees but also to the state. And that's because, most states have proof of coverage information that's available through a portal that anybody from the public can access and understand like a healthcare provider for example wanting to know when they treat a patient, is there workers compensation coverage and who is that coverage through? So, they have a way of billing it and contacting that insurer. The same thing happens with non-subscribers. You have to report to the agency when you

terminate workers compensation coverage and then you have to report annually your coverage status - whether you are a non-subscriber or not.

You also have to post in your workplace in a conspicuous place your coverage status and then provide copies of the notice to any new employees that you hire, and then obviously if your coverage status changes if you terminate coverage, you need to provide copies to all of your employees. And then if you're an employer with at least five or more employees, you have a duty to report your injuries to the Division of Workers Compensation. And that includes occupational diseases, fatalities and injuries with more than one day of lost time and those are the same reporting requirements for employers with workers compensation insurance as well. A lot of people are curious about why that injury reporting requirement exists and it's because the Division of Workers Compensation, although the Division does not regulate workplace safety, the Occupational Safety and Health Administration (OSHA) does, it does have a workplace safety education and outreach component to its statute. And they provide those workplace safety services to all Texas employers regardless of whether they have workers compensation coverage or not.

So, that injury information is reported so that the agency can use it to help tailor it's workplace safety and outreach services to those employers that may need those services the most. So, to understand coverage in Texas, it's important to understand that if you're a private employer you have the option of purchasing workers comp or not. A lot of people ask how many employers make that choice of not having work comp. Well, in Texas we've been tracking this number consistently since 1993 and we do the study every other year in Texas. It's the Department of Insurance Division of Workers Compensation who conducts the study and as of 2020 about 29% of private year round employers did not have work comp insurance and they employ approximately 19% of the private sector workforce. So, a little bit about who these employers are. These are the non-subscription rates broken down by the size of employer and it's important to remind ourselves that even though Texas is a non-mandatory state, many other state also have coverage exclusions in their statutes including numerical exceptions.

For example, if you're an employer with less than five employees you are not required to have workers comp insurance in certain states. So, this is a breakdown of the non-subscriber rates by year, by the size of employer and what I would take away from the slide is not surprising a lot of smaller employers tend to have a higher non-subscription rate. And then it's bifurcated with the larger employers, the very largest group of employers also tends to have a slightly higher non-subscription rate and those are the employers that tend to employ the majority of the non-subscribing employees. So, here's a breakdown of non-subscription rates by industry sector and this is at the one digit, next level and again, this just gives you an understanding of the non-subscription rates varying by industry. Healthcare tends to be one of those industry sectors that has the highest non-subscription rate and that would include hospitals and doctor's offices and things of that sort.

The lowest rate, not surprisingly, is in the mining construction sector and that's because in order to do business in public projects, by statute, you have to have workers comp insurance. So, part of the study is not just focused on trying to estimate coverage, it's also trying to understand what's influencing employers' purchasing decisions and that includes why employers choose to have workers comp coverage and why they choose not to have it. And so, I'm comparing here for two different surveys, and again this is

right after the 2005 reforms. The main reasons why employers gave for not purchasing coverage, and remember in 2005 the reforms were primarily focused on reducing medical costs in Texas and improving outcomes. So not surprisingly, the employer reasons were premiums were too high. They felt they had too few employees and medical costs were too high.

Now, in 2020 again, many of those same issues are still present but the order of magnitude is different. It's more focused on I don't think I have enough employees, I don't think I have enough injuries, I don't feel like the coverage is required versus the coverage is no longer affordable or the medical costs are too high. So, I wanted to give you some resources if you want to look at more detailed information about non-subscription rates including for those employers that do not have work comp insurance, what percentage of those employers have an occupational benefit plan, and also what percentage of those non-subscribing employees are covered by a non-subscriber occupational benefit plan. And in 2020 that's about 60% of non-subscribing employees are covered by some form of occupational benefit plan. So, when you look at the work comp coverage rate, plus you look at the percentage of employees that work for non-subscribers that have occupational benefit plan coverage, you get the vast majority in the 90% range of those employees that are covered by some sort of benefit plan if they're injured on the job. I'll now turn it over to Ms. Saxon.

Ms. Saxon thanked the Committee for the opportunity to speak and stated that I represent one of the non-subscriber groups in Texas. There are a couple of us that represent employer groups that work on these issues in Texas and we represent a lot of employers of all different sizes, but most of our employers are midsize employers to very large employers. We have hospitals that are part of our employer group. We have employers that are fifty employees all the way up to really large employers. Hospitals, large grocery store chains, you name it, they're probably members of our association. We have a little bit of everything. We were looking at our breakdown of our membership the other day and I think the only thing we don't have in our kind of employer mix is construction but one of the main things that's really important to be part of our group in Texas is you have to have some sort of an occupational injury program. We don't prescribe what your benefits need to be. We have a few requirements, but we don't want to prescribe what your benefits are in Texas for our employers and our group anyway.

One of the things that really works for our employers in Texas is if you've got to data entry in your company, your injuries are going to be vastly different than if you run a hospital. So, for their networks that they put together they want to put together the best network possible. If they want to put together the providers for data entry, they're going to have a lot of carpal tunnel type surgeons versus orthopedic surgeons. If you're going to do lots of back injuries, you're going to have lots of spinal surgeons and those types of doctors in your networks because your injuries are going to be very different. When I started working with non-subscribers in Texas in the early 2000s and learning about the different medical costs, they were outstanding in Texas. And that's why a lot of our employers were going to non-subscription. The medical costs and the medical treatment that these employees were getting were just, it was incredible the way that these employees were treated and the incredible medical care that they were getting and that kind of continues in Texas in the non-subscriber world.

So, it's very important for our members in the non-subscriber world and in our non-subscriber networks to get that kind of medical care. Regarding our non-subscriber history, it's kind of a carrot and stick. Our guys kind of see and are the ones that put together the plans and they kind of see it as somewhat of a little bit of competition. They want to have a little bit better programs than the workers comp system. They want to make sure that it's a really good program and a good option for employers to have to go to. We do not advocate for anyone to go bare. Going bare in Texas means not having any program whatsoever. We know that there are companies out there doing that. For our group, it's not an option. But non-subscription has been an option in Texas since 1913.

So, there's some really great options and benefits plans that we cover as most employees are covered in Texas. About 90% of employees are covered either through work comp or non-subscriber plans. With most non-subscriber plans in Texas you have immediate wage replacement benefits on day one of missed work. They provide 85% to 100% of wage replacement. So, it's not 75% as there's a wage cap in Workers Compensation. They cover that. They have access to really good medical specialists, and quality medical care and overall their non-subscribing employees report very high satisfaction with the medical care that they receive and for employers they receive lower insurance premiums and they are mostly self-insured. They get fast return to work rates and that's important for them. They have less impact on their existing workforce whenever there is an injury. They have very robust safety programs because for them if you're outside of the work comp system they're at risk of being sued. There is no exclusive remedy if you're outside of the work comp system.

Here are some of the statistics that Amy did when she was at the Division of Workers Compensation in that research group on the satisfaction rates. As Amy mentioned, there are regulations out there. All of the medical benefits are regulated by the federal Employee Retirement Income Security Act (ERISA) programs. They are very involved with OSHA. At the Division of Workers Compensation, there they have access to all of the safety programs there. They do have very robust safety programs, and that's very important to them because of their tort exposure. It works for Texas.

Rep. Lehman stated that you ended with it works in Texas and I believe Texas is the only state that does this. I think New Jersey might not but they have some other quirky things that basically make it mandatory. But is Texas the only state that does not have a mandatory requirement? Ms. Saxon stated that I think most states have some level or not all states, but some states have some level of non-subscription. Some have it based on size, some have farms of a certain level but as an overall any size of employer I believe Texas is the only one that allows it at this level. Rep. Lehman stated that I think you answered one of my questions which was the whole point of the sole remedy is takes it away from any tort action. This opens them up now to a tort action. Ms. Saxon replied yes, it does. Rep. Lehman stated so, if I don't want to participate in the program, I want to subscribe to self-insured type plan, are there statutory requirements in Texas on how much you get a for a lost finger or are there really no statutory rules in Texas?

Ms. Saxon stated all the way up to the courts there are programs that have arbitration agreements in them and they can go to mediation. There are programs that have some of that in there but they are totally open to the courts. Rep. Lehman stated that my final question is part of the issue of payment comes down to, I think Ms. Lee made the comment, of whether it's work comp or health insurance. So, has there been push back

from the health industry of paying for work related injuries when really it should be the responsibility of the employer?

Ms. Saxon stated that the employers under the occupational injury programs, they actually come to agreements with the medical providers and they put together their own networks. The medical providers seem happier as there's no medical fee guideline under the non-subscriber agreements and the non-subscriber programs. So, they negotiate their agreements outside of the system. Under the Texas system there's a fee guideline and they can negotiate only under a network situation. This is a totally different network type situation where there is no fee guideline whatsoever. And so, frequently employers will go in and if there's a specialist that they would like to see or there's a specialist in their area most employers will just pay whatever it takes to hire that physician.

Ms. Lee stated that one thing I want to add is if you are an employer and you do not have work comp coverage not only are you subject to the tort liability, but you cannot assert certain common law defenses as well. And those are statutorily prohibited. You also are prohibited by statute for you're not allowed to have pre-injury liability waivers by statute. And there are limitations on post injury liability waivers. So, those are additional guardrails in the statute.

Rep. Stephen Meskers (CT) stated that Texas is probably as far away, apart from California or Hawaii, from where I sit over in Connecticut. So, I guess the question I have is first the assessments on satisfaction on work comp that is privately provided versus mandated. Is that a survey of claimants or is that a survey of workers who have not claimed into the system in terms of satisfaction? Ms. Lee stated that the employer numbers that were put up there were from the employer survey on their satisfaction. I'll defer to Ms. Saxon on the employee satisfaction. Rep. Meskers stated that the reason I asked the question is it was the same comment we had in one of the last sessions which is no one likes the insurance carrier until they have a claim. So, I just wanted to know how that settles out. Ms. Saxon stated that she'll have to go back and look at the survey to confirm.

Rep. Meskers stated that I'd be concerned in terms of, is it the claimants and the reaction on both types of optional policies? The second question I have is if you're not in the work comp group and you're basically providing either self-insurance or purchasing a policy, you're not necessarily entering into any of the larger pools or laying off some of the risk. So, I would be concerned about the qualitative aspect of the coverage when you're using more discreet pools of workers that you're insuring where you may be negotiating your cost at a better ratio and therefore it might be cheaper but if you can't pool the risk, how are you getting to that price satisfaction if you're providing comparable work comp rates or quality? Ms. Lee stated one of the interesting things that has evolved over the last 20 years is new insurance products have evolved that are focused on the non-subscriber market. And so, depending on the size of the employer and the type of risk that they're able to self-fund, there are insurance options that can actually help spread some of that risk out. Rep. Meskers stated so, you're using pooled risk, it's just a different function? Ms. Lee replied yes. Rep. Meskers stated that was the kind of question I was trying to understand how the model gets built without pooled risk. Ms. Lee stated but it's written by a non work comp insurance company.

Rep. Rachel Roberts (KY) stated that she has two questions. The first is I'd just like us to talk a little bit more about worker outcomes, and perhaps if you could let us know what the data is in Texas as far as maybe perhaps an increase in something like long term disability claims or anything along those lines. I have a little concern when you say they have a pool of great providers to choose from but it certainly sounds like it's a narrower pool. So, if you could talk a little bit about the outcomes. And then the second question is can you talk to me about what happens if a self-funded employer for instance goes out of business what would happen to anyone with a claim at that time?

Ms. Lee stated that in the case of it's a self-funded employer there's not necessarily a guaranty fund that exists for work comp but if the insurance product does provide some ability to spread the risk out that insurance product will still be there to pay out. The employer may or may not be around but the insurance product is still there. Ms. Saxon stated that and unlike work comp in Texas which has lifetime medical they do settle claims on the non-subscriber side like they do in other states. Ms. Lee stated that in Texas, compromised settlement agreements are barred by statute and the work comp system. Outside of the work comp system you can settle lifetime medical out. Again, that might be through a legal agreement that's not regulated by the state at all, that's completely outside.

Rep. Zuber stated that my question is for Ms. Lee - as we all know a comp claim is medically or doctor driven. With that being the case, sometimes the administrative process is somewhat slow or unresponsive, so what do you do in Texas if the employer untimely authorizes medical treatment, or if the claimant refuses or delays to have medical treatment? Ms. Lee stated that's a tricky question. If an employer, keep in mind that outside of the work comp system if there's an occupational benefit plan, that occupational benefit plan will have directions on the types of services that employee is covered for and how to obtain those services and whether there's a network that that employee needs to use so if that employee follows those instructions and seeks medical care there shouldn't be an issue. If there is no network or any instructions like that, the employee would seek medical care just like they normally would and then there would be conversations with the employer and anybody who's administrating that claim on behalf of the employer about payment but it's not regulated by the state at all.

Rep. Zuber stated that I guess my follow up question is, is it part of the administrative process? What do you do if the employer refuses to authorize medical treatment? Ms. Lee stated that's where the tort liability comes in essentially. So, that's part of the carrot and the stick that the employee has is if they feel like they are not treated properly then they can use that tort liability. Rep. Zuber stated wow, that could take months or even a year, if not longer to have that authorized by a Court. In Mississippi, we have an extra administrative step that you must go through and I was just wondering if it was a little bit more efficient in Texas. Ms. Saxon stated that I believe that in the ERISA medical plans there are administrative appeals built into the plans via ERISA. Ms. Lee stated that if the employer has an arbitration agreement that is pretty common for the larger non-subscriber plans, usually that is the avenue that they handle those agreements through.

Rep. Meskers stated that having worked in the financial industry for too many years, I'm confused between the tort liability and arbitration. So, if the arbitration is binding then the risk in the tort is nonexistent, no? Ms. Saxon stated that it depends on the plan as each employer sets up their own plan. Rep. Meskers stated that you'd have to fire your lawyer if he wouldn't push you to arbitration if you were going to have tort exposure. I

mean, there must be almost nobody subjecting themselves to tort risk and you'd cover it with arbitration. So, I'm not sure that the workers have as much access if it's arbitration, right? Ms. Saxon stated that I think it really depends on the employers and how they set them up differently depending on kind of how they decide to go about things. Ms. Lee stated that and keep in mind that not every claim can be handled through arbitration. There's still tort liability even for employers that have arbitration agreements.

DISCUSSION ON FEDERAL WORK COMP PREEMPTION DEVELOPMENTS AND CONSIDERATION OF RESOLUTION OPPOSING FEDERAL MONITORING OF THE STATE BASED WORKERS' COMPENSATION SYSTEM

Rep. Oliverson stated that as the sponsor of this Resolution, I'd like to say a few words. First of all, I'm particularly appreciative of my colleague from Kentucky, Rep. Susan Westrom for partnering with me on this and sponsoring this along with me. You will find this resolution on page 128 of your binders. It's pretty simple and straightforward but it's really important and the impetus for creating this Resolution came on September 10th of 2021 when in Congress the House Education and Labor Committee voted to approve language proposed for inclusion in the reconciliation bill for 2022 that would provide funding and authority for the U.S. Department of Labor's Office of Workers Compensation Programs for "monitoring of state workers compensation programs in preparation of an annual report."

Friends, we believe such monitoring and reporting are unnecessary as it would create unnecessary imbalances and unintended consequences for a system which has been operating fairly effectively and fairly flawlessly for quite a few decades. And so, at this juncture we felt that it was important in keeping with our strong support of the state-based system of insurance regulation that we put our marker out there. It's come to my attention that the latest version of the bill may not have this language in it but since it's out there, we felt as though it was incumbent upon us to comment and just sort of raise the red flag and say, "Hey you know, this system has been in place for the better part of a century. The grand bargain has worked extremely well across many different states, different demographics, different sizes, different pools of risk and we don't think it should be messed with." And at this point, I'd like to turn it over to Rep. Westrom your comments.

Rep. Westrom stated that I'm proud to sponsor this Resolution alongside you after an absence of a few years of my attendance here at NCOIL. As some of you may know, a similar issue arose in 2009 if you've been coming to NCOIL for a period of time. And that Resolution opposed the establishment of a federal commission to examine state workers compensation laws. Luckily, that Resolution met its intended goal of avoiding the establishment of such a commission and that's why I believe it's important for this committee to again pass a Resolution to make sure that this unnecessary monitoring of state workers compensation programs does not take place. As both the 2009 Resolution, and the current Resolution state, the state-based work comp system, it's administration, legal precedence, funding, and fiscal accountability is intricately linked to each state's economy and provides the ability to experiment creatively and to borrow from experiences of other states. There simply is no need for federal monitoring of the proven state-based insurance system as the State work comp systems are already subject to robust monitoring and reporting requirements at the state level.

Frank O' Brien, VP of Sate Gov't Relations at the American Property Casualty Insurance Association (APCIA) stated that APCIA is a national trade association that represents a substantial number of work comp carriers. There's very little that I can add to the comments made by the Chair and Rep. Westrom regarding this particular issue. We are grateful to Congress and our advocacy partners who have seen the wisdom, and through their efforts, this particular provision is no longer in current legislation. But it could be. This is an issue that's particularly within NCOIL's wheelhouse as continuing to maintain vigilance concerning the oversight of our state based insurance system by state legislators is a primary purpose of this organization and your voice has been heard on this issue and it will continue to be heard and NCOIL's expertise is indeed welcome in Washington on this issue. We thank you for putting this Resolution forward and we wholeheartedly support it and we urge it's adoption.

Upon a Motion made by Rep. Lehman and seconded by Rep. Zuber, the Committee voted without objection by way of a voice vote to adopt the Resolution.

GRAND BARGAIN UNDER SIEGE? A DISCUSSION ON MATILDE EK V. SEE'S CANDIES, INC.

Jeff Adelson, General Counsel at Adelson McLean, stated that I am an attorney from California and my firm represents the insurance companies, self-insureds, and municipalities in the defense of work comp acts and related matters. My experience goes back about 43 years in this area. This is a very interesting case, and I'm going to tell it to you a little in story form. We are fortunate in that I've been able to discuss the matter with the defense attorney for See's Candy and I watched the appellate arguments yesterday. So, what I have to bring you is as current as it gets. I grew up in Los Angeles and in Los Angeles one of the greatest things you had other than the Los Angeles Dodgers was See's Candy.

So, when I saw this case come up I was intrigued by the facts surrounding it. In order to understand this, let's talk about the grand bargain a little bit. Because this case in my opinion and the opinion of many others is an absolute attack on the grand bargain. Not just in California, but you could be just about anywhere. So, in this case we are going from the joy of See's Candy to eat in which the Plaintiff's case refers to the employee, Mrs. Eck, as a vector. So, before the modern work comp system, we had tort and back in England in 1835 there's a case Priestly vs Fowler, and that was the first known case of someone suing their employer for an injury. And the employer was not liable for the injury of one employee caused by another. And ultimately in England, they thought about it and gave rise to the English Liability Act of 1880 and it was replaced in 1897.

In the United States, before work comp came to be, what was necessary? It was tough for an employee. An employee had to prove that their employer was negligent. They had to prove the employer was negligent in order to gain compensation for lost wages and medical bills. Now, this was beyond difficult. And it was heard in Superior Court or Municipal Court in California and juries heard it. So, the employers had these defenses and one was assumption of the risk. So, the Courts assumed at the time that if the employee knew of the risk, the employer was thereby removed from the duty of care. So, the employees were believed to understand the risk and if they got hurt too bad for them, they got nothing. Pretty harsh. There was contributory negligence and this asserted that if the Plaintiff was even partially culpable in causing the injury they would be barred from recovery, another absolute defense. And lastly, the fellow servant rule.

The injury by one employee to another employee was just not the employer's fault. So, people were being injured, the industrial revolution was on and there was just really no sufficient remedy for a working person. And these defenses ultimately were considered harsh and they tried to use different acts, Employers Liability Act of '06, '08. But still, even under that more enlightened view these cases were heard in front of juries.

Finally, in 1910 in New York, there was a law trying to create a work comp system but it was struck down for violating due process and surprisingly those against this law were the unions. So, on March 24th of 1911, this law was declared unconstitutional. Now, why is that interesting? On that very day, the Triangle Shirtwaist Factor Fire occurred. For those who may know about it, it was one of the most horrible things in American industry. People were working in a factory. They were on the ninth and tenth floor. If a fire occurred, they were unable to get out and 146 employees were killed, some from the fire, many from jumping out of a window nine to ten floors above the street. And you would think that something as horrible as that would have created some degree of liability where these people could have been the survivors and dependents could have been made whole or something.

But the manslaughter case against the owners resulted in an acquittal. And the civil suit against the owners netted each family who had lost someone dear to them, $75. That was what life was like before the grand bargain. And by 1913, New York had a work comp statute. So, where is the bargain? The bargain was an agreement between labor and industry. The employers agreed to pay medical bills and lost wages regardless of fault. You know even up to this day as a defense attorney in California, it's difficult to explain to certain clients what this means. You don't get to not pay benefits because somebody maybe is not paying enough attention, to be polite.

The employee agreed to give up the right to sue in civil court subject to certain exceptions and ultimately, the United States Supreme Court in New York Railroad vs White, finally said, "Yeah these work comp programs are constitutional. We do appreciate the grand bargain - compulsory insurance requirements are fine." But as I sit here today with you, and based on my experience and discussing the grand bargain with my own clients, and different insurance carriers, and being very active in claims litigation management throughout the country, they don't understand it. They still think they're paying too much for work comp. They still think they are not given adequate protection and predictability that work comp provides. They don't like it. Which brings us to the case of Mrs. Eck. Mrs. Eck's first name is Matilda. Her husband was named Arturo. A complaint was filed in Los Angeles Superior Court on December 30, 2020. It was filed on behalf of the survivor, Mrs. Eck. The date of injury set forth in the complaint is interesting because it says Mrs. Eck was sick sometime between March 1, 2020 and April 20, 2020.

What did Mrs. Eck do? What happened here? Mrs. Eck worked for See's Candy. She worked in one of the distribution type factory settings where she put the boxes together. And she worked based on the allegations closely with other employees, and alleged not enough distancing, not enough mitigating actions to make sure people didn't get sick from one another. Well, low and behold Mrs. Eck unfortunately got COVID. Now, in California at the time, there's certain presumptions of compensability but whether Mrs. Eck qualified for them or not, I do not know. But I can tell you that Mrs. Eck did file a work comp claim against See's on her own behalf. Mrs. Eck went home to quarantine and to get better because she did have a case requiring medical treatment. And it is

interesting to note here, for the basis of what happens on appeal, is that the definition of injury in the California work comp scheme can include disability and can include medical treatment without disability. The medical treatment is sufficient for there to be a legitimate claim of injury. Now, it's subjective to defenses, but it can and is defined as injury.

Mrs. Eck got home and exposed her husband to COVID who was about 72 years old and unfortunately he passed away from COVID. They had a younger daughter living at home, she also got COVID but recovered. Mrs. Eck recovered. The Plaintiffs alleged that See's should have known that proximity of work would result in employees getting infected and consequently would take the virus home and would infect family members. The lawsuit filed in Superior Court is not filed on behalf of Mrs. Eck as a result of her getting COVID. It's filed as a result of the death of Mr. Eck and her loss, property liability. Mrs. Eck had an injury, and that's important to know. Mr. Eck had never been to See's and had no reason to have anything to do with See's other than he lived in the same house as Mrs. Eck who became sick while working at See's.

As you would expect, and for non-lawyers in the room, a demurrer was filed by the attorney representing See's Candy. It basically said, there is no separate cause of action by anybody for the death of Mr. Eck. This is precluded by the exclusive remedy of the labor code and the California Workers Compensation Act and the grand bargain. So, the general negligence claim should be preempted by the Work Comp Act. The premises liability claim should be preempted by the Work Comp Act. And the exclusive remedy for any damages arising or any injuries that may have occurred to the family member are derivative or collateral to Mrs. Eck's injuries. This is very important because the derivative rule is what is at stake here, which is part of the grand bargain. The derivative rule says, in California, any claim that would not have existed in the absence of the work related injury to the employee falls within the exclusive remedy of the Workers Compensation Act.

To me this is very clear. Having done this a long time and of course have some bias on one side, based on what I do, it's very clear. And it was very clear to a lot of people. And a lot of observers of the Court except the trial judge did not find it clear and did not find it persuasive. And all of sudden out of the blue the demurrer was denied. The Judge said, this was not a derivative injury. The Plaintiff's attorney said, this is foreseeable. It's foreseeable that Mrs. Eck would go to work and if the employer did not maintain a safe workplace and she became a vector, she'd go home and she would transmit COVID. They also claimed on the Plaintiff side, in their initial opposition, that Mrs. Eck was not injured. But Mrs. Eck was injured, and Mrs. Eck claims injury by filing a work comp claim before the Workers Compensation Appeals Board. So, they're wrong.

And they argued that as a vector, someone who brought on this infection, brought it out, that this was in line with an earlier California case. There's a case in California by the name of Kesner. And the facts in Kesner are what both sides of this case are relying on. In Kesner, the employee worked in a facility that used lots of asbestos to make different brake related drums and other things containing asbestos. And Kesner went home every day for years with asbestos fibers on his clothing. And although Mr. Kesner never got or suffered from mesothelioma or any asbestos related disease, his nephew who lived with them got mesothelioma and of course died from it. And in that case, the California case said, "Yes, this is something you can collect on. We understand this

because one, Kesner never had an industrial injury. Two, premises liability, the employer should have known not to allow the employees to come home and bring the asbestos fibers home with them. They should have warned them, they should have done something about it. And there's something they could have done about it and they didn't." So, they said, "this is not a work comp case." There was no derivative injury because there was no work comp by Kesner, he never got sick.

So, in my opinion, it's different. Based on the Plaintiff's view of this, Mrs. Eck was the same asbestos fibers on clothing, she was a vector. The Judge who heard the demurrer believed it. The Judge said that See's owed a legal duty of care to all third-parties. Well, even the Plaintiff's attorney thought this was a little broad. And said, "Well, we don't really mean all parties. We don't really mean, you can go out into the world and make everyone sick, and you'll have to pay for it. We just mean your family members." I don't know where they came up with this. Kesner used that type of language but Plaintiff's attorney just kind of pulled it out claiming that foreseeability only goes so far. Which of course, we would agree. But, that doesn't mean that future Courts and future cases would self-limit it as Plaintiff's attorney did.

So, the Defendant's file a reply to memorandum and they restate their claim, they again state that Mrs. Eck's injury is vital to the case while the Plaintiff's attorney is saying it doesn't matter if she was injured or not. She was a vector. So, what does the Court do? At the trial level, the Court says, "well it's premises liability, See's didn't exercise due care. And Kesner rules because Mrs. Eck was the asbestos in the mix." They said what they shouldn't have said, they said that, "well the science is such that it's foreseeable." But that's part of the underlying claim, not part of what really happened and that shouldn't have been even commented on during the course of the demurrer. So, a Writ of Mandate is filed. In the Writ, the defense attorney finally comes up and says, "Look, it's the grand bargain guys. There's a benefit to the employee by creating this statute on not having them have liability. This is an absolute defense, this is a derivative injury. If the case goes forward there may be no end to it. And the process will be extremely slow and difficult to prove, and costly. And the work comp system is supposed to be quick and efficient."

Finally, come the oral arguments for the demurrer and the Judge, surprising to me, says "I don't think Eck's injury in the workplace has anything to do with this." But based on the definition of derivative claim and based on the cases relative to derivative claims it does. The Judge was also concerned there was no remedy here. Well, if there's no work comp coverage, then there's no remedy. And sometimes, there is no remedy and it's really unfortunate about Mr. Eck but it's not within purview. So, let's go to the amicus curiae brief. I'll tell you who filed it and why. The amicus curiae brief was filed by the Chamber of the United States of America, California Chamber of Commerce, California Work Comp Institute, Restaurant Law Center, California Restaurant Law Association, National Association of Manufacturers, National Retail Federation, National Federation of Small Businesses.

So, oral arguments on the appeal were heard before the Second District Court yesterday. I was fortunate enough to watch them. Here are my concerns, the Judges were engaged, however one Judge said "this is a case of first impression", which clearly it's not. Another Judge said, "Well this is like the but for rule" which if you've gone to law school, you know that's tort not work comp. And another Judge cited the Palsgraf of all things and whoever went to law school can laugh about this one that talks about

foreseeability and zone of danger. I don't think the Judges got it. One Judge asked a hypothetical that basically said, "Someone works in a laboratory and the laboratory negligently allows a virus to escape. The person who works at the lab gets on a bus and gets everyone on the bus sick. Should they not be sued?" And the defense attorney for See's just said, "it's nothing like what you're asking for in this case." And that's where it ended. So, with that I'm open for questions and because I've cut this a little short I am available to anybody who wants to talk about this afterwards.

Rep. Zuber stated that in most states you have either a statutory or administrative definition of a covered employee. In California do you have that language? And if so, why doesn't that supersede the common law doctrine of the derivative action? Mr. Adelson stated that we absolutely have definitions of employees and what constitutes an employee and then under what circumstances but work comp under the grand bargain the derivative rule basically helps the employer. It prevents a case such as this. It says, if there's an industrial injury and there's a consequence from it to someone else who's not injured, who's not employed then there's no remedy, you cannot file. It's covered by the exclusive remedy. It prevents a civil action.

Rep. Meskers stated that I'm sympathetic to the case you describe but on a policy basis, on the back of the SARS epidemic the insurance industry decided to exclude pandemics. The analysis of asbestos in the workplace versus a pandemic illness is discreetly different in that no one can certify to me that the disease was contracted at the workplace whether it had unsafe conditions or not because people were at the supermarket, people were on public transportation, people were in communication with other people. So, I think it's significantly different from, I picked up asbestos in the one location it's located at my workplace and brought it home. And I had family members who suffered. Apart from that, the bigger picture in question is will the workplace compensation programs support this, if we agree that the disease is always contracted at the workplace, is the system prepared to handle a pandemic? So, that's a different question, I don't want to muddy the waters. The first one is, can you prove to me that the disease was contracted versus there's potentiality?

Mr. Adelson stated that the narrow answer is that when a demurrer is filed, it's filed based on the fact that there is no cause of action. But when a demurrer is filed, it is the understanding of the parties and it is the law that the facts set forth in the complaint are accepted, for that narrow purpose. If the case were to become litigated beyond the demurrer, then all the questions you ask are part of it. The science will be involved and there will be many, many defenses to the case. But at this point, it's as if someone's got their hand over a hole with water coming through saying this doesn't belong, this doesn't belong in this system. It doesn't belong anywhere unfortunately for the family. Rep. Meskers stated that as I take it then, the first question is you believe it belongs in the system. And then the second question I would take is subsequently, should it be in the system? So, you're arguing for remedy under the existing system and I'm concerned where the system is headed on pandemics and how can the system survive them?

Mr. Adelson stated that's been the subject of the last year and a half of conversation in every state, particularly California. California created a number of presumptions to deal with the pandemic. The state compensation insurance fund in California early on said, "You know, it's far better to accept these claims and provide quick treatment and get them in there than to fight every one of them." But we now have these presumptions within the system, in California that will find that if you work under certain conditions or if

you work in certain occupations it's going to be presumed, rebuttably, that it is industrial in nature. So far, California has not had as many claims as they feared. And it's been working. But, to your point, another point is, one of the other attacks that I view on the grand bargain are just the multitude of presumptions that have come along finding injury since COVID.

CONSIDERATION OF RE-ADOPTION OF MODEL LAW

Rep. Oliverson stated that lase on the agenda, we have consideration of the readoption of the Model State Structured Settlement Protection Act.

Sen. Paul Utke (MN), Vice Chair of the Committee, stated that the Committee can re-adopt the Model today but I would like us to bring this back in March of 2022 because we have some additional language that we will be working with in Minnesota to adjust the language we currently have in statute. And there have been changes recently made in four other states around the United States here and we think with what they have done and with what we are looking at in Minnesota that there's some positive things that we can add to this Model and we would like to have that option to bring back those changes as amendments in March.

Upon a Motion made by Rep. Zuber and seconded by Rep. Lehman, the Committee voted without objection by way of a voice vote to re-adopt the Model until the Committee's March meeting at which time amendments to the Model will be discussed.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Deborah Ferguson (AR) and seconded by Rep. Zuber, the Committee adjourned at 4:30 p.m.

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National Council of Insurance Legislators (NCOIL)

Model State Structured Settlement Protection Act

Supported by the NCOIL Executive Committee on February 27, 2004, July 22, 2006, July 17, 2011, November 20, 2016, July 18, 2021, and November 20, 2021.

Sponsored by Sen. Carroll Leavell (NM)

To be considered for re-adoption during the NCOIL Workers' Compensation Insurance Committee on March 4, 2022.

SECTION 1. TITLE.

This Act shall be known and referred to as the "Structured Settlement Protection Act."

SECTION 2. DEFINITIONS.

For purposes of this Act--

(a) "annuity issuer" means an insurer that has issued a contract to fund periodic payments under a structured settlement;

(b) "assignee" means a party acquiring or proposing to acquire structured settlement payment rights from a transferee of such rights.

(c) "dependents" include a payee's spouse and minor children and all other persons for whom the payee is legally obligated to provide support, including alimony;

(d) "discounted present value" means the present value of future payments determined by discounting such payments to the present using the most recently published Applicable Federal Rate for determining the present value of an annuity, as issued by the United States Internal Revenue Service;

(e) "gross advance amount" means the sum payable to the payee or for the payee's account as consideration for a transfer of structured settlement payment rights before any reductions for transfer expenses or other deductions to be made from such consideration;

(f) “independent professional advice” means advice of an attorney, certified public accountant, actuary or other licensed professional adviser;
(g) “interested parties” means, with respect to any structured settlement, the payee, any beneficiary irrevocably designated under the annuity contract to receive payments following the payee’s death, the annuity issuer, the structured settlement obligor, and any other party to such structured settlement that has continuing rights or obligations to receive or make payments under such structured settlement;

(h) “net advance amount” means the gross advance amount less the aggregate amount of the actual and estimated transfer expenses required to be disclosed under Section 3(e) of this Act;

(i) “payee” means an individual who is receiving tax free payments under a structured settlement and proposes to make a transfer of payment rights thereunder;

(j) “periodic payments” includes both recurring payments and scheduled future lump sum payments;

(k) “qualified assignment agreement” means an agreement providing for a qualified assignment within the meaning of section 130 of the United States Internal Revenue Code, United States Code Title 26, as amended from time to time;

[(l) “responsible administrative authority” means, with respect to a structured settlement, any government authority vested by law with exclusive jurisdiction over the settled claim resolved by such structured settlement;]

Drafting Note 1: this Model recognizes that in some states a structured settlement may have been approved by an administrative body, i.e., a “responsible administrative authority,” rather than a court. The definition of “responsible administrative authority” and subsequent references to that term are bracketed, because they can appropriately be omitted in a State whose laws do not provide for administrative approval of structured settlements (or in which the only settlements that receive administrative approval are workers’ compensation settlements and such settlements are excluded from the definition of “structured settlement” as discussed in note 2 below).

(m) “settled claim” means the original tort claim [or workers’ compensation claim] resolved by a structured settlement;

Drafting Note 2: References to workers’ compensation are bracketed, because in some States transfers of payment rights under workers’ compensation settlements are incompatible with workers’ compensation laws.

(n) “structured settlement” means an arrangement for periodic payment of damages for personal injuries or sickness established by settlement or judgment in resolution of a tort claim [or for periodic payments in settlement of a workers’ compensation claim];

(o) “structured settlement agreement” means the agreement, judgment, stipulation, or release embodying the terms of a structured settlement;
(p) “structured settlement obligor” means, with respect to any structured settlement, the party that has the continuing obligation to make periodic payments to the payee under a structured settlement agreement or a qualified assignment agreement;

(q) “structured settlement payment rights” means rights to receive periodic payments under a structured settlement, whether from the structured settlement obligor or the annuity issuer, where –

(i) the payee [resides] [is domiciled] in this State; or

Drafting Note 3: This definition, which determines the applicability of a statute based on this Model, refers to the place where a structured settlement payee has his or her primary, continuing residence, e.g., where he or she pays State taxes, is registered to vote, is licensed to drive, etc. In some States that place may commonly be referred to as the payee’s “domicile,” in other States it may be referred to as the payee’s “residence.”

(ii) the structured settlement agreement was approved by a court [or responsible administrative authority] in this State

(r) “terms of the structured settlement” include, with respect to any structured settlement, the terms of the structured settlement agreement, the annuity contract, any qualified assignment agreement and any order or other approval of any court [or responsible administrative authority] or other government authority that authorized or approved such structured settlement;

(s) “transfer” means any sale, assignment, pledge, hypothecation or other alienation or encumbrance of structured settlement payment rights made by a payee for consideration; provided that the term “transfer” does not include the creation or perfection of a security interest in structured settlement payment rights under a blanket security agreement entered into with an insured depository institution, in the absence of any action to redirect the structured settlement payments to such insured depository institution, or an agent or successor in interest thereof, or otherwise to enforce such blanket security interest against the structured settlement payment rights;

(t) “transfer agreement” means the agreement providing for a transfer of structured settlement payment rights.

(u) “transfer expenses” means all expenses of a transfer that are required under the transfer agreement to be paid by the payee or deducted from the gross advance amount, including, without limitation, court filing fees, attorneys fees, escrow fees, lien recordation fees, judgment and lien search fees, finders’ fees, commissions, and other payments to a broker or other intermediary; “transfer expenses” do not include

preexisting obligations of the payee payable for the payee's account from the proceeds of a transfer;

(v) "transferee" means a party acquiring or proposing to acquire structured settlement payment rights through a transfer;

SECTION 3. REQUIRED DISCLOSURES TO PAYEE.

Not less than three (3) days prior to the date on which a payee signs a transfer agreement, the transferee shall provide to the payee a separate disclosure statement, in bold type no smaller than 14 points, setting forth —

(a) the amounts and due dates of the structured settlement payments to be transferred;

(b) the aggregate amount of such payments;

(c) the discounted present value of the payments to be transferred, which shall be identified as the "calculation of current value of the transferred structured settlement payments under federal standards for valuing annuities", and the amount of the Applicable Federal Rate used in calculating such discounted present value;

(d) the gross advance amount;

(e) an itemized listing of all applicable transfer expenses, other than attorneys' fees and related disbursements payable in connection with the transferee's application for approval of the transfer, and the transferee's best estimate of the amount of any such fees and disbursements;

(f) the effective annual interest rate, which must be disclosed in a statement in the following form: "On the basis of the net amount that you will receive from us and the amounts and timing of the structured settlement payments that you are transferring to us, you will, in effect be paying interest to us at a rate of _____ percent per year";

(g) the net advance amount;

(h) the amount of any penalties or liquidated damages payable by the payee in the event of any breach of the transfer agreement by the payee;

(i) that the payee has the right to cancel the transfer agreement, without penalty or further obligation, not later than the third business day after the date the agreement is signed by the payee; and

(j) that the payee has the right to seek and receive independent professional advice

regarding the proposed transfer and should consider doing so before agreeing to transfer any structured settlement payment rights.

SECTION 4. APPROVAL OF TRANSFERS OF STRUCTURED SETTLEMENT PAYMENT RIGHTS.

(a) No direct or indirect transfer of structured settlement payment rights shall be effective and no structured settlement obligor or annuity issuer shall be required to make any payment directly or indirectly to any transferee or assignee of structured settlement payment rights unless the transfer has been approved in advance in a final court order [or order of a responsible administrative authority] based on express findings by such court [or responsible administrative authority] that —

(i) the transfer is in the best interest of the payee, taking into account the welfare and support of the payee's dependents;

(ii) the payee has been advised in writing by the transferee to seek independent professional advice regarding the transfer and has either received such advice or knowingly waived in writing the opportunity to seek and receive such advice; and

(iii) the transfer does not contravene any applicable statute or the order of any court or other government authority;

SECTION 5. EFFECTS OF TRANSFER OF STRUCTURED SETTLEMENT PAYMENT RIGHTS.

Following a transfer of structured settlement payment rights under this Act:

(a) The structured settlement obligor and the annuity issuer may rely on the court [or responsible administrative authority] order approving the transfer in redirecting periodic payments to an assignee or transferee in accordance with the order approving the transfer and shall, as to all parties except the transferee or an assignee designated by the transferee, be discharged and released from any and all liability for the redirected payments; and such discharge and release shall not be affected by the failure of any party to the transfer to comply with this chapter or with the court [or responsible administrative authority] order approving the transfer.

(b) The transferee shall be liable to the structured settlement obligor and the annuity issuer:

(i) if the transfer contravenes the terms of the structured settlement, for any taxes incurred by the structured settlement obligor or annuity issuer as a consequence of the transfer; and

(ii) for any other liabilities or costs, including reasonable costs and attorneys' fees, arising from compliance by the structured settlement obligor or annuity issuer with the court [or responsible administrative authority] order approving the transfer or from the failure of any party to the transfer to comply with this Act;

(c) Neither the annuity issuer nor the structured settlement obligor may be required to divide any periodic payment between the payee and any transferee or assignee or between two (or more) transferees or assignees; and

(d) Any further transfer of structured settlement payment rights by the payee may be made only after compliance with all of the requirements of this Act.

SECTION 6. PROCEDURE FOR APPROVAL OF TRANSFERS.

(a) An application under this Act for approval of a transfer of structured settlement payment rights shall be made by the transferee and shall be brought in the [court of general jurisdiction or other designated court] in the [county][other political subdivision] in which the payee [resides][is domiciled], except that if the payee [does not reside][or is not domiciled] in this state, the application may be brought in the court [or before the responsible administrative authority] in this state that approved the structured settlement agreement.

(b) A timely hearing shall be held on an application for approval of a transfer of structured settlement payment rights. The payee shall appear in person at the hearing unless the court [or responsible administrative authority] determines that good cause exists to excuse the payee from appearing in person.

(c) Not less than twenty (20) days prior to the scheduled hearing on any application for approval of a transfer of structured settlement payment rights under Section 4 of this Act, the transferee shall file with the court [or responsible administrative authority] and serve on all interested parties (including a parent or other guardian or authorized legal representative of any interested party who is not legally competent) a notice of the proposed transfer and the application for its authorization, including with such notice:

(i) a copy of the transferee's application;

(ii) a copy of the transfer agreement;

(iii) a copy of the disclosure statement required under Section 3 of this Act;

(iv) the payee's name, age, and county of [residence][domicile] and the number and ages of each of the payee's dependents;

(v) A summary of:

(A) any prior transfers by the payee to the transferee or an affiliate, or through the transferee or an affiliate to an assignee, within the four years preceding the date of the transfer agreement and any proposed transfers by the payee to the transferee or an affiliate, or through the transferee or an affiliate, applications for approval of which were denied within the two years preceding the date of the transfer agreement; and

(B) any prior transfers by the payee to any person or entity other than the transferee or an affiliate or an assignee of the transferee or an affiliate within the three years preceding the date of the transfer agreement and any prior proposed transfers by the payee to any person or entity other than the transferee or an affiliate or an assignee of a transferee or affiliate, applications for approval of which were denied within the one year preceding the date of the current transfer agreement, to the extent that the transfers or proposed transfers have been disclosed to the transferee by the payee in writing or otherwise are actually known to the transferee.

(vi) notification that any interested party is entitled to support, oppose or otherwise respond to the transferee's application, either in person or by counsel, by submitting written comments to the court [or responsible administrative authority] or by participating in the hearing; and

(vii) notification of the time and place of the hearing and notification of the manner in which and the date by which written responses to the application must be filed, which date shall be not less than five (5) days prior to the hearing, in order to be considered by the court [or responsible administrative authority].

SECTION 7. GENERAL PROVISIONS; CONSTRUCTION.

(a) The provisions of this Act may not be waived by any payee.

(b) Any transfer agreement entered into on or after the effective date of this Act by a payee who resides in this state shall provide that disputes under such transfer agreement, including any claim that the payee has breached the agreement, shall be determined in and under the laws of this State. No such transfer agreement shall authorize the transferee or any other party to confess judgment or consent to entry of judgment against the payee.

(c) No transfer of structured settlement payment rights shall extend to any payments that are life-contingent unless, prior to the date on which the payee signs the transfer agreement, the transferee has established and has agreed to maintain procedures reasonably satisfactory to the annuity issuer and the structured settlement obligor for (i) periodically confirming the payee's survival, and (ii) giving the annuity issuer and the structured settlement obligor prompt written notice in the event of the payee's death.

(d) If the payee cancels a transfer agreement, or if the transfer agreement otherwise

terminates, after an application for approval of a transfer of structured settlement payment rights has been filed and before it has been granted or denied, the transferee shall promptly request dismissal of the application.
(e) No payee who proposes to make a transfer of structured settlement payment rights shall incur any penalty, forfeit any application fee or other payment, or otherwise incur any liability to the proposed transferee or any assignee based on any failure of such transfer to satisfy the conditions of this Act.

(f) Nothing contained in this Act shall be construed to authorize any transfer of structured settlement payment rights in contravention of any applicable law or to imply that any transfer under a transfer agreement entered into prior to the effective date of this Act is valid or invalid.

(g) Compliance with the requirements set forth in Section 3 of this Act and fulfillment of the conditions set forth in Section 4 of this Act shall be solely the responsibility of the transferee in any transfer of structured settlement payment rights, and neither the structured settlement obligor nor the annuity issuer shall bear any responsibility for, or any liability arising from, non-compliance with such requirements or failure to fulfill such conditions.

EFFECTIVE DATE. This Act shall apply to any transfer of structured settlement payment rights under a transfer agreement entered into on or after the [thirtieth (30th)] day after the date of enactment of this Act.

NCOIL – NAIC DIALOGUE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE
SCOTTSDALE, ARIZONA
NOVEMBER 19, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue met at The Westin Kierland Hotel in Scottsdale, Arizona on Friday, November 19, 2021 at 10:45 a.m.

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

Other members of the Committee present were:

Sen. Keith Ingram (AR)
Sen. Jason Rapert (AR)
Sen. David Livingston (AZ)
Rep. Tammy Nuccio (CT)
Sen. Travis Holdman (IN)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Asm. Kevin Cahill (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Deborah Ferguson (AR)
Rep. Stephen Meskers (CT)
Sen. Jim Guthrie (ID)
Rep. Craig Snow (IN)
Sen. Beverly Gossage (KS)
Rep. Mary DuBuisson (LA)
Rep. John Illg (LA)
Sen. Robert Mills (LA)
Sen. Lana Theis (MI)
Sen. Michael McLendon (MS)
Sen. Walter Michel (MS)
Sen. Charles Younger (MS)
Rep. Hank Zuber (MS)
Sen. Jim Burgin (NC)
Rep. Carl Anderson (SC)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Paul Utke (MN), and seconded by Sen. Jason Rapert (AR), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Tom Oliverson, M.D. (TX), and seconded by Rep. Tammy Nuccio (CT), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 16, 2021 meeting in Boston, MA.

INTRODUCTORY REMARKS

Before moving to the agenda, Asm. Cooley recognized Florida Insurance Commissioner and National Association of Insurance Commissioners (NAIC) President, David Altmaier for introductory remarks

Cmsr. Altmaier thanked Asm. Cooley and stated it's really good to be here in such a beautiful venue but also back in person with all of you and having these conversations and we had some great discussions this morning and we're looking forward to continuing those discussions here with you all this afternoon. I think the fact that we've brought so many of us here is just a testament to the fact that we're looking forward to collaborating with NCOIL going forward as we have on many issues in the past. I think we all share a common interest in protecting state-based insurance regulation as we've seen a number of issues come up in the insurance space and in the broader financial services space, and we've seen a lot of activity by the Federal government and it's very important for us to demonstrate that states can continue to lead on important issues of this nature. We're very much looking forward to having those conversations with you all this afternoon. And I just want to commend you all on your attendance here at this meeting. I understand it's your largest meeting in terms of attendance and so congrats on that and I think we all should be commended for our ability to continue all of our operations throughout the pandemic in a virtual way, but I can tell you that on the NAIC side, and I'm sure in the broader sense, everyone is excited to get back together in person and I think the attendance here is a reflection of that. We're looking forward to some very productive conversations.

UPDATE ON STATE ADOPTION OF CREDIT FOR REINSURANCE MODELS

Asm. Cooley stated that one topic that we have been addressing for a long time is the adoption of the NAIC's credit for reinsurance models. This has been an important matter arising out of European and U.S. covered agreements and the NAIC has adopted amendments to its credit for reinsurance model and regulation addressing the requirements under the covered agreement between the U.S. and European Union and a similar covered agreement between the U.S. and the U.K. We have seen that the amended model law adopted in all but three states, plus the District of Columbia at this point. So, we have made good progress on that and twenty-two states I believe have followed up with adoption of the regulation on that topic. Asm. Cooley asked the NAIC representatives to talk a little bit about how they see closing out the remainder of the states. Asm. Cooley noted that we also know that there is a role that the Federal government plays in terms of following up and conducting some surveys about the states that are non-compliant. Asm. Cooley asked what the NAIC knows about that Federal government survey process.

Cmsr. Altmaier stated that this is an issue we had been working hard on and spending a lot of time on it. I'm going to ask Alaska Insurance Director Lori Wing-Heier to provide a quick overview of this and answer some of your questions. Dir. Wing-Heier stated that we are well aware that some of the states have not adopted it and how important it is that we all are compliant. We also are respectful of the fact that the pandemic put some of us a little behind but are working very hard to make sure by July 1st the law is adopted and signed and that the regulations will be done by September 20, 2022. There is probably nothing more important that we do than monitor solvency. So, I don't think there's a director, superintendent, or commissioner, or a legislature that doesn't understands how important it is that we respond to this. For those of who are unaware,

and I know you have twenty-two new legislators, the European agreement and the UK agreement, the first one was signed by President Obama, the second one by President Trump. And what they are is an agreement where we recognize the same financial standards for reinsurers that are conducting business in the United States as well U.S. reinsurers that would be conducting business in the European Union or the U.K.

What this helps us is with is when we do a financial examination as we all do for our companies that are domiciled in our states, we know that when we go in that insurance company, that reinsurer has been examined under the same standards we are using for our own insurers. That's how we can best guarantee solvency. And that's basically a two minute primer on the reinsurance issues and I am confident we will be done by September 2022. We are working with the states and we will continue to do so.

Cmsr. Altmaier stated that the only thing that I would add is regarding the oversight from the Federal Insurance Office (FIO) in terms of monitoring compliance. We've had a number of very productive and constructive conversations with FIO. They've looked at the models that we adopted in order to comply with the covered agreements and have largely agreed that, assuming all the states adopt those, they won't have any issues from an implementation standpoint. So, that was really encouraging and good news to hear and as Dir. Wing-Heier mentioned, NAIC staff continues to work directly with individual states that are still working on adoption of either the law or the regulation, so that we can continue to have that a 100% across the board adoption. But we've gotten some really good feedback initially from FIO in terms of our models and their compliance with the covered agreement and I think all of us would be happy to answer any questions about this work that you all might have.

Asm. Cooley stated that I think for those in the audience who have an interest in maintaining state based regulation, if you know your state has not yet adopted the models, it's a good time to urge them to meet the deadlines as laid out by the NAIC today.

UPDATE ON NAIC SPECIAL COMMITTEE ON RACE IN INSURANCE

Asm. Cooley stated that an important topic in the last year and a half has been issues of race and insurance and you've had your ongoing work of your NAIC special committee and NCOIL had its own committee that met and has sunset since it met its two charges. Two issues, artificial intelligence in insurance underwriting and insurance score transparency were referred to some of our NCOIL standing committees for ongoing discussion. Yesterday on the insurance score transparency issue we had a general session with a great deal of conversation and interesting information on that topic. Asm. Cooley asked if an update could be provided as to where things stand within the NAIC on its special committee.

Cmsr. Altmaier stated that I'll go ahead and just quick give an overview of the work of the special committee. First of all, just by way of background, this is a committee that we started last summer under the leadership of Director Ray Farmer from South Carolina who was NAIC President at the time. To underscore the importance of this work at the NAIC all four officers have a leadership role on the committee, so the President and President-elect are the co-chairs and our Vice President and Secretary-Treasurer are our co-vice chairs. We've divided the work of the special committee up

into five work streams. The first two work streams look at diversity within the insurance industry and diversity within the insurance regulatory community, respectively.

And then the next three deal with race and insurance issues in the property & casualty space, the life space, and in the health space. And so, that's what we've been working on so far. In terms of work that's been done recently, back in July our committee adopted the 2021 and 2022 charges and those charges are reflective of a lot of the initial discussions that those five workstreams have had. We also have been looking at our existing NAIC committee structure to find the most efficient use of that committee structure when we're working to meet out these charges. For the most part, most of the five workstreams are going to continue to take the lead on issues of this nature, as they continue to have some important discussions. Workstream one has been having a lot of discussions with respect to diversity with the industry. And early this - this week they had a meeting with stakeholders to discuss some of the efforts that are ongoing within the industry and I should point out that in large part our regulatory community is pretty pleased with the industry's willingness to step up in this area and to really take the initiative in a proactive way to address a lot of these things.

Workstream number two is working on the same thing but instead of looking at the industry, looking at the insurance regulatory community. So, we're working now to gather some information from insurance regulatory departments in terms of best practices that might or might not exist in terms of looking within our regulatory community and ensuring that it's reflective of a diverse community that we oversee. So, workstream number three has a call scheduled for early next month. Workstream number three is working on issues within the P&C marketplace. They will likely begin work based on those discussions on some white paper activity that will look at some of the key terms in this space that could likely use some definitions -things like unfair discrimination, unfair bias, proxy discrimination, and disparate impact. Those are terms that get used a lot and I think there's an interest in discussing those terms and making sure everyone's on the same page with what we mean when we talk about those things.

Workstream number four, which is working in the life space, is collaborating with the other two subject matter workstreams in an effort to take advantage of some of the work that's being done there from a data collection standpoint. And then that brings us to workstream number five, which is focused on the health insurance space. They've made a lot of progress on a document with respect to principals for data collection. This is a document that's intended to establish some very high level guiding principles for the collection of and the treatment of data on race and ethnicity and other demographic characteristics in the health insurance industry. And I would imagine that as work continues with respect to those topics in the health insurance industry, workstreams three and four are likely going to be able to leverage a lot of those discussions as they consider the same issues in their own lines of business.

One thing I want to make sure is clear is that this is a principles document. It is not a document that imposes any kind of requirement or anything else of that nature on the industry at this point. We're just talking about principles to keep in mind as we go forward exploring this. We have just closed out a comment period on that and we've gotten a number of comment letters back on that document. We will likely be discussing those comments at the next couple of meetings and look to submit those recommendations to the larger special committee, probably sometime towards the end of this year or very early of next year. The full special committee is going to meet again

at our meeting in San Diego on December 14th. We look forward to hearing some updates from all five workstreams at that point and spending time on some of the work that's been done. The last thing that I'll say is that we are very committed to the importance to having a very thoughtful and deliberative process and we are looking forward to engaging with as many stakeholders as we possibly can including NCOIL and our state legislatures around the country. And so, it's been productive so far and constructive but we've got some work ahead of us that we're all looking forward to.

Asm. Cooley asked how the committee's deliberative processes work as he is a little unclear with some of the charges as some of that got organized and put together and at some point the conversation gets pushed out in the public domain for feedback and so it's just a process question. In California, our constitution says you pass no law except by statute, no statute except by bill, and it forces everything in the public domain. We have special transparency requirements for the conduct of our work. And I think that's sort of the framework I look at for any sort of sensitive conversation and I hear loud and clear it will be deliberative and open.

Cmsr. Altmaier stated that we did have some initial regulator only conversations but beyond that all of the charges and things of that nature have followed our existing NAIC process which is very transparent. We oftentimes tout globally the transparency of the NAIC and we're going to continue to strive for that on this issue as well. I'll use workstream number five as an example and the principles document that I referenced just a moment ago. We just concluded our second round of exposure on that and so that's been submitted to the public for comment at least twice now. They have a second exposure out now with respect to provider networks and looking at the impact of race and insurance issues on those. I anticipate that's going to continue to be robustly discussed in open meetings by workstream number five. And our special committee has not met in regulatory only session I think since the beginning of the year. All of their meetings have been open as well. And so, on all of the issues that we deal with at the NAIC, transparency is one of the most important things to us but especially on an issue of this nature that's so important and impacts so many people we're going to continue to be committed to a transparent process.

Asm. Cooley asked if there is a timeframe where the NAIC hopes to conclude its work. Cmsr. Altmaier stated that there are no real timeframes or deadlines on this because to be candid it there really aren't actually any hard defined deliverables at this point either. I think at this point and time we're just having conversations with stakeholders about things that could be barriers to access, that could be barriers to affordability that we might need to do some additional work on. I think the most tangible deliverable so far has been the information coming from workstream number five. But again, those are the kinds of things that since it's new and it's impactful, we want to make sure that we're not rushing that work and that we're being deliberative about it. We've seen other bodies in the past, some of the more global bodies that do some work, they've set deadlines and the deadline has kind of guided the work and in some cases, was detrimental to the overall product and we want to make sure that we avoid that and so we haven't set any hard and fast deadlines with respect to this work.

Rep. Stephen Meskers (CT) stated that he has a question on the process. What I hear the focus on, which I think is at some level very appropriate, is on access and dealing with risk pools in terms of the insurance products and market penetration and supply. You know, we tend to look as legislators and in the country we talk about equality of

access and equality of outcome and not equality of opportunity. But I would suggest as regulated products one of the issues that should sit in front of us is, when we look at whether it's long term care (LTC), term life, whole life, P&C, it's not so much across economic but across racial divides and are we getting to the right levels of market penetration if we're looking for that. Because most of the products that we sell in the insurance industry are either risk mitigation or wealth transfer products essentially.

So, if we don't have an equality of outcome but if we don't measure the inequality of outcome among the same economic groups of different racial terms we may miss the penetration and we may not achieve the goal of trying to provide for a better equitable solution which is that when you look at two people of an income of $75,000, you ask if the ownership of the insurance products that assist in that wealth is equal and is there an adequate display across those racial divides. We want to ensure everyone in the country is getting not only an equal opportunity but are we selling and marketing at the adequate level to get the outcomes because we are looking at some level at not just the disparity of discrimination and risk pools but are the outcomes equivalent for regulated entities and I'm not sure if we're doing that.

Cmsr. Altmaier stated that I think you've really touched on one of the important facets of the work that we're doing now which is how do we assess that? And one of the driving forces behind the principles on data collection document from workstream number five is, do we currently have enough existing data points to be able to assess whether or not those outcomes are equitable and if not do we need more, and how do we obtain that so that we can get right to the heart of the issue that you just raised. And so, I think that's one of the important facets of this work that we'll continue to work on.

Rep. Matt Lehman (IN), NCOIL President, stated that I just want to thank the NAIC for being here for also working on this issue. As you know we had our own committee where we went through some of these issues. I think we found some things that need to be addressed which leads into transparency which we'll maybe talk about that here in a little bit. But, we want to continue to be a partner in that and continue to have you reach out to us to see what needs to be done. So, we continue to watch your work and we'll follow along and see where we go. But we want to make sure that we offer at least to be a part of that discussion still. Cmsr. Altmaier stated that we hear that offer loud and clear and we'll look forward to taking you up on it.

Asm. Cooley stated that I think the discussion process is so important. As a lawyer I've always taken the idea of when I've had to run into a new area of law and draft something up, it actually takes a lot of work to develop an approach to break new ground. And when you do that, my attitude's always been well I like the way I'm doing it wrong, better than the way my colleagues are doing it not all. Someone has to take that first run to put it out there, be willing to engage around it, to let the process of people who have a great variety of viewpoints kind of go back and forth and keep recentering the conversation on what really at the end of the day is the outcome you're trying to achieve. And you know, it's the old saying as iron sharpens iron, so one person sharpens another and that is a foundation of all law. Asm. Cooley thanked the NAIC for that update and that prospect of ongoing discussion and dialogue and looking to engage in an important conversation and ultimately figure out, okay where does the river meet the road on this discussion - where does it intertwine with law, regulation, policy outcomes, such that a consensus can form around?

DISCUSSION ON NEW NAIC LETTER COMMITTEE

Asm. Cooley stated that as we were reminded this morning, the NAIC structure uses its letter committees to delve into subject matters basic to the law and conduct of insurance and the insurance marketplace and there has been long stability over many years in the array of committees that are there. Asm. Cooley asked the NAIC representatives to provide an update regarding the formation of a new letter committee at the NAIC.

Cmsr. Altmaier stated that this is something that we're pretty excited about and I'm going to ask Montana Insurance Commissioner Troy Downing to walk us through this one. Cmsr. Downing stated that this is an exciting topic as we all understand how technology is affecting us and it's going to affect industry and continue to be a growing player here. From what I understand, we've had seven letter committees for decades, and this is going to be our eighth - the H committee – but just because this is new doesn't mean this hasn't been a topic that we haven't been exploring. We've innovation and technology task forces looking into the effects of technology in our industry and what it means, and I think a big part of it is just being prepared because it's coming.

And so, we've had a number of conversations about elevating this to the status of a full letter committee and I'm actually pretty excited about that and as I mentioned the NAIC has already been heavily involved in a number of workstreams regarding innovation, technology, cyber security and this new initiative is intended to ensure strong coordination, consistency, transparency and visibility regarding this very important work. And just talking about where we're coming from now, our innovation and technology task force, it continues to serve as a forum of important discussions on innovation and the use of data. And given the growing focus on cyber security related issues, the task force has taken on responsibility related to overseeing and coordinating the organization's regulatory related efforts in this area.

In addition to that, our big data and artificial intelligence working group has developed an insurance industry survey to collect information for regulators to get a better understanding of insurers use of big data and artificial intelligence. The results of the survey conducted under the authority of nine NAIC member states will help to inform our work on developing an appropriate framework for overseeing and regulating the space, including input from industry on some of the early best practices in this area including governance. We also at our Spring national meeting created an e-commerce working committee. It was a result of discussions related to requests for information sent to interested parties asking for information related to specific regulatory relief or regulatory accommodations offered by states as a result of the pandemic. Interested parties were recommended to responded whether this was to be continued or made permanent, related to innovation and technology.

Some of the other cyber initiatives we have - two important initiatives in the cyber security area are use of the NAIC's coordination of tabletop exercises to explore cyber incidents response and ongoing coordination with Federal bodies such as Treasury and Homeland Security. And one of things we're looking at is coordinated notification of cyber breaches impacting the insurance industry with financial and market conduct regulators. It's critical that that work will continue as events unfold and will ensure regulators are prepared to address cyber related events impacting the insurance industry. As you see, there's already a large amount of important work in innovation, technology, and cyber security that is either been completed, is underway, or will be

getting underway in the very near future. And all of that said, it appears heightening the level of coordination and focus on current and future work streams would benefit all the stakeholders. This effort will also include a more forward-thinking direction to help our members better understand developments in these critical areas and address regulatory issues as appropriate. It'll also provide a better understanding of our efforts in these areas in order to eliminate potentially duplicative or inconsistent efforts across the NAIC as well as help Commissioners be better prepared for what lies ahead given the rapidly developing changes in these areas and I think I put a emphasis on rapidly there. I think there's, at least for me, there's an expectation that we see this increase not being a linear progression.

We feel now is the time to move forward with creating a new standing committee, the innovation, cyber security, and technology committee, our H committee, to provide a forum for regulators to learn and discuss these issues, to monitor developments in these areas that affect the state insurance regulatory framework, and to develop regulatory guidance as appropriate. It'll raise visibility, improve coordination and efficiency of these workstreams, ensure strong understanding of consistency where needed, and oversee cybersecurity workstreams. In terms of next steps, our NAIC members have been discussing draft changes. There's been some comments and the goal is to formally establish this new committee at our next national meeting that's coming up next month in San Diego and I personally am excited about this. I think it's very important as regulators should be talking about this and understanding how to be prepared for what's coming, and understanding the use of data, the use of artificial intelligence, the use of these black boxes, and what's inside of them and understanding how that's going to affect the ability to regulate consumer protection and all the things that we worry about. I personally am very excited about elevating this because it is some very important work that I think it's important that we all get ahead of and I'm looking forward to getting this launched in December.

Rep. Lehman stated that I'm glad to hear the reaction of this because I do think as our conversation went yesterday on the whole transparency piece and as we talked this morning I think this is kind of on two tracks with this new technology and one is the privacy issue of what is mine and not yours and what can you use and not use. The second piece of that puzzle is then how is it being used. Even if I consent to all this, what is in that black box? And I think it's interesting, it's kind of like we're going to have to use artificial intelligence to judge artificial intelligence. And so it's just who's going to come with the bigger computer so I think as legislators we're going to watch pretty closely to see what the NAIC does in saying what are those parameters that need to be put there because as the policymakers we want to make sure we're responding to good public policy and protecting the consumer. I applaud you on your H Committee drive and I hope you're very successful but again, that's an issue to keep us advised and in the loop on because it's an issue for us as you've seen through this meeting it kind of intertwines to a lot of pieces of the puzzle.

Cmsr. Downing stated that it's going to get complicated and we need to get ahead of this quickly. And as you said, needing artificial intelligence to vet artificial intelligence, it's an interesting quandary that we may have in front of us and it obviously behooves us to start having these conversations seriously about, not just that but like you mentioned the ownership of data, of what's in the black box, and how you vet it. To put it bluntly, these are not simple problems and it is important that we give them their due now and I'm really happy that the NAIC is elevating this to the level of a letter committee so that we

really show the importance of getting out and ahead of this.

Oklahoma Insurance Commissioner Glen Mulready stated that I just wanted to echo some of what Cmsr. Downing said and what he started with and that was to assure folks that there's been a lot of work being done at the lower level on these issues. But I think it speaks volumes that we are creating a new letter committee as that's not a small step. We create working groups and task forces but to create a new letter committee, we've have to go in and change our bylaws, and so that just shows I think the weight and the concern on our part on what's happening there and our desire to really dig in to that.

Asm. Cooley stated that it's interesting as he resonates with this general topic as in California I Chair the rules committee. One of the first things I did was establish in one of our policy committees that it would be the stop for all marijuana legislation cause and the goal was actually to have one body where you develop some institutional expertise and they've looked at things and you sort of bulk up some expertise that then serves the whole organization. And so, when I hear the issue of it is emerging and it is complicated, I actually think it's going to be a challenge for the NAIC and probably in even your bylaw drafting because it's not really a clear discreet topic like property & casualty or life & health. I think the edges of it will cross in a lot of those areas. Asm. Cooley asked if the NAIC representatives had any comments about how when you have topics that cross boundaries, how you approach that in the NAIC because I think that'll be a feature here. How the NAIC manages that sort of thing would be interesting for legislators to hear to kind of understand what's coming.

Cmsr. Altmaier stated that we have past examples of a variety of issues that have somewhat crossed over. I referenced earlier we did some work in the auto insurance space that was a collaboration between our C Committee and our D Committee, our Property and Casualty Committee, and our Market Conduct Committee. And they formed sort of a joint sub-committee that worked on that issue together. Long term care is another example where we formed a collaborative committee between both the E Committee, our Financial Condition Committee and our Health Insurance Committee, that eventually morphed into our Long Term Care Executive Level Task Force.

So, we've already started conversations amongst our letter committee Chairs who are evaluating the work streams that they currently have within their portfolio to determine which ones can be fully shifted over to the new committee, which ones should remain with them and which ones might benefit from some of that collaborative work. So, we've set kind of a blueprint in the past that I think has worked well and can continue to work well. But your point is well taken about how some of these issues are going to overlap and so we've been thoughtful about how to address that.

Asm. Cooley stated that the issue of LTC is not on the agenda but stated that since it was mentioned, does anyone have any comments on that issue as all of us in our states care about LTC. Cmsr. Altmaier stated that we've made some really good progress on this. I jokingly refer to this as, if we had a greatest hits album at the NAIC this would probably be track number one because we've been working on it for so long. But we've got some pretty good work products that are coming out. Notably, we've got a pilot project on a multi-state rate review process. One of the biggest issues is the lack of consistency amongst states in reviewing and approving long term care insurance rates. And so, I think our multi state rate review process is going to go a long way in terms of that. We also have some work that's being done that's getting really close if not already

in its final stages with respect to the best practice for reduced benefit options. So, consumers who are weighing whether to accept those rate increases versus looking at their coverage options and determining whether or not they can reduce them and still get the coverage that they need going forward. So, we've got some good work done on that as well and we're continuing to work on the financial side looking at the reserves of the long term care companies and how they continue to develop given the very rapidly changing landscape in terms of some of the new data points coming out of that space. So, there is some really good work being done on that front and we're going to continue to work hard on that issue.

DISCUSSION ON ENHANCED CASH SURRENDER VALUE (ECSV) ENDORSEMENTS

Asm. Cooley stated that in a minute I want to tap Idaho Insurance Director and NAIC President-Elect Dean Cameron on sort of what his vision is for the year ahead. But talking about this issue of analytics and what's the policy, what if you modify the policy, what could be done, how it affects the balance sheet, and how it affects the consumer - this relates to a new topic that has come up recently. Our Immediate Past President, Indiana Senator Travis Holdman, is interested in ECSV endorsements on universal life insurance policies and I'll ask Rep. Lehman if he will jump in on this as it was Sen. Holdman who brought the issue up and raised it with Indiana Insurance Commissioner Amy Beard and I know her team is looking at it.

Rep. Lehman stated that it's an issue that Sen. Holdman brought up and he is on a call right now and so he's deferred to me. But I think the issue really is becoming to the point of we're looking for an answer from the NAIC regarding what we've seen happen is there's a couple life insurance companies that have gone to this ECSV. They'll send out a notice that says, "Hey, for this short period of time, if you want to cash in, we'll give you a much greater settlement." And that goes against what was statutorily passed regarding things like the smoothness requirement that you know all the rates and all the cash values need to be kind of equal. You can't offer something in a period of time because you and I can get the same letter but if I miss it by a day, you get a $300,000 settlement and I'm still stuck with my $5,000.

NCOIL passed a life settlement model back in the early 2000s that dealt with the world of viatical settlements and this starts to look a lot more like a viatical settlement. Sen. Holdman did bring this to Commissioner Beard and she did recently start her job so it was quite a bit to put on her plate the first time you're there. But I would like to throw this out to the group as far as is this an issue that you've been made aware of and do you need to take a look at because it does kind of fly against the statutory requirements and the issue of needing to be treated as viatical companies.

Cmsr. Beard stated that she took this issue back to the Department and is still looking into it. I know that everybody on this panel takes this issue very seriously and we've had two discussions on it already. And it's a relatively new issue to all of us and we're looking into it. I know none of us would want to undermine the intent of the legislature. And so, if this is the case we want to make sure that our departments are looking at what was already approved and each one of us is looking into it. Rep. Lehman thanked Cmsr. Beard and stated that he looks forward to hearing from everybody. Cmsr. Altmaier stated that I think a lot of us are viewing this as a relatively new issue so we appreciate Sen. Holdman bringing this to our attention. I think Cmsr. Beard's looking

into it in her state and I think a lot of us made phone calls back to our departments to find out what we've done on this front so we're looking into it as well and we look forward to staying engaged and keeping you apprised on how this turns out.

Asm. Cooley stated that as a lawyer who drafts insurance legislation, insurance lawyers can go down deeper, stay down longer, and come up drier than anybody else when it comes to drafting. And that is true generally and it is specifically true of the standard nonforfeiture law, which goes back to the 1940s. And so the two big things that I note is amid all of that verbiage it is the standard nonforfeiture law. The thrust of the statute is that policyholders will have a common experience in general because that is seen to be the sort of the fundamental core of the position of the consumer dealing with the life insurance company. It is the standard on forfeiture law, which is sort of the issue that Sen. Holdman is raising. And, the other issue is just to think back, you know this particular provision came out of the 1980s which comes in on the heels of a time of great inflation in our national economy by the mid-eighties it was starting to improve. But we wrote this provision in law in a time of great financial pressure on individual Americans and it sort of makes sense, it sort of ensures that if they're really up against it and needing and wanting to get a fair deal that the rules support them.

And coming through COVID, we certainly know that there's a great many Americans who've been under great financial pressure. It's weird, because in California we keep seeing our revenue go up because there's high income Californians with this week we're hearing $26 billion in excess revenue next year that we're going to have to figure out what to do with. But there's a lot of people under financial pressure. So, I do think this is a very important conversation to kind of get our arms around as to are these approaches compliant with the law? Very clearly, there are consumer benefits under the viatical settlement laws that kind of enforced fairness in those transactions. And they are not really within the contemplation of what's happening now. So, your collective insights on this and your staff diving back in these old statutes and trying to understand how it relates to the circumstance we're in today and trying to put our heads together on this is very important.

Cmsr. Mulready stated that it may go without saying, but I think the shared sentiment we have is the old saying, if it walks like a duck kind of thing but if you're going to be doing viatical settlements, that's okay, but you need to be licensed and regulated as such viatical and we have the consumer protections in there so you can't be operating outside of that. So, I think that's our shared sentiment.

Asm. Cooley stated that sometimes a lot of things sneak up on you and things don't always leap out at us when we look at things. We're all professional in our work but that is true that that happens sometimes. And, my wife was a Church bookkeeper, and our Church got a letter saying that they had to redo their bylaws to add a particular provision to it. And in our little congregation that was very cumbersome to change the bylaws. So, she thought, "Man, if I'm going to tell the Board they have to redo the bylaws, they need to know why because they're going to ask me because it's such a pain." And she asked that question, and two years later the agency came back and says, "Ms. Cooley we've been sending that letter around for ten years and we have actually no legal authority for it." So, a whole lot of people thought everything was fine until somebody asked a very specific question. And then things just started to unravel. So, it's good that you're diving into this.

Asm. Cooley then recognized Sen. Holdman who had returned to the room and asked him if he would like to make any comments on this issue. Sen. Holdman apologized for having to step out and stated not necessarily since he doesn't know what was said and does not want to simply agree with the comments already made because somebody may have said something he doesn't agree with.

DISCUSSION ON NAIC PRIORITIES

Asm. Cooley stated that now is the appropriate to reach out to Dir. Cameron to speak about the great state of Idaho and his long service as a lawmaker and a regulator and what his vision is and priorities are as NAIC President.

Dir. Cameron stated that he is grateful to be here and always appreciates the opportunity to be with NCOIL. I think I've shared with you before that I've had a long history with NCOIL as I used to attend the meetings as a legislator in my 25 years of service in the State Senate in Idaho. And I spent 30 years in the industry. So, I have a great affection and love for the industry and the products which are used to help citizens better themselves and how they take people with financial situations and allow them to improve or people that are having devastating situations and allow them to get through the finances. And I can go through numerous examples and stories where people in my state were impacted by the products that I now get to regulate and I know many of you can as well. It's no accident that a year ago at this time we were meeting and I mentioned for the first time that we were in the process of trying to create a new letter committee, the H Committee. And, with a lot of help from those out here in the audience, NAIC CEO Commissioner Mike Consedine's phone started blowing up with calls about what we were going to do and why. Well, as was announced to you, we look forward to collaborating with you as we move forward in this really uncharted territory, if you will. I have six goals as NAIC President, and I'd like to share those with you today.

And I haven't shared them really outside of this conversation, but I'm going to share them with you today. The first one is improved collaboration with your organization, other associations and the industry. We regulate a wonderful product and we need to collaborate better. That means more phone calls, more discussions, and more issues as it doesn't mean we always have to agree. But when we don't agree, we want to sit around the table and talk about it like adults. We recognize the importance. The second goal is removing or eliminating barriers to access. I believe fundamentally that everybody deserves access to the products that are being made available and they should be able to afford those products and those products should be available without the barriers. And certainly, some of that gets into the race and insurance aspect but it also crosses the board in many places. We are better suited when we have citizens insured. It's better for our economy, it's better for them, it's better for their families. And so, we look forward to working on those barriers and eliminating them.

Third, I'd like to have a more slimmer, more efficient, more collaborative NAIC. We have hundreds of working groups and task forces. Our staff cannot keep up with all the task forces and working groups. And they haven't told me to say that. But I'm just watching it. When you see a staff member who's the exec on four different working groups, their issues and their abilities are too divided. So, we need an evaluation of how working groups and task forces are created, how they stand and when they end. I'm pushing, and I'll be pushing my new committee chairs, that they be goal oriented and that we work in that direction and that there is a limited scope and a limited timeframe. And

when they're work is done, it goes away and we go to the next project. So, there are some governance issues there. One of the side benefits of creating the H Committee is I think we have something like ten different working groups and task forces related to cyber security, data collection, artificial intelligence, etc. By doing the H Committee we'll be eliminating, or consolidating some of those committees and we're going to continue to look for ways to do that as well.

The fourth goal is elimination of duplicative and unnecessary regulations and statutes. And we'll need your help on this one. In Idaho, our Governor has challenged each of the cabinets to try and get rid of unnecessary regulations. Now, I started in this business nearly 40 years ago - can we just admit that the marketplace 40 years ago is not the same as today? And there are statutes and rules that are as old as I am. And we do one thing well, we pile regulation on top of regulation, on top of regulation. So, I think it's time that we review and analyze those regulations and get rid of those that aren't needed. I had the title industry folks say to me as we were getting rid of a 1,000 words, 230 pages, and 25 chapters – "well we don't like that you removed this phrase." I said, "it's in the rule five times. And it's already in statute. How many times do we have to say it before you know that's what we mean?" They got the picture and became a supporter of what we were doing. And so, I'm going to ask the NAIC to do that, and I'm going to ask my fellow Commissioners to look at it. I'm going to help them every way to share our experience, and how we did it and help eliminate that unnecessary regulation which is a little bit contrary to what a regulatory body likely does but that's the direction we're headed.

Number five, I want to increase education and understanding of the products that we regulate. We have too many people that don't take advantage of these products and don't take advantage of the industry and aren't participating. Every one of us and every one of the Commissioners that I get to talk to is struggling to try and have a trained qualified workforce and to retain that talent. We need to figure out ways to bring people into the business. How do we bring people into our departments and allow them to be involved? That'll be a high priority. And then number six, defending and advancing state-based regulation. We know that consumers are better protected when we're regulated at the state level. We know that consumers are better protected when the public policy decisions that you make are made at the state level not at the Federal level.

So, we need to continue to advance our state-based regulation, and we need your help in working on that and defending it. There are too many times where our friend across the Potomac have a brighter idea and want to shove it down everybody's throat and we want to defend against that and would ask for your collaboration whether we're talking with FIO, Treasury, or whomever. We want to work together with you on it and we want you to feel comfortable in reaching out to me or any of the other Commissioners and trying to help us advance this agenda. I would also like to say one other thing. This is Cmsr. Altmaier's year and he's done a great job and I admire him and support him and I don't want to overstep and step in front of him. We want to acknowledge his accomplishments and we'll look forward to having my time as we advance.

Asm. Cooley stated that I think as lawmakers, the whole fundamental concept is an idea gets worked out in one house but then it has to go to the second house and get worked out. And if it's done that, now it has some staying power to go down to the Governor and hold its own. It's been well vetted. And I actually think that model probably applies to the joint work of legislators and insurance regulators, vis-a-vis the Federal climate.

How do we contend for state based regulation is something that's responsive to the needs of all Americans by being responsible to the localities that Americans live in, their differences in those marketplaces. And it's sort of the electricity model, you need both plugs to make it work. I do think that the NAIC certainly has strengths and an expertise as an organization and not just in the organization because you go to people in the marketplace, or in academia or other settings that you feel you've sort of tested their quality and you feel you can bring them into the conversation to illuminate things. So, when you have those sorts of strengths going, I think it's long term, kind of working together in partnership is the best way to kind of assert and affirm state based regulation.

Asm. Cooley noted that Dir. Cameron got into some governance issues. Regarding, elimination of unnecessary, duplicative laws or regulations, time does march on. We were discussing at breakfast that California in 1988 had Prop 103, which was controversial at the time, but passed overwhelmingly but is very much time bound in the area of auto insurance as what are allowed rating factors? So, with modern conversation about rating factors, if it didn't fit Prop 103, it's not allowed in California. And so, this great innovation ends up becoming a barrier to innovation and in California we certainly think we are friendly to innovation and increased education, and understanding of the insurance products themselves and defending and advancing state based regulations.

Sen. Jason Rapert (AR), NCOIL Immediate Past President, stated he would like to provide accolades to all of the Commissioners participating, and also to NAIC CEO Cmsr. Consedine. When I first got here to NCOIL in 2011 there were several sessions where it seemed like there was great tension and a great divide. And that persisted and I think through the leadership of my predecessors and the change that we've had at NCOIL, I believe that there's been tremendous progress that's been made. And I just want to make sure that you know that. Now we are dominated by how we can try to work better together and have more collaboration. So it's good to see what has happened over the last few years and I'm very happy to hear you, Dir. Cameron, and I appreciate your work. I won't go into all the accolades of the pharmacy benefit manager (PBM) regulations but I thank you for that and you all have done great work but I really am happy to see that we're at a point now where I think that the NCOIL-NAIC relationship is probably as good a relationship as I've seen in ten years.

Asm. Cooley stated that sitting in this room crowded with people, our biggest ever meeting, good things are happening in NCOIL and I think a lot gets contributed to we made a choice during COVID to keep Rep. Lehman as President so we thank you Rep. Lehman for your leadership. You're a part of the good things happening here and a part of the relationship with our regulators.

Rep. Meskers stated that I think the cooperation between the groups is pretty impressive and the quality and intellectual effort we're bringing to the table is important. I think the NAIC's focus on access is a very laudable goal but as I sit with my legislature and my constituents, I think the elephant in the room is the 7-11% compounding, particularly in the healthcare industry. So, when we talk about regulation and deregulation, I think the access to affordable healthcare whether it be the hospital bills, the pharmaceutical bills, those are the elephants in the room. And I guess one of the - I don't know if it's the appropriate role - but the question is how do we empower the insurance companies at the table with the providers of healthcare to negotiate the prices to be able to get some

cost containment. Because I worry that 7-11% a year is just that compounding will make healthcare insurance unaffordable over time. And I'm not sure how we address that issue. I mean, we've seen the beginning of negotiations at the Federal level on pharmaceuticals and we went from a fairly aggressive price cap to one now that's coming out in the bills which has got a ten or 12 or 20 year period of adjustment on certain drugs. So, I'm not sure how the NAIC feels about the affordability question on healthcare.

Cmsr. Altmaier stated that I'll kick it off a little bit and then quickly defer to whoever else would like to make comments, but I think speaking on behalf of my state's experience, we look at the increases in the health insurance rates and a lot of that is driven by medical trends and just the fact that the cost of healthcare generally is going up. And since insurance is how people finance their healthcare it's a byproduct of that health insurance goes up as well. And so that complicates the equation because that involves a significantly larger number of stakeholders in terms of who needs to be at the table when addressing the cost of healthcare. And so that is a very important conversation, the affordability for us is always a really tough nut to crack because we certainly want insurance to be affordable for everyone. But at the same time, we've got to balance that with the fact that we need to keep our markets buyable and sustainable. And so, sometimes the rates have to accommodate the increased costs of some of these things. So, you've touched on a seriously important issue. And I think you're two for two on that so far this afternoon, so we'll spend a lot of time working on this and collaborating with folks on best ways to address this for our consumers. But I think you touched on the PBM work and things of that nature - I think those are good examples of things that we've looked at in the past that can help address the cost issues. So, we'll continue to do that as we look forward to this.

Dir. Cameron stated that I'll share some thoughts with you and some of them everybody may not agree with but nonetheless I'll share my perspective. We've been fortunate in our state because we've been out on the forefront of elimination of unnecessary regulation which has helped. We have strong competition in our state. We started with four carriers now we're up to six, with a seventh and eighth and ninth in the wings looking to come into our state and market. It starts with trying to figure out ways to attract the young and healthy back into the marketplace because under the current rules, under the current Federal guidelines and provisions, many of those folks are being forced out of the marketplace and forced to either go uninsured or to go elsewhere. And so, from our state we've had three years now of no increase or some side of decrease. We had a decrease this last year of about 5% because we've been trying to do some of those approaches and trying to find places for the young and healthy to be able to participate in the insurance marketplace. In my mind that fits within the barriers of eliminating barriers to access to coverage. We have a high Hispanic population in my state, and they don't take advantage of health insurance like they should. So, we're working on ways to make it more friendly if you will, and to speak to them in a manner that they can address.

So, there are things that can be done at the state level and I think it starts with looking at your regulations, looking at what is causing the rates to increase. I would say that I do think, and I'm surprised it's actually not on the agenda because every state is scrambling to figure out how they're going to deal with it, surprise balance billing is important. There are some components with the Federal rules that I think will actually be very helpful in this arena and actually will lead to better networks and more providers accessing

networks. I think there's an impetus that they are not going to want to jump through all the hoops that will be there if they're not part of a network. So, I think that there's some help coming in that direction although I don't think it was necessarily intended in that way. And while I'm on surprise balance billing, I encourage you to work with your Commissioner and figure out how best to deal with the surprise balance billing laws and provisions that are coming. I know that CMS is working really hard to have the states regulate it but most of us don't have the regulatory authority. So, we're having to sort of boot strap the authority to be able to work with hospitals and providers at the same time we have the authority with the carriers.

DISCUSSION ON NEW NAIC IMPROPER MARKETING OF HEALTH INSURANCE (D) WORKING GROUP

Asm. Cooley stated that in this general area of health insurance, a recent development at the NAIC is the working group on improper health marketing. Asm. Cooley asked the NAIC representatives for brief comments as to what was behind the formation of the working group.

Cmsr. Mulready stated that we do have work happening there – it started at the end of last year of just an ad hoc group coming together such as anti-fraud folks and consumer affairs folks. In this situation we've got the Health Committee, the B Committee, and then Market Regulation, the D Committee, because of the crossover issues which we previously discussed. From that they formed a more formal group and they will facilitate and engage in discussion about the marketing plans that are improper. The goal is to have participation of regulators at the state and federal level, and to provide assistance, guidance and knowledge regarding these activities.

Regulators from all areas of expertise, health, market conduct, fraud and legal divisions will be involved. So, we've established this new working group and the Chair is Martin Swanson, who's a Deputy Director in Nebraska and Frank Pile who's a Special Deputy from Delaware. And the Delaware Commissioners, the Chair of the anti-fraud task force so I know they've been doing a lot of work. I've heard the reference of sometimes it's like playing whack-a-mole with some of these folks out doing things and that can be the case here. In order to keep this short, they have had two public sessions and most recently at the Kansas City Insurance Summit but that work is continuing. And one other thing I would mention that they're looking into that's a little bit sticky for us in trying to stay in your lane and not have mission creep that's constantly there is the lead generators that are a big part of that. So, they're creating a database that to be shared back and forth and so there is lots of work happening on that.

ANY OTHER BUSINESS

Asm Cooley stated that time is almost up and I want to just remark upon we know that the work of your agencies has persevered during COVID. The work doesn't stop and it's been a very difficult time to get things done. We can all remark on Zoom and those sorts of things but just developing new routines to persist in a very important public work in the middle of a pandemic is quite exceptional. So, I thank you all for your leadership and it does allow me to reflect upon and acknowledge our own President, Rep. Lehman, for his leadership - what an organizational banana peel to step on, COVID, that suddenly you're off into new things and persevering despite all the impediments to success and productivity. Not to mention the legendary phone calls and text messages from NCOIL

staff. Asm. Cooley offered Rep. Lehman the opportunity to provide closing comments in light if his great leadership.

Rep. Lehman stated that to sit in this room and see everybody here is great. When we left Austin, TX in 2019 we thought this is what we would see every year going forward and then COVID hit. It's been great to see how everyone stepped up and with the large panel we have here today, it tells me that we're back and it tells me that everybody's in the same place now, saying we want to come and do the work of the people. So, I'm really looking forward to the future and handing things over to Asm. Cooley. We're in a good place and I know you'll take it to the next level.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson and seconded by Sen. Hackett, the Committee adjourned at 12:00 p.m.

LIFE INSURANCE & FINANCIAL PLANNING
COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 19, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at The Westin Kierland Hotel in Scottsdale, Arizona on Friday, November 19, 2021 at 9:00 a.m.

Senator Paul Utke of Minnesota, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Sen. Keith Ingram (AR)
Sen. David Livingston (AZ)
Asm. Ken Cooley (CA)
Rep. Jonathan Carroll (IL)
Rep. Matt Lehman (IN)
Sen. Travis Holdman (IN)
Rep. Joe Fischer (KY)
Sen. Charles Younger (MS)
Asm. Ken Blankenbush (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Sen. Jim Guthrie (ID)
Rep. Doug Gutwein (IN)
Rep. Craig Snow (IN)
Sen. Beverly Gossage (KS)
Rep. John Illg (LA)
Sen. Lana Theis (MI)
Sen. Mike McLendon (MS)
Sen. Walter Michel (MS)
Sen. Jim Burgin (NC)
Sen. Pam Helming (NY)
Sen. Jay Hottinger (OH)
Sen. George Lang (OH)
Del. Moore Capito (WV)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a Motion made by Del. Steve Westfall (WV), and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 15, 2021 meeting in Boston, MA.

UPDATE ON INTERSTATE INSURANCE PRODUCT REGULATION COMMISSION (IIPRC)

Karen Schutter, Executive Director of the IIPRC, thanked the Committee for the opportunity to talk about a very important State initiative and that is the Insurance Compact (Compact). Hopefully you've heard about that in your state as 47 states belong to this very important, and what I would say has been successful, initiative of state-based regulation. What I'm going to cover today is the "What, the Why, and the How" about the Compact because it was by statute that many of the states joined the Compact many years ago and it was for the purpose of really modernizing and making the state based insurance regulatory approval process much more efficient.

Many of you are likely familiar with Compacts in other areas. I know that there's a big effort in the occupational licensing field right now with regards to Compacts whether it's medical, nursing, or physical therapy. So, the principal of a Compact is it's a creature of state law and it really is an agreement amongst states. You are coming together to agree upon collaboration and cooperation. One of the most important things about a Compact is you're in charge - it must be enacted by a legislature and approved by the Governor. So, it must be an enacted law, it can't be a regulation or any other form and each state in the Compact firmly controls its participation. and there are a lot of safeguards within the Compact.

It was developed nearly twenty years ago jointly by the National Association of Insurance Commissioners (NAIC), NCOIL, and the National Conference of State Legislatures (NCSL). There were a lot of meetings and a lot of negotiations about the terms of this Compact before it was available for states to consider and enact. It was created in March 2004 and Compacts are like contracts, they're contracts between states. So, you need two states first to join and then you create an agreement amongst states. And one of the safeguards in our Compact was at least 27 states had to enact the Compact before it could get up and running. It wanted to wait until a majority of states were in this Compact before it could do the important work. This Compact became operational in May, 2006, and it took about a year to get all the foundations in place. So, it's really been working for states and their industry since 2007. You sometimes hear that states are a bit outdated in their legislation or regulation and need to catch up. What I would say to you is that this Compact is an innovative regulatory paradigm. The states really got out ahead of the calls for Federal regulation.

We'll now talk about the "why" about the Compact and what this Compact does is it covers individual and group annuities, life insurance, long term care (LTC) insurance, and disability income insurance. States come together to develop what we call uniform standards that apply to the content of a product. And all of the states participating have their departments of insurance (DOI) participate. So, it's a state-based organization and what it allows for is a company rather than going state by state by state taking months to get a product approved they come through the Compact and we work on behalf of all the compacting states.

It's really important to remember that the Compact is important today to state based regulation of the insurance industry. As we know, Compacts are legal frameworks for cooperative solutions to issues that really transcend state borders. Your sister organization the Council of State Governments (CSG) has a national center of interstate

Compacts so there is a resource there. It's a tool for states to really work together to harmonize their regulations and their laws in a certain area. And they commonly create what they call multi-state bodies, which is the Commission and we'll talk about that in just a minute. So, for more information as to "why" this Insurance Compact - for those of you that were here 20 years ago, you remember that your discussions were about the very real threat of Federal preemption. Congress was really in the weeds with regards to the life insurance industry, talking about a charter because the life insurance industry was now competing with banking and securities products through Gramm-Leach Bliley and removing the barriers to competition. And as you know, banking and securities are generally regulated at the Federal level with one approval and focused on getting their products out to market in a uniform manner.

So, the insurance industry has always felt that they're at a disadvantage and that again is the reason that the states said, "We want to come together and solve for this problem." These are mobile-borne products. So, a life insurance policy, an annuity, even an LTC insurance product you can buy that in one state, say you're in Minnesota and you want to retire in Arizona or vice versa. You can take that product and claim on it. You can't do that with your health insurance, or property & casualty coverages. So, these are mobile-borne products. You want to help all your consumers in terms of they should all have a uniform product. And they're non-local risks. Mortality and morbidity are generally national or aren't local like your weather risks. Regulators could not voluntarily agree to uniform standards as they needed a legal mechanism. In fact, they needed legislatures to join the Compact. And it's definitely been 20 years of getting states, if you remember 2006, we had 27 states so over the last 15 years, we've brought 20 more on. It's a member-driven joint public agency of state officials. Your insurance Commissioner/Director/Superintendent are actively involved as they're experts in their department and are actively involved in this Compact. So, they're the ones that are helping you make sure and really controlling the participation in this Compact.

So, here's our map and you'll see that we have most of the states and Delaware joined this year, so states are still joining this Compact. We worked with Senator Spiros Mantzavinos down there in Delaware. California, Florida and New York they're as you know some of the biggest markets in the nation, so they take a little longer and we're still working with the Dakotas. So, "how" it works, just really quickly. By enacting the Compact, states agree to develop uniform standards that apply to the products approved by the Commission. Your experts are developing our standards. They're based on model laws, regulations and really standards across the states. They're the best practices. Once approved through the Commission a Compact product can be issued in the participating Compacting states. So, it's a speed to market, it's efficiency, and really saves quite a bit on the systems testing implementation. But, we want to make sure you understand, it's a very open, transparent process as legislatures are our partners. There is a legislative committee comprised of eight state legislators from Compacting states. Every year or two you appoint four of those members from NCOIL and NCSL appoints the four others. You also have a consumer advisory committee, along with an industry advisory committee.

So, what is the role for you? First, I want to tell you about our legislative committee, as Representative Lehman (IN), NCOIL President, has been kind enough to serve as Chair for probably just as long, if not longer than his tenure as NCOIL President. Rhode Island Representative Brian Patrick Kennedy is the Vice Chair. And then we have Georgia Representative Matt Dollar, Kentucky Representative Joe Fischer, NCOIL Secretary,

Illinois Senator Laura Fine, Nevada Assemblywoman Maggie Carlton, Chair of this Committee, and Utah Representative Jim Dunnigan. So, your colleagues are very active and involved. We've also had Indiana Senator Travis Holdman, NCOIL Immediate Past President, Ohio Senator Bob Hackett, and Arkansas Senator Jason Rapert, NCOIL Immediate Past President, all participate on our legislative committee.

So, what is your role? It's very important as you have the power to enact which many of you have done and you have the power to withdraw. We hope that never happens, but that is your ultimate power. But it's a State legislative-regulatory initiative and we have another safeguard: we develop uniform standards for products like a term life and you have at the legislative level the power to opt out of that standard. We have seen very high success, high participation in our standards, which means they're very high, robust uniform standards. Here's another touch point that you may see. You may get in your emails from time to time an email from the IIPRC Public Notice. We are required to do so under the Compact statute as there are a lot of touch points put into this Compact and one is to send notice to all of our legislatures when we're about to adopt a uniform standard when it's under consideration. And here's who we send it to: the Presiding Officer of each Chamber; your majority and minority leaders of each Chambers; and the Chair and Ranking Member of each committee of insurance jurisdiction. So, these aren't junk mail and aren't spam. These are telling you the work that the Commission is doing on your behalf working with your state insurance departments. If you have any questions you are always welcome to call us. But also give your Commissioner a call because we work very closely with them and they support it.

Here are the benefits to everyone. States receive thoroughly reviewed products. We have actuaries, we have reviewers, and we look at products under detailed standards. It allows for your state resources to focus elsewhere. Your consumers, whether they've come into your state with a product they bought in another state, or one they have, they have access to products reviewed under those standards and with strong consumer protections. And companies don't – want to hear the call for Federal regulation and there's a lot of reasons for that, but I would say that this has really transformed the way companies are able to go through the product review and regulatory approval process as it is much more efficient. Today, 400 insurance companies use us. There's over 11,000 products that have been issued over the Compacting states. The speed to market is great as we're able to get to approval along with a careful review. And companies have shared so if you have a question about the Compact ask your companies as they're the ones that have that experience.

We're a joint public agency so we don't belong to the NAIC. They help us out and they're the bigger organization that gives us those services so we can do our core mission. But we are an arm of each of our Compacting states. Here's a good fact for you: we're revenue neutral to our states. We actually collect and remit to all of you, those of you that have filing fees, we remit those. So, it doesn't take away from any revenue and we've collected over $27.5 million dollars for you. We have a couple of key issues going on at the Compact. We've kept Rep. Lehman, Rep. Fischer, and our legislative committee involved in those. There was a court case that didn't understand Compacts, which I would say is a little concerning for the state legislators as well as regulators. And that case said that without Congressional consent a state's general assembly could not delegate to the Compact the power to develop uniform standards that could conflict with the state law. And so that was concerning. We're looking at that

and I think we're going to hopefully have a path forward working with our state legislators. I'd be happy to answer any questions.

Rep. Stephen Meskers (CT) stated that he is a little confused about the conflict in drafting model legislation and why that would be conflicted with Federal law or that your usurping power - ultimately we have to bring it back to our legislature, the model law has to be passed. And we have to agree within our legislative organization within our state that it doesn't conflict with our local law – is that correct?

Ms. Schutter stated that the Compact statute, the one you enacted, gave the Commission, which again is your member, the authority to develop uniform standards. And those uniform standards apply to the product. And as I said, they are based on model laws. If a state were to have a variance in the model law or with our uniform standard that state has the right to opt out. There's a lot of our uniform standards that actually have more stringent protections, or more detailed protections than state law does. Our standards, when I say our I mean your, they cover every provision in a Compact and are very detailed so if there were a conflict, your state would work through that and talk, definitely within their DOI, as well as with the legislature. And states have opted out of our uniform standards because of that very reason.

Rep. Meskers asked if that is specific to a piece of legislation or have they opted out across the board because of the conflict? Ms. Schutter stated that it's more-so legislation. We had one state who opted out because an exclusion period was different than in their state law. Their legislature decided a certain exclusion period should be this and the uniform standard followed what the majority of states did. So, each state has the unfettered right to opt out of standard. You control your participation.

Rep. Lehman thanked Ms. Schutter for being here and said he offers a challenge to the other members of this Committee and to other members of NCOIL and that is to engage in this issue because the IIPRC has done great work over the years, and it's really opened my eyes more being the Chair of the legislative Committee. And I think there's some heavy lifting ahead of us and I think we need to stay engaged. So, I challenge NCOIL to stay the course and stay engaged. And if this is your area where you say I can really sink my teeth into this, let us know because we want to make sure NCOIL continues that seat at the table. Ms. Schutter stated that we are happy to meet with any states working with your DOI to give you even more detail about the work we do on your behalf.

DISCUSSION ON REGULATORY OBSTACLES TO THE RECRUITMENT AND RETENTION OF INSURANCE PRODUCERS

The Honorable Greg Serio, Partner & Managing Director at Park Strategies and former Superintendent of the New York Department of Financial Services (NY DFS) stated that his purpose here today is just to do a couple of introductions and to tee up an issue that we're working on and that I think it's something we would like to bring to your attention and make it part of your 2022 workstream. First of all, I represent Finseca which is the amalgam of the AALU and GAMA - GAMA was the General Agents and Management Association. AALU represented the life underwriters and they merged last year and they created Finseca which means essentially financial security for all. And in that role I serve as one of their State Advocacy Advisors and going around the country talking about Finseca and what we do as a profession. And I wanted to first, not only introduce

you to Finseca but also to our newly minted Vice President of State Affairs Melissa Bova here on my right. Ms. Bova comes out of the State House in Harrisburg, PA. She is well versed in state legislative affairs. And she is a great addition to the Finseca team and she will be the lead on state legislative and regulatory affairs for Finseca and we are very happy to be working with her.

And one of the prime issues that we are working on that we wanted to bring to your attention is something that you have dealt with over the last couple of years in the context of COVID, but something that we believe needs far deeper analysis and far greater reengineering: the agent licensing process. I spent ten years at the NY DFS, I spent 12 years with the New York Legislature and I've been representing the life agent profession for the last seven years. And I will tell you that something that I always appreciated but didn't always have the opportunity to do something about was dealing with some of the statutory and regulatory impediments to licensing of agents. As the old slogan goes, this is not your father's life agent world anymore. It is a new environment and we are trying to deal with a mobile society and that's one of the things that came up during COVID. We're also trying to bring in the next generation of agents - a huge issue for all of us. Agencies around the country are talking about they need to attract not just more agents but a more diverse group of agents.

The 2020 census has shown less than 15% of the agent force is from the Hispanic community. The Hispanic community, the single fastest growing economic component in the United States, only had the representation of less than 15% in the agency force. Less than 10% is black. Less than 6% is Asian. Now, we can say we have to go out and we have to recruit. But you start to look at some of those recruitment impediments and you say we need to significantly rethink our approach to agent licensing. And, because we're lawyers, we go back, and we start to look at the law. And we start to see things like the increasing arduousness of exam and pre-exam requirements. That's the first place we have to look.

The second place and a very close second, is the issue of first year agent compensation. Now, there are lots of stakeholders in that conversation. It's the agents, it's the general agents, it's the carriers, it's the Department, financial aspects, marketing aspects, production costs aspects. But for example, in New York, the cap on the subsidy for new agents is $67,000.00 a year. That's it. Nobody is coming in or nobody's staying in the life insurance business past the first five years, if they're getting compensated $67,000.00 a year as a subsidy. And you know what's happening -the guy from the investment bank, the retail investment bank down the street, is saying you can make a lot more money tomorrow, you don't have to wait for your third year, or fourth year, or fifth year to make money, to make real money. And so, we're not only not attracting people into the agency force to begin with, but we're losing them to the other financial services. And that's something that we have to take a very serious look at. And that by the way, in New York's example, is in statute. That is we think a statutory impediment to attracting a new generation of agents.

When my father came over from Sicily he went to dental school in New York and it was a dental school that was designed, it was NYU. Now, everybody thinks NYU is an Ivy League school but NYU was a school that trained people from the emerging communities to serve the emerging communities. So, there were lots of Italian dental students, lots of Jewish dental students for the influx of people from those communities. That's what we're trying to do with the agent profession - bring in those folks who are

going to serve their own communities going forward. And that we need to do is think outside the box, how do we do that? What Finseca is planning on doing, of course speaking with all the various stakeholders and our friends, we had a great conversation last night about this very issue with some folks here. And what we are planning to do is come back to you in March, no later than March for the March NCOIL meeting with a piece of draft model legislation that starts to address some of these issues and hopefully have a Model Act on a reengineering of the licensing process.

We want to promote mentorships. We want to get out of the regulatory strictures, and I enforced them, so I know exactly how they're built. But we need to rethink this for more authority and more responsibility in the hands of the general agent because the general agent is asking for these folks to come in. Our membership is saying, we need new people. And if they're willing to take on that obligation, and you already know, and this is in Congress to the way the statute is built, carriers are ultimately responsible anyway from a market conduct standpoint and other things. And when I was in regulation we always looked to the carrier if there were things, bad things happening, if you will in the agency force and on the street. They're already there. And the funny thing is that the law doesn't even recognize the role of the carrier or the general agent in the development, in the mentorship of new agents. The Honorable George Nichols, former NAIC President and former Kentucky Insurance Commissioner, and I had a conversation last year about mentorships. And he and I agreed that mentorships are the single best way to have new agents get past the first five years of being in the life insurance business. And I think that a law has to reflect the value of mentorships. And if you do that you can change the examination process, you can change the education process, and you can change the continuing education process and take away some of those things that have been inherent roadblocks to people thriving in the agency world beyond the first five years.

This is an ambitious project by Finseca and others in the profession. But we know that the time is now building on some of the changes from COVID and that we have a place to go and an objective to achieve. The last thing that I'll say is that this comes on the heels of a report from the Hispanic Leadership Foundation which just came out talking about products. Now, the other side of the coin of getting agents in the community is giving them something to sell. And they report on the regressive impact of the 2016 Department of Labor (DOL) rule that came out. We all know about the fiduciary rule, the regressive impact of it and how it affects lower income and minority communities more than any place else. Why? You put more burdens on trying to produce a single life insurance product and you will get people discouraged from selling those lower end products.

The same thing is happening in New York with Regulation 187, and we told the NY DFS on day one that 187 will have a chilling effect on serving some of these communities that need life insurance products the most. And we told them that, and NY Senator Neil Breslin, former NCOIL President, is sponsoring a bill in New York to create a safe harbor for life insurance products, term products under $1 million dollars face value to get it out of the strictures of Regulation 187 so that we can encourage producers to sell these products to the people who most need them.
And now, the Hispanic Leadership Foundation has now quantified and has now officially determined through its research that some of these rules are actually having a negative effect on the people we are trying to serve the most. So, agent licensing reform and some of the rule reform are two sides of the same coin. We appreciate very much the

receptivity of NCOIL to bring up this topic before you and to work with you over the course of the next year to bring this to fruition.

Sen. Beverly Gossage (KS) stated that as a health and life insurance agent she writes these products and as former President of Kansas' Association of Health Underwriters, she has seen some of these same issues. Sen. Gossage asked Supt. Serio to repeat his main points as Sen. Gossage had to leave the room for a few minutes during his testimony.

Supt. Serio stated that number one is that examination and pre-examination education has to be fundamentally reformed as that is an inherent roadblock. People see how many hours that have to go into it and they say, I just can't do it particularly when they have somebody whispering in their ear, "don't worry you can come with us." And then, number two is the issue of compensation reform because some of the other guys don't have the same strictures that we do. If you look in the agent licensing statutes in most states, you will not find those compensation restrictions. Go to the carrier sections of statutes and you'll find restrictions on what carriers can pay. It's a carrier financial restriction but it impacts the agent. Number three is the promotion of mentorships and using mentorships to actually do some of the things that we're already trying to accomplish in the law through education, pre-licensing education, and continuing education, and have that built into the mentorship and give carriers and general agents credit for promoting and for supporting mentorship programs.

There is a movement in the marketplace and other areas of licensing where we're getting out of the business of the state managing the examination process. If the state says, this is a good exam but we don't need to run it and let trade associations run it, let other organizations run the exams that have been approved by the Departments. And by the way, another adjunct to this is, "approved by the Departments in various states." One thing that we are looking at also is the notion of enhancing reciprocity between the states. You move from one state to the other, you give up your license in one state, that doesn't mean that you're getting your license in the other state right away. Why isn't there a bridge of reciprocity when you move from one place to the other, until that state has executed and issued your license. And then it's finally getting the products to the market that these new agents particularly in new and emerging communities so they can sell to their clientele. And that is as important as any of the other provisions that I just mentioned.

Sen. Gossage stated that we're basically talking about captive agents here as opposed to independent agents, so that they can get that first-year commission right away and not have to wait three or four months before they get that first commission check. Sen. Gossage asked Supt. Serio if he has visited with any of the carriers about some of his recommendations?
Supt. Serio stated that we've just started the process as we wanted to get a framework together to start to socialize the framework. We know everybody's been talking about it, but we needed to go to the next level and put a framework together that people can look at and use a red pen on. But we need to have a construct and so what we have in Finseca is that we just reviewed this with our state advocacy working group on Wednesday and we are going to be socializing this with others including the American Council of Life Insurers (ACLI) to get their input and request their feedback. We will also talk to individual carriers as well. Frankly, I think we're all in concert on this notion that we need to do something about agent licensing. Speaking for New York, we haven't had

an agent license modernization in years. Article 21 needs to just be started all over again and frankly, for licenses across the spectrum, not just life agent licensing. But we do need buy-in by all the stakeholders in order to really make this work.

Sen. Gossage stated that regarding reciprocity, I'm licensed in half the states and it's just a matter of paying your $100-150 every two years or so through the National Insurance Producer Registry (NIPR) and I haven't found that to be a barrier but perhaps there are some states in which I'm not licensed that that would be true. Supt. Serio stated that there are people who are not licensed in all states and because we're a very mobile society now, we had a member talk about this just the other day on our working crew call - they're moving from New York to another state. They give up their New York license, going to the other state. But that other state has not issued a license. Now, are you putting that experience, it's not a new agent, you're putting an experienced licensed agent on the shelf because they haven't gotten their license yet. And it may happen in cases where you were not anticipating to be moving to that state, but you still need to be licensed. They're earnestly trying to be compliant, but the problem is that they don't get that bridge. And so, building a bridge to use the old license while they're in the new place for a period of time. By the way, in working through the NAIC, everybody's talking at the same table anyway, whether through NIPR or elsewhere, but can we construct a bridge that works so that somebody can continue the business in a place they weren't thinking about being in. And you're right, it's de minimis in terms of the fee, but can we enhance the ease of licensing for those people as well so that they continue operating. Sen. Gossage noted that is particularly true for those who are moving, because you're right that is a different situation than having your in-state license and then your out-of-state license.

Sen. Lana Theis (MI) stated that she understands what Supt. Serio is saying about the difficulty of getting agents. We have difficulty getting employees in every single area of the entire country right now. But this is a particular area that has had difficulty getting people into this for years so this isn't new. I do have some questions with respect to your commentary about the reform for licensure. Was the bar set too high?

Supt. Serio stated no, I don't think it's a bar issue in terms of capability and attracting good people and good candidates. I think the problem is we're discouraging good candidates with the other bars, the non-qualitative bars, like the number of hours of licensing, like the ability to start to earn a living that maybe they were expecting to earn being in this profession sooner. I never thought about it in terms of a bar being set too high. I think the regulation was trying to be too careful in terms of how we protect against over expense of production of costs. Paying agents who are not producing business, things like that. I think we've been too tepid if you will on who we are, or who we were trying to bring in and get through the profession. So, I think if you take it from a regulatory mindset, that's what we were. The regulatory mindset is always overprotective. But I think if we understand where the points of responsibility are and especially if carriers or general agents are willing to take on more responsibility in order to get people in, I think that's a sufficient trade off. And I think regulators are going to have to exhale a little bit and let some of that work because they already know that the regulatory process is that I would still have somebody I can hold accountable. That's what the regulators are always concerned about. There are multiple people in the chain who are accountable if something goes wrong with a new agent recruit. Why then, I would ask, do you have all those other regulatory strictures in place when the marketplace has already accounted for it by holding the carrier, or the general agent

responsible for it. This is a question I had all during regulation and even talking to the regulators now, I still ask that question. If you have this ultimate authority, why are there all these kinds of intermediary hurdles that you're insisting on people jumping over just to get to that point if you still have this plenary regulatory oversight. So, maybe that bar was set too high.

Sen. Theis stated that she was going to suggest that we're parsing words because everything you're saying to me is a different bar that they have to jump over. Sen. Theis stated that she understands and doesn't disagree with what you're saying. I'm a huge fan of deregulating wherever we possibly can in order to encourage participation in the market. But I would also suggest that if we're going to change the rules, we should change it for everybody. Because somebody who isn't capable of buying a higher-level policy should have the same standards in their agent as someone who is capable of buying that. There shouldn't be one rule for less and another rule for more.

Supt. Serio stated that he didn't mean to imply that and I'll take a step back on the two sets of rules. I've always been of the belief, no matter who I've represented, no matter the time and regulation, that agents worked in the best interest of their clients. Because of these bars we're talking about and because of the fact that there's so many checks and balances that, it's never been an issue, and I always find it kind of silly that we're always worried about an agent selling somebody too much insurance. Because there's so many checks and balances in that process for a carrier or underwriter to look at it and say, this doesn't fit with that person's profile. We're not about to go on a hook for $10 million for somebody who doesn't clearly fit that prospective.
But we built a rule thinking that people are going to be oversold. That's the premise of 187 and it's just antithetical to how life insurance is actually sold. And I'm talking about the process of the sales, not just what's being spoken about across the kitchen table.

The other part of it is that if you have been selling a $10 million policy, that person at the other side of the table can't afford that policy. And they know it too. So, I think it's the regulatory approach that has been too paternalistic and unnecessarily protective when you have all these other safeguards in place in the system. And some of the rules that are coming out, and I agree everybody should have the same guarantee, and the same assurance that the agent is working in their best interest, whether selling them an annuity or a $50,000 term policy. But that's not where those rules have gotten us. All we have found out is that it's actually cutting off people from getting access to starter life insurance products, starter financial products. Nobody starts at a $2 million policy. We start at a $50,000 term policy. Well, guess what, when a term policy transaction looks like a house closing in the amount of paperwork that you have, which is exactly what 187 has created, and we explained this to the Department, you've lost the value of the relationship in all the paperwork that's there. With a house closing, you come in, you come out and there's not a relationship there. With a life insurance advisor relationship, that is a relationship that will transcend their lives because they'll move up, and they'll get better products as their economic fortunes increase. And if you talk to anybody, and I mentioned my father earlier, we lived off of Northwestern Mutual Life products because my aunt worked for the company. And so we started with the Northwestern starter kit and worked our way up as my family's fortune improved. That's what we do. And so, I don't think there's an inherent fear that people aren't getting the same level of protection whether they're buying a $50,000 policy or a $2 million dollar annuity.

Sen. Theis stated that perhaps she misunderstood Supt. Serio because he spoke to a carveout which to me is exactly that. Supt. Serio stated that yes, I did - a safe harbor. And again, we're not talking about two different levels. But what New York did, is that New York took the annuity protection and by the way, this exists in the law right now everywhere. You have these higher protections for annuity sales and more complex sales. We have been talking about it in the terms of two levels of protection, and that's not really it. We're talking about two different levels of product. We're talking about two different transactions. If you have the requisite protection for a term sale that translates to the same level of protection when you try to do a complex product sale, then I think we've achieved it. But they try to do a one size fits all, certainly in New York. They try to do a one size fits all and what it did, and the DOL's rule is the same way as the Foundation found out, it had the untoward and unintended consequence of actually discouraging sales at the lower end of the marketplace. And that's what we're trying to fix. We'll figure out to make sure that those folks are being as protected as the people at the upper end of it. And I don't think you're going to do anything that won't assure that as well. But I think the way they've been coming at it, and I think what the Foundation's core belief is, is that we haven't been doing it the right way. We have to reengineer that process.

Rep. Meskers stated that the presentations to me were relatively complex in the requested framework. Is it that the regulations across the states are that disparate or is it that the licensing is that disparate in terms of getting uniform licensing? The second question, which seemed to focus on compensation issues and retention, it's a problem from a competitive structure that the people who would be qualified to enter into this financial product sales are going to go elsewhere because they don't have the same caps, and so your suggestion is we need to lift the caps, to allow the markets to determine what levels people should be able to be compensated at so you can attract the proper talent levels, is that where we're at? Supt. Serio replied yes. Rep. Meskers stated then back on the other issue then of licensing, I worked in the securities industry and it was uniform with a blue sky with a state subsidy - a separate state licensing, so you'd go through a seven and sixty-three and twenty-four, etc. Rep. Meskers asked if it is the case that we don't have that framework within Supt. Serio's product line and is he suggesting we need to get to that type of a licensing program?

Supt. Serio stated that we weren't necessarily suggesting a uniformity issue. I think we were trying to focus on that they issue specifically and I think uniformity would certainly be the best way to have it that you have uniformity, predictability, on compensation so that people can say, yes I'm going into this business and I am going to make this amount. Rep. Meskers stated that he was referring to licensing, not compensation, and regarding the practice across state lines, is it that we don't have a uniform process to license people? Supt. Serio stated that he thinks that answer's yes and I think we need to look at the question of uniformity of compensation. And I think we need to look at the basic level of compensation. Everybody says they want their kids to be doctors and lawyers. And why - because in their head they're thinking compensation is good. It's a good living, things like that. I think what we want to do is put that same notion in the profession that life agency is a profession that there is adequate compensation in that you don't have people washing out after the first few years. Our New York President has said, if he did not get through it he would never try this again. He's been in the business fifteen years and he would never try it again because there's just not certainty of compensation and there's not uniformity of compensation.

Asm. Ken Blankenbush (NY) stated that for someone who has lived in New York and was licensed in New York and I was one of those sales managers who was in charge of recruiting and training. We always were told and I hope it's a little bit of change now, but it was almost opposite with the regional managers and the district managers of a company for the first year, and I'm talking about first year salary caps. We were told then, let's not start them at the highest level of income because of the fact that these companies are going to come back and say, you have a production requirement and it really hurts in the second year if in fact you set their salary so high that they cannot hit the mark and the reason I'm bringing that up is because when you talk about New York, and I'm sure other states have the same problem, when you talk about NYC and when you talk about Westchester County, when you talk about all of the places that a $1 million policy is nothing, but then come to where I live in upstate New York where a $50,000 or $100,000 policy is probably one or two years of salary for many of the people where I service.

And the problem was trying to get the agent to produce the same amount of business that Westchester can. I had friends in Nyack for example, where the minimum policy in Nyack was x amount of dollars. So, what we were doing is we were really trying to put pressure on our young producers because the companies were saying they must produce x amount. Asm. Blankenbush asked Supt. Serio, since he hasn't done this in a while, has he seen a change in the philosophy of the companies themselves?

Asm. Blankenbush's second question relates to the fact that in my area, right now there isn't a Prudential agent, there isn't a MetLife agent, and there isn't a Hancock agent. I can name all of the companies that used to have 10 to 20 people in my area and now there are zero - customer service is bad because we don't have enough of the agents and I'm just wondering with the companies, of course MetLife, their philosophy was they sold it to Mass Mutual, we're sitting here talking about the $67,000 cap which really isn't high in New York City but still where I live would be an okay starting salary. So, I'm just wondering if all of the companies now are getting to the point where they say, it may not fit where I live, but if I lived down near the City with higher income levels it might. As a manager, I always had that problem trying to convince a regional manager for example, they want us to sell a maximum premium and it just didn't work in a lot of the instances and I think that caused a lot of the problems of losing agents - losing good agents.

Supt. Serio stated that those are two issues. Number one, I think what we're trying to do is approach it as a profession and not have these wild economic fluctuations. And you're absolutely right, I've lived in both worlds in New York and I know what the difference is. I can't speak for the companies but my own experience is that the companies were just exacerbated for all sorts of reasons such as lots of regulatory overreach and restrictions that they would back out of the market for a whole host of reasons. A lot of them are regulatory in nature. I'm just trying to deal with the agent issue for the moment. But I think there are a lot of reasons but the effect is still the same. They pull out of a market, they take the agent away, and it is what we call essentially a constructive withdrawal. Yes, they're still in the market but you just can't find them. Because you don't have an agent nearby, they effectively have withdrawn from the market whether they've done so formally or not. And a lot of the things that I've heard, I couldn't blame them for how hard it was getting to do some of this. And I think some of them, some of the conversations I've had over the years are right along those lines that carrier and agent interests are aligned on how do you promote agents and keep agents, because the cost of bringing an agent online, you don't want to lose a

candidate in the first year or second year because all your costs are already into that agent with onboarding and everybody loses if that agent doesn't stay in and that's what we're trying to prevent.

Asm. Blankenbush stated that the problem is what's going to happen in the second year. Supt. Serio replied yes – they are focusing on the first five years.

Wes Bissett, Senior Counsel, Gov't Affairs at the Independent Insurance Agents & Brokers of America (IIABA), stated that the IIABA is very interested to review the framework that Finseca is talking about but I would like to talk briefly about some of the requirements that apply to actually get that initial license. From our prospective, there's not the barriers to entry that Supt. Serio has suggested - states do require you in your resident state to complete and to pass an exam. We have not found that to be a significant barrier to entry. We would be very strongly opposed to any efforts to kind of dumb down that exam. In terms of the licensing requirement, that needs to be completed before you pass that exam. Many states don't have any education requirements whatsoever as there's a zero hour requirement. Other states do require up to twenty hours. But it's only twenty and it's not a significant barrier. States have moved very quickly towards reciprocity; we've not encountered the problems that Supt. Serio mentioned with agents moving from one state to another. The NAIC's producer licensing model act already addresses that. We're also seeing states move to a system where you can take the exam online. And in states where pre-licensing is required, online education can generally be completed as well. So, the licensing part of it doesn't seem to be the burden. But if states are, in some of these other areas, regulating things related to compensation or retention we would agree with Supt. Serio and Finseca that those would be issues worth pursuing. But some of the others we'd be somewhat concerned about getting into especially if it comes down to dumbing down standards as part of the process.

Supt. Serio stated that we're not going to dumb down any process. I think that was the answer to the question before as I'm not sure that is even in the thought process. I think what we're trying to do is reimagine how we do this and I don't think having the private sector do examinations that are approved by the Department is dumbing down the process at all. And I don't think we talked anything about reducing qualifications and if we are going to continue to provide the same level of service, we can't dumb it down. But the bottom line is that there are enough people who are accountable in the system that I don't think we have to worry about that because they're still going to look to attract the kind of people that they will be proud to be serving with and I don't think that dumbing down is anywhere in that equation.

PRESENTATION ON PROTECTING VULNERABLE ADULTS FROM FINANCIAL EXPLOITATION

Maeghan Gale, Director of State Gov't Relations at the National Association of Insurance and Financial Advisors (NAIFA), stated that she, along with her colleague, Michael Hedge, Policy Director, Gov't Relations, are here to talk today about senior financial protection.

Mr. Hedge thanked the Committee for the opportunity to speak and stated that he focuses on federal financial services issues and works with the U.S. House Financial Services Committee and the U.S. Senate Banking Committee and the U.S. Senate

Special Committee on Aging. He has worked for two Members of the House of Representatives and he has been doing NAIFA's lobbying on the financial services side as mentioned since then. NAIFA is the preeminent membership association for the international multi-generational community of financial professionals in the United States. We have fifty-three state and territorial chapters and thirty-five large metropolitan local chapters. We have members in every congressional district of the country and we advocate on behalf of producers and consumers at the State, interstate and Federal levels. And we have a very strong vested interest in senior protection. When I started with NAIFA which was just six years - I looked at the portfolio that I was picking up and I said where can we be more proactive on the Federal side? And senior protection was one of those issues we'd worked in for a long time but I really thought there was room for growth and what we could do, and also how we can collaborate with state legislatures at the same time. And so, we're going to talk about senior protection; some Federal trends; the Senior Safe Act which is a legislative piece that's now law that I worked on intimately; and some other stuff with the Financial Industry Regulatory Authority (FINRA); and then Ms. Gale is going to talk a little bit about some North American Securities Administrators Association (NASAA) model language that we've been pushing and what needs to be improved and tweaked on in that language as well.

Starting with senior protection, when a person retires, their need for insurance and financial service guidance doesn't end. In fact, for many it's just the beginning. Financial advisors help their retired clients adjust their budgets, they estimate expenses, develop disbursement strategy for the retirement savings accounts, find healthcare as well as limited and extended care solutions, and create legacies to leave for loved ones and for charities. And financial advisors also provide front line protection against scams targeting older Americans. Now, how do NAIFA members help? And, this applies to financial advisors in general but obviously I work most closely with our own members: understanding social security utilization of social security and planning processes; Medicare enrollments; understanding and navigating Medicare; annuitizing 401K's; Medicare supplemental policies; financial planning or downsizing; emergency preparedness; charitable giving; and estate planning. Those are some of the primary areas that our members and financial advisors work in.

And I want to go right into some of our work with the Special Committee on Aging. When a person retires that's really when they start to become more vulnerable in terms of their financial spending because they're looking at access areas that hadn't previously been accessed in their financial portfolios. And the Aging Committee right now is doing an annual outreach to stakeholders. So, basically the Aging Committee is currently gathering information for its annual report that seeks to inform policymakers in Congress. And I wanted to provide a brief overview of what they're doing on the Federal side and what they're looking at currently. And so basically the Ranking Member and the Chairman put out a call, they're looking for comments from among other professionals who assist seniors and people with disabilities in making decisions about claiming social security, enrolling in Medicare, annuitizing a 401K, downsizing a home, giving to a charity, and responding to natural disaster loss. So that's what the Aging Committee is seeking comment on right now and the types of information and skills that are necessary, that's what they're looking to us for answers for. And I've worked specifically with Senator Tim Scott from South Carolina who's reached out and asked for details as to what NAIFA has been doing on these issues.

And sources of confusion and mistakes when making these decisions is also what they're very much interested in right now such as possible sources of abuse when making decisions and fraud and scams that have been cropping up more recently again. We conducted a survey of our membership to really see how involved financial advisors in general are with seniors and as you can see here from the respondents that we got 100% provide financial services to older Americans. That might seem self explanatory, but the reality is when you look at one in five older Americans are victims of financial exploitation and you're looking at $125,000 loss on average, that's a protected class that really doesn't get all the attention that it sometimes needs.

And when you're looking at it, I have up here the U.S. financial industry loses roughly $1 billion every year because of exploitation of adults over 50. I've seen numbers as high as $2.9 billion from the Government Accountability Office (GAO) in terms of senior losses per annual year through exploitation and fraud. So, of the respondents, 100% worked with clients of retirement age and 100% had also developed strategies to increase the confidence of older Americans in trusting their financial advice with over 59.8% ensuring that inclusion and involvement of a trusted person of the older client is involved in the decision making process. So, we've worked extensively with our advisors on how to better serve their clients at the senior level and one of the things we've done is we worked with AARP very closely to develop a program called Bank Safe and it helps spot and prevent financial exploitation of seniors and that's really been very useful. There's been a lot of positive response from different government agencies in terms of the practicality and what it seeks to accomplish.

Discussing the ethics component of the membership they hold with NAIFA is also one of those things that really helps instill confidence in the senior client. Regarding Bank Safe, it's basically NAIFA and AARP developed this new core specifically for financial advisors, and it has the potential to exponentially increase our collective impact on the fight against financial exploitation. It protects millions of older adults from losing their hard-earned savings and the financial advisor Bank Safe training platform arms NAIFA's representatives for the ability to take better confidence in dealing with their clients. AARP really had the expertise obviously serving the retirement base of American consumers whereas we were able to work with our advisors and get them involved with the program as to how to best develop and address the concerns that senior savers have and also, the family members of senior savers.

Moving on, I want to talk about the Senior Safe Act because this is Federal law and some of you may be aware of it and some of you may not be. According to a 2008 GAO report, which I cited just a moment ago, financial fraud targeting older Americans is a growing epidemic that costs seniors up to $2.9 billion dollars a year and too often vulnerable seniors are victims of actions by unscrupulous individuals. It's often family members as family members are one of the primary, if not the primary source of fraud committed against their older relatives. And in the coming years, millions of Americans will be transitioning from the workforce into retirement and will be living on fixed incomes and other assets that need to be preserved to protect their financial independence and security. And our members continue to lead this vital effort in protecting our nation's seniors. Basically, the Senior Safe Act allows agents and advisors to report suspicious financial activity and creates a safety umbrella, an immunity if you will, for reporting any potential fraud on a client's accounts without having to be worried about violating privacy restrictions upon that financial professional.

I worked very closely with the bill's sponsors, one of which was Susan Collins from Maine and she based the bill on the 2014 initiative by the Maine Council on Elder Abuse and Prevention. At that time she was Chair of the Special Committee on Aging in the U.S. Senate and when she introduced the bill it dealt only with securities investment and did not address insurance at all. A companion bill was introduced in the House by then Congresswoman Kirsten Sinema of Arizona and I worked with her staff to get a full umbrella immunity protection for insurance. And so, as I said, it essentially creates a safe harbor for financial professionals to report suspected criminal activity without fear of violating privacy law. The immunity established by the Senior Safe Act is provided on the condition that certain employees receive training on how to identify and report exploitative activities against seniors before making a report and that reporting of suspected exploitation are made in good faith and with reasonable care. The immunity applies to employees in firms, and what it does is, in order to qualify for immunity there are steps. You have to actually be trained, you have to belong to a covered financial institution, and you have to have the actual wherewithal working with the certain protected class that's encompassed by this legislation. Now, what's great about it is, it really covers insurance producers and it covers the registered representatives of broker dealers. It covers investment advisors. And what we've seen is the attempt in Maine to rectify this, there's been a 50% increase in Maine in reporting financial fraud against seniors since the Maine Council on Elder Abuse enacted that kind of prevention.

They're looking at doing studies right now to see if there's been any effective positivity in an overall increase by implementing this as law on the Federal level. It is important to point out that the law does not countermand State law as it is a complementary law. If a state has a weaker provision or protection for immunity for reporting financial abuse then the Federal law comes into effect in that state. But if the state actually has a more stringent or better protection in place, then the State Law supersedes the Federal law on that aspect. And that's one of the things we really worked for and we are very committed to keeping insurance oversight at the state level, but having a uniform policy at the Federal level to strengthen state programs is also something that's been very useful for us.

Another bill that was introduced in 2019 by Congressman Josh Gottheimer from New Jersey in the House of Representatives was the Senior Security Act 2019. It did pass the House and was introduced by Senator Krysten Sinema in the Senate and it failed to get any traction and didn't make it out of Committee. But this basically is a companion piece to the Senior Safe Act and what it would have done is create a task force and Commissions at the SEC to do more studies on how seniors are exploited. And that's something that we think is really important. What's interesting is that on Monday, Congressman Gottheimer introduced another bill that was passed out of the House Financial Services Committee, and in this one it would authorize Federal grants to states to support senior investor rights. And basically, the Act that was introduced on Monday would grant funds to states for hiring staff and identifying and investigating and prosecuting cases involving senior fraud. It would also help states fund technology, equipment and training for regulators, prosecutors and law enforcement officers in order to investigate and prosecute that fraud.

We have a really good working relationship with Congressman Gottheimer and the senior protection issue is something that he believes firmly in. He was elected to Congress after the first time Senior Safe was introduced but from the moment he got into Congress he really looked at his District and said, "I want to help protect the seniors of

my District and I'm going to be very proactive with this." I've talked to him about this new bill that was introduced and I don't know the feeling yet in terms of whether it will make it on to the agenda for a vote but I haven't seen anything negative yet. There is no specific directive where money must be spent by the State specifically - it gives guidance on spending those dollars by the State to help protect and increase their programs that are in existence. It doesn't create any additional Federal laws - it is a very pro-state Federal piece of grant legislation.

I want to touch very briefly on FINRA and some of the stuff we worked on with FINRA's adopted Rule 2165 to permit members to place temporary holds on financial transactions. Basically, the model was, and this is an actual case, that you would have an older woman, she was 70 years old, and she came into her financial institution with her nephew and she said she was withdrawing $10,000 to give to her nephew to send to Canada to make an investment. The person working at the disbursement center, said, "This looks suspicious, I don't believe this money's going to be allocated to her best interest." And so the transaction was frozen but at that time, it was a seven day hold and seven days later, she came back and withdrew $10,000 from the same financial institution, sent it to Canada, and that money was gone. She had been a victim of fraud. And so even though the disburser of the funds had the wherewithal to say, "No, this isn't a good decision" the law would not back him up in terms of making a permanent asset freeze. The FINRA rule is specifically looking at a case by case basis and not freezing entire accounts but freezing certain transactions. I will now pass it over to my colleague, Ms. Gale.

Ms. Gale stated that to bring this back to the states, this is a very important issue and we've seen a lot more prevalence of senior fraud and it's important that the states laws and regulations work well with the new Federal things we're seeing. In 2016, NASAA adopted its Model to protect vulnerable adults from financial exploitation and it gives the industry participants and state regulators these new tools to detect and prevent financial exploitation. Under the Model, the eligible adults are those 65 and older but the Model mandates reporting to state securities regulators in state adult protective service agencies when a qualified individual has a reasonable belief that the financial exploitation of an eligible adult has attempted and has occurred. We've seen pretty good adoption of this as according to NASAA the Model or similar law including several that predated the Model have been adopted in 34 jurisdictions since NASAA members voted on it in 2016.

That is pretty good coverage but not universal. When NAIFA was working with NASAA on this Model there were a couple of points that we felt were really important and wanted to bring to your attention. From an insurance producer perspective, we support the Model and have been active in advancing its passage in a number of states but we support a voluntary, not mandatory, reporting process. This mandatory notification could result in firms and advisors reporting an excess number of transactions sometimes based on limited evidence or suspicion just to avoid legal liability and you want to avoid those cry wolf situations. And to better protect client's assets from financial losses, advisors should have the flexibility to determine whether disbursement is connected with exploitation since they truly are the ones with the relationship in that front line defense. Also, to permit advisors to report financial suspected exploitation to firms rather than directly to the authorities and that this determination of whether it should be reported to the authorities should come at that firm level. That additional set of eyes and that additional level of comfort for those front-line advisors is important.

So, while the first two bullets that we've talked about here don't necessarily align with the NASAA Model, the third bullet, where it creates a legal safe harbor for advisors who report suspected financial exploitation, we believe that advisors should be immune from legal liability and protecting them from the situations of if they had to violate client's privacies in situations is important. So, I promised to be brief. As we continue the fight to protect seniors, there's been some pretty large instances we've seen in the news lately about this. It could be worth a second set of eyes on how we can protect seniors on the state level. And of course, NAIFA is always here. We work with our senior members daily and recognize that they are in need and through advocacy and education we want to make sure that we provide the protection and they receive it and we are here to be an asset for you as you look at this issue.

Sen. Utke thanked Ms. Gale for the presentation and stated that since she sat through the prior topic, did she have any comments or any questions concerning that? Ms. Gale stated I think we would just echo the comments made by Mr. Bissett. Sen. Utke thanked everyone for speaking and noted that while time is running out, all of the speakers can be reached out in the hallway or after the conference.

UPDATE ON PAID FAMILY MEDICAL LEAVE (PFML) DEVELOPMENTS

Karen Melchert, Regional Vice President, State Relations at the ACLI, thanked the Committee for the opportunity to speak and said that she is here to provide an update on work ACLI has been doing on PFML over the past year and a half. At the NCOIL March 2020 meeting in Charlotte right before the world shut down, I, along with my colleague, came before you to tell you about a proposal ACLI had been working on to allow for insurers to offer PFML coverage as an insurance product. While ACLI is still pursuing that goal, our focus has changed just a bit as Congress has been debating including PFML in the Build Back Better Act and what that would look like and how it would be paid for. We have been advocating for the creation of a public private partnership that offers a private option for those that want it, alongside a government program for those that do not have access to employer provider benefits. America's life insurance companies are eager to work with private employers and government to expand this crucial coverage. Private insurers have assisted states in the administration of PFML for decades. This has resulted in timely claims payments and valuable services to both employers and employees.

In New York, the private sector worked closely with the state to expand its existing disability income program when they added the PFML component to it. Private carriers oversee and deliver most of the New York disability income and PFML program both for public salaried employees and for independent contractors and gig workers. This public private partnership is extremely efficient for both regulators, insurers and employers and their employees. Massachusetts recently created a public program to deliver PFML benefits but did give employers the choice to provide benefits through a private sector plan that meets or exceeds the standards of the government program. With coverage available from more than 20 private carriers, and many employers providing self insured benefits, the private sector helps ensure all Massachusetts workers receive paid leave benefits while reducing the burden on government to process claims and other payments.

When we presented to you in March in 2020, ACLI had been working on a model law that would enable licensed disability carriers to file products with state insurance departments to offer PFML benefits. Disability insurers are well equipped to offer family leave benefits. We have the experience, the expertise, and infrastructure in place to begin working towards providing these benefits, either through employer sponsored group insurance products, or voluntary purchased policies. And disability insurance currently provides the most extensive coverage to employees for wage replacement purposes. Following our presentation last March, we continued to have conversations with regulators and legislatures in states that were considering or interested in a PFML program. Our proposal was well received, but when we continued these discussions we began to realize that our solution was really two fold. It required a statutory action and regulatory action. But the issue that remains, and when we first brought this to you, is that there is no ability for insurers to offer this product unless the statutory change is made to add that as a line of authority under state law.

In the summer of 2021, ACLI was part of a task force with the Virginia Bureau of Insurance to create that new line of authority that would allow insurers to write these policies. They're closely tied to the Federal Family Medical Leave Act, so there's eliminating the confusion of eligibility leave time and administration and because there is no current line of authority in Virginia law to write family leave, we are working with them to draft legislation that would provide that line of authority. And then the remainder of our model law that we had presented to you in 2020 would become the regulatory piece of that effort. So, what are we asking of you? For starters, when your state is considering a PFML program, make sure that you and your state insurance regulator are included in the conversation and then bring carriers into the conversation as well. We are the people who are best equipped to determine how best to build a PFML program. And as we work with Virginia to craft our path forward, we envision creating a new model law that we hope to bring to you for consideration starting in March at the Las Vegas meeting. We believe it's important that NCOIL members and your fellow insurance legislators who already appreciate the role insurers play in providing medical benefits through disability coverage are involved in this discussion surrounding family leave insurance benefits in your state. We want to be part of the solution to providing this extremely important benefit for today's workforce.

Dave Lujan, President and CEO of Children's Action Alliance in Arizona, stated that PFML law is one of the policy issues that we advocate for here in Arizona. With PFML currently in the United States, 23% of workers in the United States have access to it. And so that is why there's been a real effort around the country and nationally to enact the state policies around PFML and as was mentioned, there's a national effort right now through the Build Back Better Plan. There's a measure that actually passed this morning that includes a PFML component in it for a national program but it's likely, and most people I think expect that portion that's in Build Back Better will get stripped out when it gets to the Senate. So, that is why a number of states in recent years have been enacting their own state PFML laws. So, currently we have nine states and the District of Columbia that have enacted PFML laws but I think you can expect to see that in many other states around the country you're going to see efforts to introduce and try and pass similar laws in other states.

So, of those nine states that have passed laws, they're all different but there's a lot of similarities in them. So, I thought I would just give you just some key features of what the state PFML laws look like. And in all of these states, they're basically set up as

social insurance programs, so they're generally set up so that both the employee and the employers make payroll contributions to help fund them. And in all of the states the acceptable reasons for taking PFML include caring for a newborn child, caring for a family member with serious health conditions, or caring for your own serious health condition. When you talk about family members, which family members? Well, in most states that includes your own children, step children, parents, spouse, domestic partners, grandparents, grandchildren and in some states you also can take leave to care for siblings. The state laws vary in terms of how long and how much PFML you can take. I think in most of the states it's twelve weeks of maximum leave, but some states are eight.

Regarding funding, in most states, they're funded jointly by employer and employee payroll contributions. What those contributions are vary by state. Generally, from 0.4% to 1% of the employees' wages. Small employers are typically exempt in most of these states. Typically, it's 25 or fewer employees to be exempt from having to make contributions. And the benefit amounts range from 50-90% percent of the person's wages. So, if you go on paid leave, most states what they do is they have a sliding scale. So, the lower wage you make, you are entitled to a higher percentage of your income in PFML. So, those lower paid employees typically will get about 90% of their wages if they go on leave whereas the ones who are making more will typically get only about 50% of their wages. And then I mentioned there's a national proposal in the Build Back Better plan - that one is a much scaled down version of what you see here from the states if that indeed gets passed the Federal PFML will offer four weeks, currently that's what's in the bill, of paid leave per year.

Rep. Deborah Ferguson (AR), asked, in states, if you're talking about disability insurance being the administrator, is that an RFP where it's just one disability insurer that it's contracted with or is it available to numerous disability insurers? Ms. Melchert stated that she thinks it varies. What we're talking about is not just being the state administrator like in Massachusetts there is a state administrator for the state portion of it. We're talking about being the private sector solution for employers who opt out of the state program. But yes, in Massachusetts, I believe there's one company that runs the government side of it. But there are twenty carriers that offer, it's similar to disability but it's family leave, and there about twenty carriers that are licensed to offer that in Massachusetts. So, it's truly a combination.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson and seconded by Sen. Hackett, the Committee adjourned at 10:30 a.m.

Paid Family Leave Insurance Model Act

Proposal submitted for discussion by the American Council of Life Insurers (ACLI). To be introduced for discussion during the Life Insurance & Financial Planning Committee on March 4th, 2022 and throughout 2022.

Table of Contents

Section 1. Title

This Act shall be known as the [State] Paid Family Leave Insurance Act

Section 2. Purpose

The purpose of this Act is to create a new line of insurance, known as paid family leave insurance, under which any insurer licensed to transact life insurance or disability income insurance business in this state may be authorized to issue policies covering such risk.

Section 3. Definitions

In the appropriate "Definitions" section of [State] Insurance Code, the following term shall be added:

"Family leave insurance" means an insurance policy issued to an employer related to a benefit program provided to an employee to pay for a percentage or portion of the employee's income loss due to: (i) the birth of a child or adoption of a child by the employee; (ii) placement of a child with the employee for foster care; (iii) care of a family member of the employee who has a serious health condition; or (iv) circumstances arising out of the fact that the employee's family member who is a service member is on active duty or has been notified of an impending call or order to active duty.

Family leave insurance may be written as an amendment or rider to a group disability income policy, included in a group disability income policy or written as a separate group insurance policy purchased by an employer.

Section 4. Paid Family Leave Insurance License

In the [State] Insurance Code, the following language shall be added to the Classes of Insurance section indicating what policies a licensed life insurer or disability income insurer may issue in this state: “family leave insurance”

Section 5. Rules

The commissioner may adopt rules as necessary to effectuate the provisions of this Act.

Section 6. Effective Date

This Act is effective immediately.

Section 7. Addendum

The following may be used to as a basis for developing rules referenced in Section 5, or, in the alternative, may be used as a basis for a more detailed statutory addition to a particular state’s insurance code.

The rules may be based on the following, or in the alternative may be included in the statute as law.

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

§ 100. Short Title

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

§ 101. Purpose

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

§ 102. Definitions

As used in this Article:

1. "Armed forces of the United States" includes members of the National Guard and Reserves.

2. "Child" means a person who is (i)(a) under 18 years of age; or (b) 18 years of age or older and incapable of self-care because of a mental or physical disability; and (ii) a biological, adopted, or foster son or daughter; a stepson or stepdaughter; a legal ward; a son or daughter of a domestic partner; or a son or daughter of a person to whom the employee stands *in loco parentis*.

3. "Family Leave" is any leave taken by an employee from work for reasons enumerated in Section 103.

4. "Family Member" may include a child, spouse, or parent as defined in this Section or any other person defined as a "family member" in the policy of insurance.

5. "Health care provider" shall mean a person licensed under the public health law of the [State].

6. "Parent" means a biological, foster, or adoptive parent, a stepparent, a legal guardian, or other person who stood *in loco parentis* to the employee when the employee was a child.

7. “Serious health condition” means an illness, injury, impairment, or physical or mental condition, including transplantation preparation and recovery from surgery related to organ or tissue donation, that involves inpatient care in a hospital, hospice, or residential health care facility, continuing treatment or continuing supervision by a health care provider as defined in the insurance policy. Continuing supervision by a health care provider includes a period of incapacity which is permanent or long term due to a condition for which treatment may not be effective and where the family member need not be receiving active treatment by a health care provider.

§ 103. Family Leave Benefits:

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

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

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

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

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

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

§ 104. Explanation of Family Leave Reasons

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

§ 105. Benefit Period

The policy of insurance shall set forth the length of family leave benefits that are available for each covered family leave reason, which will in no event be less than [two weeks] during a period of fifty-two consecutive calendar weeks. Fifty-two consecutive calendar weeks may be calculated by (i) a calendar year; (ii) any fixed period starting on

a particular date such as the effective or anniversary date; (iii) the period measured forward from the employee's first day of family leave; (iv) a rolling period measured by looking back from the employee's first day of family leave; or (v) any other method that is specified in the policy of insurance.

§ 106. Waiting Period

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

§ 107. Amount of Family Leave Benefits/Other Income

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

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

§ 108. Permissible Limitations, Exclusions, or Reductions

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

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

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

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

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

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

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

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

§ 109. Payment of Family Leave Benefits

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

§ 110. The Insurance Policy

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

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

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National Council of Insurance Legislators (NCOIL)

Secondary Addressee Model Act

Adopted by the NCOIL Life Insurance Committee on November 17, 1996, and by the NCOIL Executive Committee on November 20, 1996. Readopted by the NCOIL Executive Committee on July 12, 2001, February 27, 2004, July 22, 2006, February 26, 2012, and March 4, 2017. Amended by the Life Insurance & Financial Planning Committee on July 15, 2017 and approved by the Executive Committee on July 15, 2017.

To be considered for re-adoption by the NCOIL Life Insurance & Financial Planning Committee at the 2022 NCOIL Spring Meeting.

Section 1. Secondary notice.

A. Except as provided herein, no individual contract for life insurance issued or issued for delivery in this state (one year after the effective date of this Act) covering a natural person, which has been in force for at least 1 year, shall be lapsed for nonpayment of premium unless, after expiration of the grace period and at least 21 days prior to the effective date of any such lapse, the insurer has mailed or if agreed to by the applicant, e-mailed or texted, a notification of such impending lapse in coverage to the policyowner and to a specified secondary addressee if such addressee has been designated in writing by name and address by the policyowner.

B. An insurer issuing such a life insurance contract on or after (one year after the effective date of this Act) shall notify the applicant of the right to designate a secondary addressee at the time of application for the policy on a form provided by the insurer, and thereafter the policyowner has the right to designate a secondary addressee, in writing, by name and address, at any time the policy is in force, by submitting such written notice to the insurer.

C. For purposes of any life insurance policy which provides a grace period longer than 51 days for nonpayment of premiums, the notice of possible lapse in coverage as required by this section shall be mailed or if agreed to by the applicant, e-mailed or texted, at least 21 days prior to the expiration of the grace period provided in such policies to the policyowner and to the secondary addressee.

D. This section shall not apply to life insurance contracts under which premiums are payable monthly or more frequently and regularly collected by a licensed agent, or paid by a credit card or any pre-authorized check processing or automatic debit service of a financial institution.

Section 2.

This Act shall take effect upon becoming law.

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National Council of Insurance Legislators (NCOIL)

Insurance Compliance Self-Evaluative Privilege Model Act

Adopted by the NCOIL Life Insurance Committee on February 28, 1998, and by the Executive Committee on March 1, 1998. Readopted by the Executive Committee on July 13, 2001, February 27, 2004, July 22, 2006, and February 26, 2012 and March 4, 2017.

To be considered for re-adoption by the NCOIL Life Insurance & Financial Planning Committee at the 2022 NCOIL Spring Meeting.

Section 1. Insurance compliance self-evaluative privilege.

(a) To encourage insurance companies and persons conducting activities regulated under this Code, both to conduct voluntary internal audits of their compliance programs and management systems and to assess and improve compliance with State and federal statutes, rules, and orders, an insurance compliance self-evaluative privilege is recognized to protect the confidentiality of communication relating to voluntary internal compliance audits. The Legislature hereby finds and declares that protection of insurance consumers is enhanced by companies' voluntary compliance with this State's insurance and other laws and that the public will benefit from incentives to identify and remedy insurance and other compliance problems. It is further declared that limited expansion of the protection against disclosure will encourage voluntary compliance and improve insurance market conduct quality and that the voluntary provisions of this Section will not inhibit the exercise of the regulatory authority by those entrusted with protecting insurance consumers.

Drafting Note: An insurance compliance self-evaluative audit is not intended to replace a market conduct examination by regulators.

(b) (1) Except as provided in subsections (c) and (d) of this section, an insurance compliance self-evaluative audit document is privileged information and is not discoverable, or admissible as evidence in any legal action in any civil, criminal, or administrative proceeding. The privilege created herein is a matter of substantive law of this State and is not merely a procedural matter governing civil or criminal procedures in the courts of this State.

Drafting Note: An alternative to this approach would be to include subsection (b) in the exception clause which would allow a regulator to discover (gain access to) the work product of a self-evaluative audit.

(2) If any company, person, or entity performs or directs the performance of an insurance compliance audit, an officer, employee or agent involved with the insurance compliance audit, or any consultant who is hired for the purpose of performing the insurance compliance audit, may not be examined in any civil, criminal, or administrative proceeding as to the insurance compliance audit or any insurance compliance self-evaluative audit document, as defined in this Section. This subsection (b)(2) does not apply if the privilege set forth in subsection (b)(1) of this Section is determined under subsection (c) or (d) not to apply.

(3) A company may voluntarily submit, in connection with examinations conducted under this Article, an insurance compliance self-evaluative audit document to the Commissioner, or his or her designee, as a confidential document under Section [ ] of this Code without waiving the privilege set forth in this Section to which the company would otherwise be entitled; provided, however, that the provisions in Section [ ] permitting the Commissioner to make confidential documents public pursuant to Section [ ] and access to the National Association of Insurance Commissioners shall not apply to the insurance compliance self-evaluative audit document so voluntarily submitted. To the extent that the Commissioner has the authority to compel the disclosure of an insurance compliance self-evaluative audit document under other provisions of applicable law, any such report furnished to the Commissioner shall not be provided to any other persons or entities and shall be accorded the same confidentiality and other protections as provided above for voluntarily submitted documents. Any use of an insurance compliance self-evaluative audit document furnished as a result of a request of the Commissioner under a claim of authority to compel disclosure shall be limited to determining whether or not any disclosed defects in an insurers' policies and procedures or inappropriate treatment of customers has been remedied or that an appropriate plan for their remedy is in place.

(i) A company's insurance compliance self-evaluative audit document submitted to the Commissioner shall remain subject to all applicable statutory or common law privileges including, but not limited to, the work product doctrine, attorney-client privilege, or the subsequent remedial measures exclusion.

(ii) Any compliance self-evaluative audit document so submitted and in the possession of the Commissioner shall remain the property of the company and shall not be subject to any disclosure or production under [state's Freedom of Information Act or sunshine law(s).]

(4) Disclosure of an insurance compliance self-evaluative audit document to a governmental agency, whether voluntary or pursuant to compulsion of law, shall not constitute a waiver of the privilege set forth in subsection (b)(1) of this section with respect to any other persons or any other governmental agencies.

(c) (1) The privilege set forth in subsection (b) of this Section does not apply to the extent that it is expressly waived by the company that prepared or caused to be prepared the insurance compliance self-evaluative audit document.

(2) In a civil or administrative proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege set forth in subsection (b) of this Section is asserted, if the court determines one of the following:

(A) the privilege is asserted for a fraudulent purpose; or

(B) the material is not subject to the privilege.

(3) In a criminal proceeding, a court of record may, after an in camera review, require disclosure of material for which the privilege described in subsection (b) of this Section is asserted, if the court determines one of the following:

(A) the privilege is asserted for a fraudulent purpose;

(B) the material is not subject to the privilege; or

(C) the material contains evidence relevant to commission of a criminal offense under this Code, and all three of the following factors are present:

(i) the Commissioner, State's Attorney, or Attorney General has a compelling need for the information; and

(ii) the information is not otherwise available; and

(iii) the Commissioner, State's Attorney, or Attorney General is unable to obtain the substantial equivalent of the information by any other means without incurring unreasonable cost and delay.

(d) (1) Within 30 days after the Commissioner, State's Attorney, or Attorney General serves on an insurer a written request by certified mail for disclosure of an insurance compliance self-evaluative audit document under this subsection, the company that prepared or caused the document to be prepared may file with the appropriate court a petition requesting an in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Section or subject to disclosure. The court has jurisdiction over a petition filed by a company under this subsection requesting an

in camera hearing on whether the insurance compliance self-evaluative audit document or portions of the document are privileged or subject to disclosure. Failure by the company to file a petition waives the privilege for this request only.

(2) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection shall include in its request for an in-camera hearing all of the information set forth in subsection (d)(5) of this Section.

(3) Upon the filing of a petition under this subsection, the court shall issue an order scheduling, within 45 days after the filing of the petition, an in-camera hearing to determine whether the insurance compliance self-evaluative audit document or portions of the document are privileged under this Section or subject to disclosure.

(4) The court, after an in-camera review, may require disclosure of material for which the privilege in subsection (b) of this Section is asserted if the court determines, based upon its in camera review, that any one of the conditions set forth in subsection (c)(2)(A) and (B) is applicable as to a civil or administrative proceeding or that any one of the conditions set forth in subsection (c)(3)(A) through (C) is applicable as to a criminal proceeding. Upon making such a determination, the court may only compel the disclosure of those portions of an insurance compliance self-evaluative audit document relevant to issues in dispute in the underlying proceeding. Any compelled disclosure will not be considered to be a public document or be deemed to be a waiver of the privilege for any other civil, criminal, or administrative proceeding. A party unsuccessfully opposing disclosure may apply to the court for an appropriate order protecting the document from further disclosure.

(5) A company asserting the insurance compliance self-evaluative privilege in response to a request for disclosure under this subsection (d) shall provide to the Commissioner, State's Attorney, or Attorney General, as the case may be, at the time of filing any objection to the disclosure, all of the following information:

(A) The date of the insurance compliance self-evaluative audit document.

(B) The identity of the entity conducting the audit.

(C) The general nature of the activities covered by the insurance compliance audit.

(D) An identification of the portions of the insurance compliance self-evaluative audit document for which the privilege is being asserted.

(e) (1) A company asserting the insurance compliance self-evaluative privilege set forth in subsection (b) of this Section has the burden of demonstrating the applicability of the privilege. Once a company has established the applicability of the privilege, the party seeking disclosure under subsection (c)(2)(A) of this Section has the burden of proving that the privilege is asserted for a fraudulent purpose. The Commissioner, State's Attorney, or Attorney General seeking disclosure under subsection (c)(3) of this Section has the burden of proving the elements set forth in subsection (c)(3) of this Section.

(2) The parties may at any time stipulate in proceedings under subsections (c) or (d) of this Section to entry of an order directing that specific information contained in an insurance compliance self-evaluative audit document is or is not subject to the privilege provided under subsection (b) of this Section. Any such stipulation may be limited to the instant proceeding and, absent specific language to the contrary, shall not be applicable to any other proceeding.

(f) The privilege set forth in subsection (b) of this Section shall not extend to any of the following:

(1) documents, communications, data, reports, or other information expressly required to be collected, developed, maintained, or reported to a regulatory agency pursuant to this Code, or other federal or State law;

(2) information obtained by observation or monitoring by any regulatory agency; or

(3) information obtained from a source independent of the insurance compliance audit

(g) As used in this Section:

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

(2) "Insurance compliance self-evaluative audit document" means documents prepared as a result of or in connection with an insurance compliance audit. An insurance compliance self-evaluative audit document may include a written response to the findings of an insurance compliance audit. An insurance compliance self-evaluative audit document may include, but is not limited to, as applicable, field notes and records of observations, findings, opinions, suggestions, conclusions, drafts, memoranda, drawings, photographs, exhibits, computer generated or electronically recorded information, phone records, maps,

charts, graphs, and surveys, provided this supporting information is collected or developed for the primary purpose and in the course of an insurance compliance audit. An insurance compliance self-evaluative audit document also includes, but is not limited to, any of the following:

(A) an insurance compliance audit report prepared by an auditor, who may be an employee of the company or an independent contractor, which may include the scope of the audit, the information gained in the audit, and conclusions and recommendations, with exhibits and appendices;

(B) memoranda and documents analyzing portions or all of the insurance compliance audit report and discussing potential implementation issues;

(C) an implementation plan that addresses correcting past noncompliance, improving current compliance, and preventing future noncompliance; or

(D) analytic data generated in the course of conducting the insurance compliance audit.

(3) “Company” has the same meaning as provided in [Reference specific state code].

(h) The insurance compliance self-evaluative privilege created by this legislation shall apply to all litigation or administrative proceedings pending at the effective date of this legislation.

(i) Nothing in this Section nor the release of any self-evaluative audit document hereunder shall limit, waive, or abrogate the scope or nature of any statutory or common law privilege including, but not limited to, the work product doctrine, the attorney-client privilege, or the subsequent remedial measures exclusion.

(j) Effective Date. This bill shall become effective immediately upon its passage by the Legislature and approval by the Governor.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 19, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at The Westin Kierland Hotel in Scottsdale, Arizona on Friday, November 19, 2021 at 2:45 p.m.

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

Other members of the Committee present were:

Asm. Ken Cooley (CA)
Rep. Stephen Meskers (CT)
Rep. Matt Lehman (IN)
Rep. Jonathan Carroll (IL)
Rep. Joe Fischer (KY)
Rep. Derek Lewis (KY)
Rep. Chad McCoy (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Sen. Michael McLendon (MS)
Sen. Walter Michel (MS)
Sen. Charles Younger (MS)
Asm. Ken Blankenbush (NY)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Sen. Jay Hottinger (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Tammy Nuccio (CT)
Sen. Jim Guthrie (ID)
Sen. Beverly Gossage (KS)
Sen. Julie Raque Adams (KY)
Rep. Rachel Roberts (KY)
Rep. Mary DuBuisson (LA)
Rep. Kyle Green (LA)
Rep. John Illg (LA)
Sen. Lana Theis (MI)
Rep. Hank Zuber (MS)
Sen. Jim Burgin (NC)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Derek Lewis (KY), and seconded by Asm. Ken Cooley (CA), NCOIL Vice President, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Del. Steve Westfall (WV), and seconded by Sen. Bob Hackett (OH, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 16, 2021 meeting in Boston, MA.

DISCUSSION ON STATE EFFORTS TO LOWER THE UNINSURED MOTORIST POPULATION

Victoria Kilgore, Director of Research at the Insurance Research Council (IRC) thanked the Committee for the opportunity to speak as this is her first NCOIL meeting. I understand you've been having several discussions about ways to reduce the rate of uninsured motorists in your states and to that effect I've been invited here just to kind of level set and make sure that everybody understands the measures that we use to estimate this issue. Obviously, this is a very important issue as the National Association of Insurance Commissioners (NAIC) has estimated that in 2017 $14 billion in premiums were paid by policyholders to protect themselves against losses due to injuries from uninsured drivers. This conversation fits exactly into the mission of the IRC which I represent and we are a nonprofit institute formed to look at public policy issues that affect the P&C industry. So, this is the perfect audience for us to share our 40 years of research on the issue of uninsured motorists.

So, what I plan to share today, is first some background on some various methods that have been used to measure the uninsured motorist population, describe in detail the method that the IRC has been using since 1980 to estimate the uninsured motorist rate, share some of the most recent results both countrywide and state by state that we have released, and then talk about some of our other research that touches on the issue. So, what are some possible ways to measure the uninsured motorist rate? One possibility would just to be to ask people whether they're driving without insurance. And the IRC has done some survey research along those lines over the years. Obviously, one issue with that is are people going to tell you the truth? And that seems to vary according to what other questions you're asking as you ask those surveys.

But over the years we've asked consumers how many vehicles in their household are licensed and how many of those vehicles have insurance and come up with the percentage of households who have uninsured vehicles. But of course, just because they're licensed doesn't mean that they're actually being driven, so that isn't always the best way. Some other government data that can be used from the law enforcement community might be motor vehicle records, accident reports, police reports, citations for driving without insurance. But unfortunately, most of those data sources are either inaccurate or widely inconsistent across states, especially given that states have different requirements for reporting accidents.

A seemingly simple way would be to look at the aggregate number of vehicle registrations in the given state and then compare that to the number of insured vehicles reported by insurers. That would seem to be simple but is quite problematic in that sometimes you actually get measures that show a negative number of uninsured drivers in the given state. And the problem really is that you're comparing apples to oranges. That the registration data is looking at vehicles by body type, so a small truck may not be counted as a personal vehicle and the insurers are looking more closely at how the vehicle is being used. A more sophisticated way of really looking at registration data,

comparing it to insurance data is to look at a very specific vehicle rather than aggregate numbers and then looking up whether or not that vehicle is insured.

Historically, these types of data programs were extremely difficult to implement, and very expensive and inaccurate. Obviously, data technology has come a long, long way since the early 1980's when the IRC first started computing our methods. But even this technology does have some problems and you're going to get mismatches in registrations and finding the proper insurer. You still have out of state registrations, you have unregistered vehicles who are out there driving presumably not with insurance. And you have again, vehicles that are licensed but may not be actually driven and that could be a seasonal issue of people traveling out of state or even with the economic cycle. Insurers and state governments spend a lot of resources on these verification systems and newer technology is very promising as a way to look at this issue. But as I said, historically it seems that the way to accurately look at the issue is to look at insurance claims data. As I said, we first developed these estimates in the early 1980's and since then this estimate has proven to be a reliable way as to get a proxy for the rate of uninsured motorists that can be applied consistently across states and over time.

I apologize if this is going to be a little too basic but as part of my charge to level set, I thought I would very briefly go through where the uninsured motorist claims data comes from and how we use that. We conduct a data poll on a voluntary basis of insureds asking for their claim exposures and their claim counts for uninsured motorists, and which we call UM, and bodily injury liability coverage, or BI. And just as an example, if you and I were in an accident in which I was at fault and you were injured, normally you would file a claim against my insurance company, my bodily injury insurance because I was the at fault driver and that BI coverage would compensate you for the costs associated with your injury, medical expenses, lost wages and even general damages or the pain and suffering associated with your injury. But if I did not have insurance and you could not file a claim against my BI policy, you would then turn to your own uninsured motorist policy and that would be the way that you would receive compensation for the economic damages you experienced as a result of your injury, as well as the pain and suffering payments.

So, the UM coverage designed to compensate policyholders for these injuries caused by an at fault driver who is not insured, it is, as I'm sure you know, required in many states. In some states their insurers are required to offer it but insureds are allowed to decline and in other cases the insureds have to specifically ask for UM coverage. So, to get a measure of how many uninsured motorists there are we could look at the frequency of UM claims or the number of UM claims made per insured vehicles. That does give some information but there are some problems when we try to look across states or over time, because there are other factors that are going to impact the frequency of uninsured motorist claims. Most notably, that would be accident frequency, if you think back of the past almost two years now, while we haven't done any research on UM statistics during the pandemic era, I think it's safe to say that the frequency of uninsured motorist claims will have fallen. And that's not because loads of people who had not previously had insurance decided to go out and buy it. Rather it's just that the accident frequency has gone down because they're not out there running into other people.

So, what we do to make these consistent across states and across time, is that we divide the uninsured motorist frequency by the bodily injury claim frequency to create a UM to be a claim frequency ratio. Literally, what that means, is that produces a measure

of the probability that an injury to an insured car's occupant will have been the fault of a driver who was not insured. That's kind of a mouthful, so that's basically a proxy for the percentage of drivers who are out there driving without insurance. Like other measures, it's not perfect and it does rely on some key assumptions. One of those assumptions is that uninsured drivers experience the same frequency of at fault accidents as do insured drivers. If you believe that the accident rate for uninsured drivers is greater than that for insured drivers, which is logical, perhaps that's why they are uninsured because they have a poor driving record and hence, have high rates, and are hence uninsured.

If that's true, then our estimate is going to understate the true prevalence of uninsured driving. If on the other hand, uninsured drivers are less likely than insured drivers to get in an accident, maybe they're extra careful because they know they don't have insurance. In those instances, we would be overstating the prevalence of uninsured drivers. Some other assumptions behind this is that claiming behavior, specifically the propensity to file a claim is the same whether someone's deciding to file a BI claim versus deciding a UM claim. UM claims also provide coverage for hit and run accidents. Not having insurance may be one reason why a person may not stop when they have caused an accident but clearly, there are other reasons. And finally, in some states it's difficult to distinguish between UM claims and UIM claims, or underinsured claims in the states data sets.

So, onto our results that we've gotten from our most recent study. This was based on as I said insurance data collected for the years 2015 through 2019. And we found that in 2019 the ratio of UM claim frequency to BI claim frequency was .126, or 12.6%. In other words, when someone was injured in an auto accident in the U.S. in 2019 the chances were about 12.6% or one in eight that an at fault driver in the accident was uninsured. This estimate of 12.6% is up slightly from the low that we saw of 11% in 2015. It is lower than the 16% that we saw in the 1980's and early 1990's. And for many years now this estimated UM rate has remained within a fairly narrow range. The range becomes a little more interesting and really this is where most of the attention from the media goes to our IRC research is to look at the wide variations across states.

In 2019, the UM rate ranged from a high of 29% in Mississippi to a low of 3% in New Jersey. At the higher end states where the UM rate was more than one out of five we had Michigan, Tennessee, New Mexico, Washington and Florida. Other states in addition to New Jersey which had a low rate were Massachusetts, New York, Maine which were all below 5%. I will provide a copy of the full report that we issued in 2019 so you can see all of the state information. I will be giving that to NCOIL staff so that they can forward that to the members of the committee. And then just to turn very briefly to some of our other research that looks at the issue. I've mentioned before that we have done public opinion surveys and noted some of the issues with using that as a measure of the UM rate. But one advantage is that we can get some more information about the people who say that they do have uninsured vehicles and we can ask them some questions about their attitudes towards it.

When we look at the characteristics of the people who are most likely to say they have uninsured vehicles, that's really not too surprising, it's the younger folks, those with lower household incomes, lower educational attainment level, and those who have fewer assets to protect. We did also ask some opinions about the rights of uninsured motorists to compensation if they themselves were injured by an insured driver. We did find that two thirds agreed that the right to recover damages for pain and suffering should be

limited for uninsured drivers and more than half even agreed that we should be limiting compensation even for economic damages, not just the pain and suffering. Finally, some of our research has looked into the factors behind differences in the uninsured motorist rate, both over time and across states. One thing that comes to mind of course, is the cost of auto insurance and when we've compared the affordability of auto insurance with the UM rate we have found that yes the uninsured motorist rate is higher in states where insurance is less affordable. A little bit of a chicken and the egg in terms of are people uninsured because insurance is so unaffordable? Or is insurance unaffordable because the policyholders are paying for the uninsured motorists?

Several years ago we did publish a study that specifically looked at no pay no play laws. And the results of that study did find that the enactment of such laws could have the effect of lowering a UM rate, although the effects were fairly modest. We were able to provide estimates by state for the amount of compensation that would be saved by such laws. More recently, in 2019 we hired Milliman to conduct some statistical analyses looking at factors associated across states. They did some simple correlations and found, as I mentioned, that UM rates were correlated with education level and income. We found that states where they had higher penalties for driving without insurance tended to have lower UM rates. We found that tort liability systems a rating of how business friendly the tort environment in the state was seemed to have correlation in that UM rates were higher in states where the tort system was judged to be less business friendly. And finally again, with no pay no play laws, we found that states with a no pay no play law had smaller UM rates. Again, by a small amount. And then they put all of this together to see how these factors interacted and the basic summary of their report is that it really was the economic and employment numbers that had the largest explanatory value for the differences that we see in UM rates across states. Some of the policy levers that they also looked at did have an effect although they were significantly smaller.

So, in summary we may not have super easy answers or simple answers on how to solve this complex problem of uninsured motorists, an issue that continues to challenge the industry and you all as legislators. The IRC will continue to look at this issue. Some of the things that we haven't even looked at or talked about yet that further complicate the issue will be things such as the prevalence of undocumented drivers and how legislation to allow them to have a driver's license, what impact that will have on uninsured motorists. And then finally, what will be the impact of the pandemic as economic hardship, especially at the lower ends of the income scale, will interact with the dramatic changes in driving behavior. And as I said, we will continue to investigate this issue as we have for the past 40 years.

Alex Hageli, Director of Personal Auto, Electronic Issues, Specialty Lines & Counsel Policy, Research & International, at the American Property Casualty Insurance Association (APCIA), thanked the Committee for the opportunity to speak and stated I am also the Chair of the Insurance Industry Committee on Motor Vehicle Administration, an insurance trade association that focuses entirely on compulsory insurance law enforcement. I want to thank you for the opportunity to speak on this topic today. It is something that is very near and dear to my heart. A quick overview, my presentation builds on the information that Ms. Kilgore just reported on to all of you. Here is a quick overview in terms of the uninsured motorist situation. Currently, 48 states compel motorists to purchase auto insurance, the exceptions are New Hampshire which is the live free or die state and Virginia which allows motorists to pay a $500 a year uninsured

motorist vehicle fee. But generally speaking across the country you're required to buy auto insurance.

Despite those laws, as the IRC report mentions, approximately 12.6% of motorists nationwide do not comply with those laws and purchase auto insurance. So, what are the states doing to make sure that people buy auto insurance? There is a lot going on here, this is the obviously a map of the United States with IRC numbers for each individual state overlayed with the type of program that each state operates. Starting from the bottom, the white states up at the north don't have any kind of enforcement program. Just for an example, the state of Wisconsin just adopted, well not just, but they were the last state to adopt compulsory auto insurance laws about eight years ago now. So, they haven't really had time to adopt a program to enforce. The next type of program is a just a couple states have a random sampling program where they pull out a certain percentage of motorists and try to verify their coverage on an annual basis. Most of the states have a database program which is simply collecting business data from auto insurers in any given state and matching that up with the Department of Motor Vehicles (DMV's) registered motorists. Theoretically, at least if you do that process you match up who has insurance with who has a car, you will determine who does not have insurance and attempt to enforce or require them to buy insurance. But it's not so simple, and I'll talk more about that. And then finally, the dark shade is the latest iteration, what I believe to be the superior method of enforcing compulsory auto insurance. And again, I'll talk a little bit more about that in detail but web services for sure in terms of what states are doing to verify coverage, web services is certainly the wave of the future, at least I believe it is.

So, what are the results overall of that map basically? It's interesting to note based on the IRC numbers that three of the top five lowest UM states as well as four of the top five highest, they all have some type of programs. But I would note that perhaps the IRC numbers with respect to no fault states have a little bit of an issue accurately capturing the UM rate. I really have a hard time believing that New Jersey is under 5% uninsured motorist. It's got to be triple that. The top five with the highest rates, Michigan, Mississippi, New Mexico and Tennessee four of them they all have programs. Two of them have database programs, two of them have the web services program. Web services is alternatively referred to as online verification (OLV), but the bottom line is the majority of states with above average UM numbers have database programs.

What are the problems with the database programs that most states run? Well, it's the same problem any database has, which is the data that's in the database becomes dated the second it is uploaded to that database. So, that's an issue, number one. Number two is simply matching motor vehicle registration records with insurance coverage issues is a surprisingly complicated endeavor. It's not that easy. It sounds easy, and I can't tell you how many people outside of this arena will just say, well why don't you just have the insurance companies report data and match it up with the DMV registration and you'll know who's uninsured. It's not that simple at all. Other problems are that these database programs are relatively speaking in the IT arena, very old and a lot of them aren't even serviced anymore and the software's not being serviced anymore. So, they're kind of stuck in time. The bottom line with all the data is that there's just no proof that they actually reduce UM rates.

A subset of database programs are what are called transactional databases. And I'll kind of skim through this because this is just more detail. But, some of the iterations of a

database was well just tell us when there's a cancellation and a new business and through collecting that data and matching it up with registration records we'll figure out who doesn't have insurance. But my gosh, it creates so many problems. Typically, people will buy new coverage today to cover them starting at some point in the future, like a week or two weeks. So, the business will get reported immediately to the DMV but then the cancellation comes in two weeks later and that cancellation will actually cancel out that new business that hasn't even kicked in yet. So, basically the transactional database, there are a whole host of problems beyond even those that just your usual database have.

What are the alternatives to a database? So, of course you have increased enforcement efforts, and mandatory fees that cannot be reduced and increased law enforcement presence at courthouse. About 10 years ago, in my hometown of Chicago one of the two major city newspapers put a reporter out in the parking lot of a local courthouse, took pictures of people who were going to court, had their license suspended for not having insurance or what have you. There were pictures of them getting right back in their car and driving off to work. And they did a daily newspaper article every day with those pictures on them for like a week. Of course, the local law enforcement felt compelled to respond to that. So, then they increased the law enforcement presence. But everybody understands when the heat dies down those police officers will be moved elsewhere and it'll go right back to what it was before. An interesting project was started in Indiana – previously there in Indiana there was an uninsured registry where people who were identified as driving without insurance were placed on a registry basically and subject to random verification requests over a period of five years. But, the American Civil Liberties Union (ACLU) stepped in and interfered.

Another interesting program is the Oklahoma Temporary Motorist Liability Plan. If you were pulled over and you did not have insurance they would actually take your license plate off your vehicle, automatically enroll you in pool coverage and then when you went to go collect your license plate from the police station, they would hand you a bill for however long you didn't have coverage. I'm not actually sure if this program is still in place because Oklahoma has since moved to a web services program but it was certainly a unique take on things. Ms. Kilgore already talked a little bit about no pay no play laws which simply prohibits uninsured motorists from suing insured motorists to collect on economic damages, basically pain and suffering. The most recent state to adopt no pay no play was Indiana. We're at 11 states total. Ms. Kilgore also mentioned that they did do a study that no pay no play legislation results in a statistically significant drop in the UM rate. The great thing about no pay no play is there's no enforcement expense. It's self-executing. Regarding OLV and web services, this is the wave of the future for enforcing compulsory auto insurance laws in the country. So, as a result of those deficiencies with databases that I mentioned, the insurance industry got together to develop web services, OLV to remedy those deficiencies. Web services provides instantaneous verification of coverage at any particular time that you need it. Whether it's on a traffic stop at the side of the road, or with a DMV clerk that's attempting to register or renew a vehicle and it gives you an instantaneous answer as to whether or not that person has insurance.

You can also schedule it to do ongoing verification, you know every month, every six months because, everybody knows when you go in you register your vehicle, you buy the coverage the day before, or even on the way to the DMV. You get your card, you get your papers, you show the state in fact you do have insurance at that moment. So,

they go ahead and renew your registration. And then you call up the insurance company within the hour and get all your money back or most of your money back. This addresses that by a setting up periodic reviews to make sure that you're actually maintaining coverage. How does this system actually work? Four data elements are inputted into the system and sent directly to the insurance company. It basically uses the cloud to send a query directly to the insurer that you're attempting to verify coverage with and that information is provided to the insurer and then it's up to the insurer to say yes there is coverage on this vehicle or no there is not coverage.

In order to provide those four data elements it was hoped that insurers could get away from book of business reporting to the states but that's not realistic. So, insurance companies in web services states continue to report book of business to the state so that they are able to create what we call a pointer file, which basically tells the system which insurance company to ask to verify coverage against. Because a lot of times people don't want to input the data, type it in on the side of the road, which I understand. People don't have their insurance ID card with them, I understand that, so the book of business, the pointer file helps alleviate that gap. And then finally, there are variations of the program where you can broadcast to see if you don't know who the carrier of record is, you're able to send out certain data points to find coverage for that person. How much does it cost? So, it's an open-source model. It was created via the insurance industry and basically just turned over to the jurisdictions and said here this is the better way to go. So, there's no cost to using it. There is a setup cost and states can either build it in house with their own IT personnel or retain a vendor who will run a system for them and based on the numbers that I've heard from various DMVs, the program more than pays for itself. Who uses all OLV's? You saw the map earlier but here's the list of states. And again, the trend is to move off of a static database which is a dated system, to OLV which is much more dynamic. What conclusions can we draw from this data? The IRC numbers suggest traditional database programs have little effect on UM rate. Targeted enforcement is probably a better way to go, but if you're going to do a comprehensive system, OLV is certainly superior to database programs.

Andrew Kirkner, Regional Vice President, Ohio/Mid-Atlantic Region at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak on the important topic of uninsured motorists. During my comments, I want to address two things. I thought it might be helpful for the committee to understand a little bit about why insurance is expensive, specifically auto insurance. I think anyone that has taken a look at uninsured motorist rates would agree that cost and affordability is at least a part of the equation where we see higher uninsured rates. And I'm going to do that in the context of a white paper that NAMIC has coming out probably in the next two weeks which outlines some of those cost drivers. I know in your states when you have hearings on affordability or availability, cost drivers are something that comes up. So, hopefully the paper can serve as a resource to you. And then the second item I'd like to touch on very briefly is to return the committee back to the Fairness for Responsible Drivers Model Act (Model) that is currently pending before NCOIL. So, to dig into the forthcoming NAMIC auto insurance cost drivers paper, I have bad news. And the bad news is that insurance is expensive and the price of auto insurance is rising and there are a number of items that are causing that and I'm going to briefly touch on those, but the good news is hopefully we have some solutions to offer the committee as you do your work here and head back into your states.

So, why is auto insurance getting more expensive? The first thing is there are more drivers on the road so there are more opportunities for risk. The United States population has grown approximately 10% in the last decade. There are 230 million licensed drivers on the roads, which is a pretty wild statistic and before preparing for this testimony, I did not realize it was that high. The second item is that there's riskier driving and there are consequences that come with riskier driving. So, data has shown that despite overall miles driven decreasing over the last year and a half during the pandemic, fatalities have actually increased by about 7% which is a pretty harrowing statistic. I believe 2019 there were more than six million crashes and that's a number that has increased year over year in nine of the last ten years. That probably ties back into the fact that there are more drivers on the road but it certainly speaks to the safety in terms of how people are driving. There were 38,000 traffic deaths in 2020. That's the highest number since 2007. Again, a pretty sobering statistic to consider. Finally, distracted driving – there is more distracted driving with there being nearly one million distracted driving related incidents in 2019 alone. The next cost driver is what I've sort of described as shiny new objects. If you see a new car commercial, the majority of the commercials are spent on sort of the bells and whistles. Whether that is back up cameras in bumpers or flip down tailgates and that tailgate is exponentially more expensive than an F-150 tailgate from 25 years ago. It's got sensors in it and it's got various items that make it more expensive but that kind of cuts two separate ways. Not only does it have those items but manufacturers rightly or wrongly are becoming more proprietary in terms of replacement parts and what can go back into those vehicles.

And then you have labor. Gone are the days where you could take any car into your local garage and they can get it fixed for you and get it back out the door. It makes sense that the more specialized parts are the harder it is to source labor and so costs have increased there as well. We've also seen a significant uptick and in increased medical costs. From 2010 to 2017, medical care costs generally are up 30% and hospital care costs are up 45% - huge increases. And certainly, that impacts auto insurance carriers as they pay out claims related to medical costs. Finally, other cost drivers are weather and fraud. We've seen an uptick in catastrophe claims and weather related claims - a 4% uptick over the last decade, which may not seem like a huge number but when you combine that or compound that I should say with the other cost drivers it's certainly significant. And then auto theft is also a large cost driver. Statistics show a 9% increase in 2019 and I keep using 2019 because that's the last year of available data for some of these statistics.

So, that is why auto insurance is increasing, or appears to be increasing. Again, that's a national level overview and certainly state to state there are varying reasons but let's bring that back to uninsured motorist coverage. I was listening to the earlier panelist and Michigan was mentioned as one of the higher uninsured motorist rates in the country. And we have Sen. Lana Theis here who worked on a comprehensive auto insurance reform. I think reasonable minds on either side of the aisle on all ends of the spectrum can agree that cost is at least one source of uninsured motorist coverage. It's a dangerous game to try to project out but if you had to project what will happen to that uninsured motorist rate in Michigan, I think as insurance becomes more affordable you will see that number trend down somewhat. So, that's certainly the theory and it's being put to test in Michigan and hopefully it's the goal of NCOIL and certainly each member here to lower that uninsured motorist rate and I guess the accommodation would be to lower the cost of insurance.

So, how can we fix it - how can you go back to your states and help try to lower the cost? The first thing I would suggest is read the NAMIC paper and do everything it says. But short of that, we have some more targeted suggestions. The first one would be the instant verification or OLV verification, and education and enforcement are absolutely critical to lowering uninsured motorist rates. The second is continued tort reform efforts. Part of what we've seen in the increase in auto insurance candidly is a broader conversation around social inflation. I'll leave that there and I'm happy to answer any questions there. The third is right to repair laws - making sure that consumers have abilities to repair vehicles in a more cost effective sense and I should say, insurers and policyholders. And then finally, and I'll close with this, you've heard both of the earlier panelists mention in a different context the Model that is currently pending before NCOIL that would, in our view, help decrease the uninsured motorist population. In short, if you haven't heard of the Model before, it would prohibit illegally uninsured motorists from receiving non-economic damages. In other words, it would stop those drivers from receiving windfalls and getting the benefits of a system in which they do not participate. I think from a fairness standpoint, that makes a lot of sense but it's not lost on me that I'm in a room with folks who have to go back and continually get the mandate of the people through election. So, I was happy to hear from IRC earlier that it also polls well - I think two thirds was the figure that was cited of folks supporting similar efforts. I'll end there and I would reiterate NAMIC's support for the Model and certainly would request your support as well.

Sen. Paul Utke (MN) stated that as I'm listening to all this I'm just looking at the title of this section and it was you know efforts to lower the uninsured motorist population and I think we heard a lot about trying to collect the data and various things and I was hoping there was going to be more on how to actually reduce that number. There's been a couple things that are brought up and number one, how do you institute personal responsibility into the driver and the owner? Because we talk about the high cost of insurance but, if you're a responsible person and have a good insurance rate and everything like that, I mean I look at my insurance and I think it's pretty darn cheap for what I drive and what it costs. But you've got a lot of people on the other end, the ones that end up being the uninsured because they get themselves in trouble with their driving habits, or lose their driver's license and get caught without insurance, or without a license, then goes their insurance. So, it kind of goes full circle. How do we get to that personal responsibility? I think education and enforcement are going to help that. The no pay no play laws I think is a big deal but that's just one of the things. I think we all know what the problem is, but how do we get to the root of it and change people's habits?

Mr. Kirkner stated that in many ways we're fighting a losing battle with human nature in some context but I think more broadly speaking a healthy and competitive insurance market keeps rates as low as possible. Insurers are unique. We are asked to price a product before we know what it costs. And so, as part of that calculus we have to figure out what an individual's risk profile is before we sell them a product. So, I would say anything that you can do to allow insurers to price risk more accurately and then to go out in the marketplace and compete on price will help the consumers and drive rates lower.

Mr. Hageli stated that I think you do that by a sum of everything that the speakers have touched upon. I think enforcement does work. I think it's a cultural thing. My home state of Illinois did not have any type of program and everybody knew what was going

on. Everybody knew that you could buy coverage right then and there, get your car registered, then cancel it. Everybody knew that. But now Illinois has adopted an OLV system and it's going to take time to change that culture, that mentality of I got this smartphone that cost me $100, I got a car, I can afford it, I just don't want to pay for it. So, I think it's going to take time but I think it's doable.

Rep. Jonathan Carroll (IL) stated that I am glad to hear about my home state of Illinois because it seems like no one here is from Illinois. I have a question about the Model you were talking about which is very interesting about how uninsured motorists can't go after insured motorists. I'm going to guess that in the state like Illinois where the trial lawyers have a lot of power, that they're not going to love that. Is that sort of a fair perception of that? Mr. Hageli replied what do you think? Rep. Carroll stated that I think it's a great idea and I would be very curious to look at it in Illinois but I think the problem is, it's going to be fighting an uphill battle to begin with. Mr. Hageli replied yes, absolutely but we're ready to fight that battle. Rep. Carroll stated that I wish you luck and you should come and see me about it because I'd be interested to have more of a conversation but I know in a case like that it's going to be a real uphill battle but I like the premise of the idea.

Mr. Kirkner stated that I think the Model before NCOIL does thread the needle a little bit. So, what it would do is prohibit the collection of non-economic damages, that pain and suffering element. We have some trial lawyers amongst the membership here today and that issue is not going to I think neutralize trial lawyers and their opinion of the Model but I do think it's a good job by NCOIL to at least try to thread the needle a little bit to say you can still collect economic damages but if you're not participating in the insurance system which is against the law to do that in 48 states, then you should not have the benefits of a system that you are not paying into and so, I think it sends a clear message. I think education will be a key element. Letting folks know that, look if you're driving around without insurance, you're going to be in a tight spot when you get in an accident that's your fault. I think it sends a strong message and it would be important for NCOIL to do. Rep. Carroll stated that I fully agree with you, I'm just saying that I know what I know, and I know that as soon as you limit the ability to take something forward, it's going to create those challenges. So, if you guys have an idea of how to do that, I'm all ears.

Rep. Chad Mccoy (KY) stated that with regards to the Model you're talking about, you said when they're in a wreck where they're at fault, and if you could clarify that because I was hearing it to be if I'm not at fault but I'm also not insured, so I'm a poor person and I couldn't afford coverage I get hit through no fault of my own, that's when I'm limited is what I was understanding. So, if you could just clarify that I'd appreciate it. Mr. Hageli stated that I may want to return to the Model to give you an accurate answer but I believe that the Model would prohibit the collection of non-economic damages across the board. But it does have two exceptions including where a driver is injured through intentional conduct, through a DUI, and I believe there's some additional exceptions. So, it would be an across-the-board prohibition to your point but there are exceptions. Rep. McCoy stated but isn't insurance already excluded for those under the crime rule and intentional conduct? So, the insurance wouldn't apply regardless. Mr. Hageli replied I think there's some additional exceptions, but I'd have to get back to you on that.

SURFSIDE COLLAPSE: IMPLICATIONS FOR THE FUTURE RELATIONSHIP BETWEEN PROPERTY INSURANCE AND BUILDING STANDARDS

The Honorable Greg Serio, Partner & Managing Director at Park Strategies and former Superintendent of the New York Department of Financial Services, stated 40 years ago, about a month separated two of the three largest building disasters in the United States. They were different in their respective natures. One was a building collapse and the other was a failure of a skywalk inside a hotel but both events managed to have a very similar impact in terms of the lives lost or irreparably changed and in terms of their impacts upon the insurance market and the building construction community in both Kansas City and in Florida. And in fact, it's curious to - to note that with the Surfside Condominium collapse actually, there were fewer fatalities there than in the skywalk collapse in the Hyatt Regency in Kansas City. In that case, two skywalks on the second and fourth floors broke loose, pancaked on one another and then collapsed onto a dance taking place in the lobby of that hotel.

The reason I bring this up is that NCOIL held a series of hearings on the intersection of insurance and building codes to determine what if any action state insurance legislators should have taken, or take to essentially leverage insurance and public policy to compel needed changes in building codes and construction methods. This action by NCOIL in its early days back in 1981 helped to establish its interest and its role in a wide variety of issues beyond the traditional four corners of insurance legislation. Senator John Dunne from New York who was the Chairman of that task force at the time, he immediately came to my mind after hearing about the collapse of the Surfside Condominium. Once again, it was a calamitous engineering event with a devastating human and property cost. It created the nexus that brought NCOIL to the Hyatt Regency four decades ago. In the case of the condominium collapse, it's a question of the engineering oversight of an aging structure impacted by natural and manmade forces and clearly suffering from deferred maintenance issues. As for the Hyatt, it was a brand new structure that failed on its first big stress test, the cause of which was determined to be human error in the engineering. Irrespective of the new construction or the aging infrastructure the role of insurance and insurance legislators was clear - overseeing the covering of the country's construction activities and using their collective influence to understand why disasters of insured structures occur and what we need to do to limit their occurrence and/or their impact in the future. This committee understands that past and is to be commended for assembling our panel here today to see where we have come over the past 40 years and where we need to go from here.

We were also going to be joined by Dottie Mazzarella of the International Code Council (ICC), she's known to many of you here at NCOIL and she and I had worked together in insurance regulation back in the day. She unfortunately had a scheduling conflict and couldn't be here but she left behind a three page memo on what the ICC has found in the aftermath of the Florida disaster including and there's a number that is striking that more than 70 Florida communities have not adopted minimum building or property maintenance codes for existing structures. Not talking about new construction but talking about for existing structures. The issue of existing structures and the codes they operate under clearly provides an important interface for insurers, property owners and managers, and public officials and the ICC on her behalf looks forward to working with NCOIL on this issue as we go forward. So, now I'd like to turn it over to Daniel Dean, Risk Mitigation Officer at Bridgepoint Global Property Consultants, to talk about some of the risk mitigation issues that arose out of the Florida collapse.

Mr. Dean thanked the Committee for the opportunity to speak and stated that Bridgepoint specializes in bringing solutions to manage large catastrophic claims so we do a lot of hurricane work where we come in and do damage assessments and apply building science to understand the magnitude of damages. So, throughout my course of work, I work a lot with different engineers, different companies who are used to responding to disasters especially with a lot of hurricanes. We are based in Florida and it's one of our biggest issues and now here with Surfside it's raising even more concerns which is really rippling through the insurance community as well as the reinsurance markets and I think it's interesting to note that there have been some studies done that have really brought to light two different issues. So, on one side we have what are the implications of how the laws that govern how inspections are posted and also things with the bylaws with the condominium associations.

And then on the other hand it's looking more at the physical structure and how do we capture that information from an engineering standpoint. This is a very serious issue and we need to understand that there were a number of people who died in this incident, I believe 98 and the thing really to look at and to realize is that this is a situation that could have been avoided, and should have been avoided, and there was data and information that was presented to Board Members of this condominium association. Engineering reports were done and the engineering reports were complying with regulations that applied to Dade and Broward Counties. In those two counties, condominium associations of more than three stories are subject to doing a 40-year inspection and that 40 year inspection, the purpose obviously is life and safety preservation to make sure that the building is sound.

And unfortunately, we're dealing with a building that was 40 years old, which brings to light when should these inspections be carried out and we had a task force that came together with various engineers from Florida and there was another task force through the Florida Bar Association and looking at the situation, recommendations were given and one of the recommendations that came out was to establish statewide minimum structural inspections for all existing buildings over a certain size throughout Florida. I think that's fairly obvious but getting into the minutia of it you can see that there's specific requirements that need to be looked at. One of them is the forty-year inspection. The proposed recommendation was to move that to a thirty year and also using that thirty year to establish how often the reserve studies need to be done. Digging in further, in the case of Champlain Towers this is a building that's located directly on the beach and if you're not from Florida, what you maybe don't realize is that we're kind of in a sweatbox for most of the year. It's very humid and it's a hostile environment for buildings. It's a hostile environment for concrete and rebar and most of these buildings that are in South Beach, that are on our coast, are concrete buildings with either post tension or rebar construction.

And in looking at Champlain Towers what they have found is that this is a building that was compromised by those conditions. This is a building that needed to have more attention done which also brings up another issue that is key in this situation, which is bringing forth some way of legislating or some new laws that will bring to attention, how do we manage the maintenance? How is the maintenance reported out to the members of the condominium association? So, it really is bringing forth a lot of important items that get to be looked at right now in terms of on a local level and on a statewide level. I can tell you there are not enough engineers in Florida to do all of these inspections and what needs to be looked at is a hybrid model of capturing the data and then having

engineers sign off on that data. I get to do a lot of cool things with my job. We go out and we respond to disasters, and one of the overwhelming messages that I've heard here in this panel and this conference has been that we need to make insurance more affordable and there's a lot of tools there such as artificial intelligence and light detection and ranging such and creating three-dimensional models of these buildings.

So, with the technology that we have now, we can apply that technology to a more substantial underwriting pool and underwriting process and supply these insurance companies and the reinsurers with detailed 3D models of these buildings so that we can properly identify the exposure for the insurance market. In the current system now, it relies on information from the Boards, it relies on the broker going out and quickly putting together whatever's required from the different carriers for underwriting and the information is often not very comprehensive and it allows for the condominium associations to go out and obtain insurance. It often does not. In Florida, we really are in a situation where we're in crisis. We have over 100,000 claims in litigation in the state of Florida and we have a system that is begging for change and there are solutions out there that can be applied right now and it really comes down to disaster planning. There needs to be a comprehensive way of looking at buildings whether they are on the coast or in the interior of Florida and as you know, as we progress over the years, we've seen more and more events.

There was the freeze in Texas this past year. It was estimated that those damages were at $55 billion and as I travel through and work on these large catastrophic losses I can't help but see an opportunity to start working now more with engineers and architects to build buildings and to influence code enforcement and new coding laws so that we are creating a more disaster resilient community which in turn is going to allow for insurance companies to understand their exposure and at the same time, protect people against having to be relocated due to disasters and it's a very interesting issue that I'm passionate about and I'm just looking forward to seeing what will come out of legislation in Florida mid-2022. With that I'm going to hand it over to Dennis Burke, Vice President of State Relations at the Reinsurance Association of America (RAA).

Mr. Burke thanked the Committee for the opportunity to speak and stated that since not all of you are veterans of NCOIL, reinsurance is simply insurance for insurance companies. It is a risk management tool that insurers use to address a variety of capital needs that are based upon the exposure they may have to a windstorm, earthquake or even liability issues. So, it is tailor made for the insurance company based upon its needs. With regard to SurfSide, I'll openly start by saying that this is not really an insurance issue. If you're looking for my conclusion, what is the insurance legislation we should pass in response to SurfSide? The conclusion is don't do anything. Do not pass insurance legislation because it's not necessary. These are structural and maintenance issues. That's not an insurance issue. It affects insurance, it will affect how insurers look at a building, and it also affects whether or not the building stands.

Going forward, stated simplistically, insurers like insuring buildings that stand on their own. Is the market going to change? Less than two hours ago there was a national underwriter article that came across in my email and that article said, who knows? They basically said, this is the type of information that insurers should be interested in but it's a great opportunity for another broker to come in, swoop through and get the account and go to a different insurer who won't require as much data. So, the jury is out like I said, do something different. The issue in Florida with SurfSide in addition to the

absolute lack of maintenance was a failure of Florida's condo laws and rules which do not require them to have adequate reserves for their capital needs and it's a problem with their inspection laws. There is not an insurance legislation response, but there are issues with, if you run into a similar situation, how do you take a $15 million assessment and get that paid? You need money up front and the condo's need to be able to borrow money and spread it over time and then in the SurfSide situation, the condo owners refused to acknowledge that they had a problem. They wanted to put their heads in the sand and ignore it. They need to have some way to address these issues, whether it's judicial or otherwise to force an appropriate life safety response.

Lisa Miller, CEO and Owner of Lisa Miller Consultants and former Florida Deputy Insurance Commissioner, thanked the Committee for the opportunity to speak and stated that I live in Tallahassee, Florida and I am watching what's coming out of our legislature in terms of the response to SurfSide. As Mr. Burke rightfully said, there are not insurance bills that are coming out. There are bills that are coming out to hold board members accountable. For those of you that live in a condo association, I dare say that many of you probably won't volunteer to be on boards anymore because you can imagine the SurfSide board members, their lives have been ruined. I can't even imagine how they spend their days. There's proposed legislation that would make it a felony if a board member takes a kickback from a vendor. I'm sure you've heard in your respective states that board members do business with vendors that will kickback some of their fees.

There is legislation to take all of our data and put it in one place. Kevin Guthrie, our state emergency manager, he is an amazing American. He is Florida's emergency manager and spent 47 days in SurfSide, every single day with the Mayor and his biggest frustration is there's no centralized database of our condominium association buildings in Florida. Every condominium association that has what's called a declaration of condo, which is not to be confused with the declarations page of an insurance policy, those are filed in the individual clerks of court in every county. We have 67 counties. So, there was no way possible for us to even find out how many buildings are in the same shape as SurfSide. To say that our condo market has been ruined by this is an understatement. We have about seven carriers in our state that write 90% of this business and for the sake of perspective, the Florida realtors estimate there are 900,000 condo buildings that are over 30 years old.

So, when Mr. Dean says there's not enough engineers to go look at them, he's absolutely right. His artificial intelligence and the platform that he and his team put together is kind of a hybrid between what a building inspector does and what an engineer does. He works with engineers. I'm sixty-one years old, this kind of technology is fascinating if I may say so and it is helping so much for the condo associations that have reached out to him and others to say, "we want to know what's in our structures." And there are two types of Boards. There are Boards who don't want to know. They just don't want to know what's going on with their buildings and then there are those that do and are leaning in. What's driving those that are leaning in are the insurance companies who are saying, "I want to see all your maintenance records. I want to see your board meeting minutes to see if there were discussions of deferred maintenance. We want to see if there are any reports of engineers you've had in the past few years." The insurance companies, the seven or eight of them that are writing 90% of this business have gotten very, very smart after this. So much so that one of the companies that writes about 2,500 of these policies, and that might not sound a lot, but

2,500 condo associations is millions of residents in those condos. And they sent letters to about 500 of them and those letters said something like this, “We appreciate your business but if you want to find insurance somewhere else, we wish you well.”

So, there’s not a lot of appetite right now as you can imagine. There’s a little bit of skepticism about this market. We have a lot of challenges in Florida but I think that if the legislature does a few things to strengthen what happens with Board members that would help. Should there be any volunteers that want to volunteer for boards? Strengthening databases and ways to track the data of these condominium associations would be helpful and educating those that live in these condo associations that sticking your head in the sand and trying to avoid an assessment for structural reinforcements is a ruse, it’s just not the way to go. The Building Officials Association of Florida, a great group, participated with several of these task forces that have come out. They work closely with the ICC. To say that this is probably going to suck all the oxygen out of the room in our legislature is an understatement. Between redistricting and this issue, we will be very busy. And the Senator who’s district this was in, Senator Jason Pizzo, the videos that he posted are fascinating and we watch them daily and he was there every single day during that tragedy.

So, for those of you from the other states that have condos, we’re all happy to work with you. I can keep you posted on what’s going on in Florida and can connect you to those that are involved in this from a stakeholder standpoint because you don’t want this happening in your state. And for those that say this is just a onetime thing, I know how old these buildings are in Miami. If you’ve not been to Miami and driven along the beach, you’ll see these old buildings. They're fascinating and they look vintage, but they’re dangerous. So, I’m happy to work with all of you and appreciate you taking the time to listen to what we’re saying. We need to know what’s going on with these buildings. We need to take a proactive approach to make sure they stand up, so that folks like Mr. Burke and his members will continue to reinsure them.

Rep. Derek Lewis (KY) asked how often are these buildings being inspected? Ms. Miller stated that Miami and Broward County have a provision that 40 years and older have inspections. There are recommendations in these reports that have come out that say any building that’s over 30 years old will have an inspection that can be statewide. Some counties are being proactive and doing things individually. After 20 years they’ll have an inspection but I see the look on your face. You’re sitting there thinking, you know we have people come into our homes what every three or four years and check our water and heater or whatever. It’s just amazing to me that some folks think that inspecting a building every 20 years is acceptable but I’m not sitting as an elected official. Rep. Lewis stated you talked a lot about taking a proactive approach and I think it starts off with the inspections and I appreciate your insight. Mr. Dean stated that the ICC also is looking for uniformity of it. So, it’s not only a question of whether they inspect, and when, but the fact there’s no set schedule for anybody so in the same state you’ll have a variety of dates, if they do it at all. And of course, without uniformity they may or may not be happening and you have no idea what the standard might be from one community to the next.

Mr. Burke stated that it goes to the vintage of the building and the structure particularly buildings that may have been repurposed from a commercial structure to a residential structure. That’s the other thing, that it wasn’t originally built to be a residential structure. So, it goes to the vintage and the nature of the construction and where they’re

located. If you go from Florida to Long Island in New York, you'll get the same exposure – a lot of wind, a lot of water, a lot of sand and concrete buildings right on the water. They may not be condos but they're rental apartments, they are converted commercial structures and things like that. You really have to look at the nature of the exposure regardless of what title might be on it.

DISCUSSION ON SAFETY AND INSURANCE REQUIREMENTS FOR ALL TERRAIN VEHICLES (ATVs)

Jon Schnautz, Regional Vice President at NAMIC, thanked the Committee for the opportunity to speak and stated that he is happy to be attending my first NCOIL meeting. This is very much in the category of an emerging issues kind of discussion. What I'm going to talk about very briefly today are off highway vehicles and some of the issues that can happen at the intersection of those and insurance. What are we talking about with off highway vehicles? Well, broadly these are as the name implies vehicles that are not intended to be used on public highways, they have an engine and then within that broad description three different categories.

All-terrain vehicles or ATV's it's things that you basically straddle and have handlebars. I think everybody's kind of visually familiar with those. What are called recreational off highway vehicles, these have bench or bucket seats, more auto type controls, go up to about 30 mph. And then the third category are what are known as utility terrain vehicles, UTV's. These are, if you know what a mule is, kind of similar to that. It has a seat, it's mostly for cargo. That's kind of the big picture of the category of things we're talking about and just in the interest of describing the complexity of something that sounds very simple, there are a couple of national trade associations for these OHV's. One of their websites has a fifty-state comparison of laws and it's got 14 different categories of separate things that states regulate all the way from whether they have to be registered, and whether there's an age limit. The tiny sliver of that that I want to talk about today, is just around insurance and public road use of these.

Why talk about this today? Well, this is a growing market. Why is that? I don't know exactly but I think part of it could be, kind of the growing interest that may or may not be sustained in outdoor recreation that is kind of happening everywhere, partially driven by COVID. Just to kind of go into some of the numbers. I need to correct something a little bit on that statistics as you see a market value of $20 billion, that was actually a 2018 number, but if you just do the math on that, basically the projection is that in about six years this market is going to increase by about 40%. So, that's a pretty big growth spurt and it's all fun and games until someone needs coverage. With all good fun comes risk. There are some federal statistics from the consumer product safety commission on injuries and deaths from these. There are about 85,000 injuries in a year and roughly 900 fatalities related to OHVs. The interesting thing about the fatalities statistic is that these are not intended for highway use, and the manufacturers are very explicit about that more than half the fatalities occur on public roads. So, there is clearly some public road use of these going on. Move forward with some good news on this, there is a market response going on in the P&C market. There are insurers that offer coverage for these, either as a rider to homeowners or farm and ranch policy, or standalone.

So, the development of an insurance market around these would come with all the usual questions. Should coverage ever be mandated? If it is mandated, under what circumstances? What limits? What other ancillary coverages might be included in that?

I think going forward an issue is that there is going to be a lot of definitional things that will have to be worked there that would go to the specifics of when coverage would be required, if ever. Some examples include for those of you who aren't familiar with kind of the emerging places where this might be an issue, West Virginia and Kentucky both have these extensive trail systems that are very popular and they sort of rely on limited use of public roads or crossing public roads to work, because they're very extensive. Something interesting I found out from one of my states, New Mexico, is that a question came up with their department of insurance about a month ago, just out of the blue, and had nothing to do with preparing for this presentation. New Mexico is one of many states that generally prohibits these on public roads but allows for local options otherwise.

So, a locality can say, "yes, you can use them here." Well, apparently New Mexico already has a requirement that if they are used on public roads, they are subject to state minimum liability for auto at exactly the same limits. Frankly, I'm not sure that anyone knew that because when we had the conversation with the department it was kind of an ah ha moment. So, there's probably kind of a public education role here too going forward in terms of where all this might be headed from NAMIC's perspective. This is something where we are still in the stages of kind of evaluating and looking at what a proper policy might be here that would help inform your discussions if you want to look at this issue further. Probably, the best place to start is whether it's appropriate in situations where these are being used on public roads to subject them to some kind of minimum liability requirement when they start to cross over into things that look like more what cars do and start interacting with other traffic. The only other thing that we would say on top of that is, whatever you all might decide to do here in terms of future discussions, it's important to provide as much flexibility for the market to meet this need across the country in different ways.

ANY OTHER BUSINESS

Rep. Rowland stated that one topic that's been brought up to my attention is that NCOIL a few years ago passed model legislation around transportation network companies (TNCs) and how we regulate them and what insurance coverages are for them. But since that time, services like DoorDash, Grubhub, Uber Eats and have popped up. So, I would like the Committee and those present here today to think about whether this is an issue that you think we need to address. Please send any thoughts to me or NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Utke and seconded by Sen. Bob Hackett (OH), the Committee adjourned at 4:15 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING
FEBRUARY 11, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, February 11, 2022 at 12:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Peggy Mayfield (IN)
Sen. Robert Mills (LA)
Del. Courtney Watson (MD)
Rep. Brenda Carter (MI)
Sen. Vickie Sawyer (NC)
Sen. Shawn Vedaa (ND)
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 Asm. Ken Cooley (CA), NCOIL President, and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement

INTRODUCTORY REMARKS

Rep. Rowland thanked everyone for joining the meeting. Before we go any further, I would like to note that I'm delighted to serve as Chair of this Committee for another year. I've really enjoyed Chairing this Committee and working with everyone on important issues. I'm looking forward to another successful year. Regarding today's meeting, the purpose is for the Committee to conduct some business in advance of its meeting next month in Las Vegas so that the Committee is able to handle all of the issues on its Las Vegas agenda in a timely manner. The Committee also need to determine how to move forward with some issues so that, as we begin 2022, our agenda is as clear and organized as possible. As you can see from today's agenda, the Committee is very busy so it's important that we give each topic the time and attention it deserves while still ensuring that every topic is afforded its proper time. So, I know everyone will understand that I'll need to manage the discussion closely.

DISCUSSION ON DEVELOPMENT OF DELIVERY NETWORK COMPANY (DNC) MODEL ACT

The first topic on the agenda is a discussion on the development of an NCOIL Delivery Network Company Model (DNC) Act. As you may know, in 2015 NCOIL adopted a Model Act to Regulate Insurance Requirements for Transportation Network Companies and Transportation Network Drivers – commonly referred to as the TNC Model. The Model has been one of NCOIL's most successful with it serving as the basis for almost every state's TNC law. During the last couple of years, delivery network companies, commonly referred to as DNC's, have grown in popularity. When I use the term DNC, I'm referring to companies that allow people to use their personal vehicles to deliver food or beverages to your home – companies such as Grubhub or Drizly.

Recently, there have been conversations started, and in some instances, bills introduced, focusing on the need to develop a framework setting forth insurance requirements for DNC's – much like NCOIL did with the TNC model. This is because the TNC model and the state laws based on the model only address transportation of people for hire, not delivery of goods. You may recall that I briefly mentioned this issue at the end of the Committee's meeting in Scottsdale, and I'd like to use today's meeting as a starting point for the Committee to discuss the issue along with interested persons. I think everyone would agree that insurance protection is essential, but the same level of coverage is not required for a sandwich as there is for a family. Before we open this up for discussion among Committee members and other legislators, I'll first ask if there are any interested persons who would like to comment. If so, please announce yourself and state who you are representing.

Joe Messina, Legal Director, Insurance Law & Legislation at Uber thanked the Committee for the opportunity to speak and stated that Uber appreciates the Committee's consideration of these issues and the opportunity to provide comments. Uber is supportive of a model DNC bill and recognizes the unique risks that are posed by delivery activity especially as compared to TNC's. I think some of those risks are obvious to the committee, perhaps some less so. Of course, in the DNC context there is obviously no passenger and much less risk associated with carrying a salad than an individual. But perhaps less obvious is the period one risk in particular which is the time while a diver is awaiting to receive a request but is online on the app and its much different for DNCs than TNCs. In the delivery context what we see at Uber is the drivers don't simply drive around circling blocks on the app awaiting a delivery request as they might in the TNC context. The business models of DNCs are also importantly different as you're starting to consider a model bill like this. For example, if you look at Target or Amazon Flex, those folks actually permit drivers to prebook time slots so that again means drivers aren't trolling the streets looking for requests they are just always in a state where they are fulfilling a request. Uber is certainly supportive of a model bill we just don't think the standard TNC insurance model requirements should necessarily apply in the DNC context.

Andrew Kirkner, Associate VP – State Affairs at the National Association of Mutual Insurance Companies (NAMIC), stated that NAMIC and its members are interested in a model bill as it makes sense for standardization to occur in this space. The good news is that I think the TNC framework makes sense for a place to start and there may be some discussions on what levels of coverage are appropriate inside that framework. The one thing I would point out and ask NCOIL to keep in mind as it considers this is at the end of the day whether its driving individuals around or delivering food, there is a change in risk from general driving behavior under a normal auto policy so if we take the phase one period Mr. Messina referred to perhaps an individual is parked in a different

neighborhood than they normally would be. That doesn't necessarily mean the commercial limits need to be higher or that the same standards in the TNC model need to apply but there is a change in risk and so as we go through this process we'd certainly be looking to work with Rep. Rowland and Uber and other companies that are in this space on the production of a model bill.

Marty Young, Co-founder & CEO of Buckle stated that we provide insurance and credit to gig workers in partnership with a number of the TNC's and DNC's and we have a very unique model where we are able to adjust the indemnity based upon what the driver is doing. To echo some of the comments made by Uber and others, one of the things we'd ask you to consider and we'd certainly be happy to provide you the data is that not all deliveries are the same. We agree that ride share risk is very different than delivery risk. The delivery for a restaurant is very different risk than delivering for a grocery store which is very different than delivering for a convenient store and very different than Amazon delivery risk. We support and insure all these different flavors of delivery risk and we would simply suggest as you consider a DNC model that it may not be a one size fits all but may need to be contextualized depending upon the risk of the driver, the recipient of the goods and the general public.

Frank O'Brien, VP – State Gov't Relations at the American Property Casualty Insurance Association (APCIA) stated that it bears mention that the fact that we're even having the start of this discussion is reflective of the benefit that NCOIL has brought to this particular space. Many of us recall the battles that took place when the TNC law was being developed and we welcome the opportunity for NCOIL to serve as a space where all aspects of this particular issue are heard whether it be by the traditional insurance market, the trades, Buckle, or Uber. NCOIL has become a leader in the shared economy space, and we look forward to having this discussion with NCOIL and we're optimistic that an appropriate model will be able to be developed with the assistance of this committee. We look forward to that discussion commencing in Las Vegas.

Hearing no further comments or questions form interested persons or legislators, Rep. Rowland thanked everyone for the discussion and stated that by the time of the Las Vegas meeting we could have a rough draft where we can at least start a discussion. It's a very important issue and one in which I am interested in perhaps sponsoring and I look forward to working with everyone.

CONTINUED DISCUSSION ON STATE EFFORTS TO LOWER THE UNINSURED MOTORIST POPULATION AND NCOIL FAIRNESS FOR RESPONSIBLE DRIVERS MODEL ACT

Sen. Shawn Vedaa (ND), sponsor of the NCOIL Fairness for Responsible Drivers Model Act (Model), stated that many of us as legislators have dealt with the issue of trying to lower our respective state's uninsured motorist population, and different states have utilized different methods to do so. In 2014, NCOIL adopted a Resolution in support of "No Pay, No Play" laws – the draft Model that you see before you which I am sponsoring is intended to be viewed as the next step in support of those laws in the form of a Model law. The Model, and the laws in the approximately 10 states that have similar laws, including my home state of North Dakota, prohibits uninsured drivers, or personal representative of said drivers, who sustained bodily injury or property damage as the result of a motor vehicle accident from recovering non-economic damages for the person's bodily injury or property damage or death. It's important to note that such

prohibition does not apply to economic damages, and there are several what I think are appropriate exceptions set forth in the Model.

The discussion of the Model when first introduced in Charleston last April generated an important dialogue and serious concerns regarding possible unintended consequences of the Model were raised which made clear that the Model was not ready to proceed. Since that time, the Committee has been presented with other methods states have utilized to lower the uninsured motorist population such as: simply increasing the penalties for driving uninsured as it's likely that it is less expensive to risk a penalty than to pay the auto insurance premium; Increased education efforts about the auto insurance system in general and the benefits of coverage and how those with higher premiums can lower them; tort reform efforts; developing an Online Insurance Verification (OLV) web-based system – this system provides instantaneous verification of coverage at any time. Approximately 15 states have implemented this type of system, with Illinois being the latest to do so.

Regarding how it works in Illinois, it's my understanding that twice per year motorists are subject to random checks for insurance coverage. A written request will be sent to the vehicle owner if electronic verifications are unsuccessful, and the Secretary of State will suspend the registration of the vehicle if the owner does not show proof of insurance. Vehicle owners must contact their insurance company or notify their insurance agent that they received the Secretary of State's letter and the specific reference number on it. Vehicle owners who receive the letter are urged not to visit driver services, but to contact their insurance company or agent, who can provide them with the necessary electronic proof of insurance. License plates of vehicles without automobile insurance will be suspended unless they obtain insurance, and they will be charged a $100 fee to have their plates reinstated. Also, another method some states have utilized, is permitting all residents of a state, regardless of their immigration status or citizenship, to obtain driver's licenses thereby permitting them to obtain auto-insurance. These laws are commonly referred to as "Green Light" laws. I understand laws like this would not pass in many states, but following New York's passage of such a law, New York's uninsured population declined.

In consultation with Chair Rowland, we agreed that we'd like to hear feedback from legislators and interested persons as to what direction the Committee should take with respect to this issue - should we: proceed with further development of my Model; proceed with developing a different Model such as one setting forth the legislative framework for an online insurance verification system; endorse another method via a Resolution; or put a pause on discussing the overall issue?

Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, stated that she is a big believer in data and asked if there is any data as to who the uninsured are – are they primarily illegal immigrants or younger people? Are there groups who can provide that data to us? Sen. Vedaa stated that he has heard similar data before in committee meetings in his home state and is not sure if NCOIL has that data or if there is anybody on Zoom that would be able to speak up on that.

Asm. Cooley stated that I do think very often individual state insurance departments may have a summary every few years and can offer an estimate. The Insurance Research Council (IRC) or similar organizations will often have marketplace estimates so that's a good online source to look for but it's kind of a moving target. Another way to look at it is

what has been happening to the cost of auto insurance in a given state. The backstory to “no pay no play” in CA is that it was adopted by the voters of CA as a ballot proposition in 1996 and 1996 followed a period of time when for a lot of reasons and of which litigation was a key factor, auto insurance rates had increased in CA by 150% during the 1980s. So, when auto insurance was soaring so rapidly more than double we did see a jump in uninsured motorists and at that point it was passed by the voters and if you were look at that it was proposition 213 in 1996 in CA and I imagine there is quite a bit of commentary online about the proposition and by this time even its effect and how people analyzed what it did. Those are just some thoughts on the general data, but I do think checking in with your insurance department is prudent as they will have data wizards and other sources relative to your state.

Sen. Vedaa stated that he just looked back at some of his notes and in ND the state insurance dep’t has estimated it as high as 19% of the drivers in certain demographics in the state failed to keep the liability portion of their insurance for an extended period of time. There are people that hop in and hop out as they are able to pay but that was one of the estimates that they had at the time. Cmsr. Tom Considine, NCOIL CEO, stated that staff could likely nail this data down by March.

Mr. Kirkner stated that I’ll be brief, and I would like to briefly re-emphasize the impetus behind what’s been dubbed as the Fairness for Responsible Drivers Model and what is also known as “no pay no play” in some states. I had the opportunity to present to NCOIL on this topic and as I believe Sen. Vedaa said there are about 10 states that have adopted something similar. It’s important to note that the results have been mixed in terms of lowering the uninsured motorist population so there is not in our view a strong correlation between those two things although there could be I want to be clear on that but the purpose behind the model is embedded in the name – to make sure the insurance system is fair. If folks are illegally uninsured, they should not be collecting non-economic damages as a result of their failure to participate in the insurance pool. This is a problem that drives the cost of insurance up for those that do choose to participate in the insurance pool and it’s our belief that its absolutely appropriate for NCOIL to act on a freestanding Fairness for Responsible Drivers Model Act. We are certainly supportive of other efforts to lower the uninsured motorist population and we would certainly be happy to participate in conversations outside of the model as well but we very much support development of the no pay no play model.

Cmsr. Considine stated that if there are no other comments we don’t want to go back to the old NCOIL where something stays on the agenda for years so Sen. Vedaa did list a number of different options and a desire for committee members to think about this between now and March with the thought of coming to Las Vegas and deciding on the best path to go whether that’s the model or another model that incorporates the Illinois approach or any of the other approaches but rather than just having a continued dialogue it would be wonderful if the committee could move toward consensus in March and wrap up some approach so it doesn’t go beyond this year. Rep. Rowland agreed.

UPDATE ON STATE LAWS REGARDING DOG BREED INFORMATION IN INSURANCE UNDERWRITING

Will Melofchik, NCOIL General Counsel, stated that this topic was the focus of a general session at the last NCOIL conference in Scottsdale and it sparked a lively discussion. Laws have been enacted in several states, and bills have recently been introduced in

other states, that, generally speaking, focus on how insurers can utilize the breed of a dog in underwriting. Some laws and bills prohibit certain insurers from refusing to issue, cancel, renew, or increase a premium or rate for a policy of insurance based solely on the specific breed or mixture of breeds of a dog that is harbored or owned on an applicable property. There are other approaches focused more on information gathering. For example, Illinois law requires certain insurers to collect certain information relating to claims involving a dog-related incident and annually report that information to the Department of Insurance. I'm happy to provide the information that is required to be reported but I won't read it all now in the interest of time. A copy of the law is also on the NCOIL website. New York and Nevada have recently enacted laws codifying the first approach I mentioned, and Minnesota has recently introduced a similar bill that will be the subject of hearing later this month.

Also, a bill has been introduced in Arizona that prohibits the breed of a dog from being considered or used in several situations such as: underwriting or actuarial purposes; information gathering regarding ownership or presence of a dog on premises insured or to be insured; or findings of fact or conclusions of law regarding whether a dog is aggressive or vicious or has caused liability to occur in coverage determinations. I note that this is not meant to be a complete, exhaustive legislative analysis of each state's action or inaction on this issue but rather an update on the most recent state actions. We invite this to be supplemented of course when this opens up for discussion.

Rep. Rowland stated that before opening it up for comments, he would like to note that this issue will not be on the Committee's agenda in Las Vegas. Neither he nor staff have heard from any legislator yet looking to a sponsor a Model. Rep. Rowland stated that he would like to have a discussion today to hear thoughts on the issue and how NCOIL should be engaged.

Asm. Kevin Cahill (NY), NCOIL Vice President, stated that the bill that was passed in NY fits the first category of laws that Mr. Melofchik mentioned. It doesn't include a study, but I'd like to discuss very briefly the impact of the bill that was signed into law in December. The impact of the law has been that largely across the board that insurers have honored and complied with the spirit and letter of the law but there was one company that decided that the law didn't say that they couldn't exclude the coverage even though we made all those motions to make sure that was clearly the intent they said if we exclude the coverage altogether that is allowable. The other circumstance that we encountered is that some insurance companies have lowered umbrella policies from the desired level to a significantly lower level because the dog exclusion is no longer allowed. We are amending the law in NY at the present time and are amending it to add the words "or exclude coverage under the policy or contact." We believe that will empower the NY Department of Financial Services (DFS), our insurance regulatory arm, to prohibit insurance companies from discriminating against their policyholders based upon the breed of dog. I didn't want to provide this update without saying that there is this interpretation of the law, which by the way our DFS does not necessarily disagree with, that the law as written is not broad enough to have the impact it was desired to.

That being said I will take you up on your offer to introduce a model act, but my model would include both components of what was mentioned. I think it's important to recognize that current science tells us that the breed of dog does not determine the dangerousness of the dog but there are many other factors that do. That doesn't mean that its definitive or final and we should require our departments of insurance to go back

and give us that additional information so I will between now and Las Vegas come up with a generic proposal and ask that you consider taking it up in due course in accordance with the rules of NCOIL with the introduction of a model.

Rep. Tammy Nuccio (CT) stated that I'm not going to be able to attend the Las Vegas meeting, but I'm definitely interested in helping with any model legislation on this. It's something that I've helped start conversations on in CT and I have seen some of the other state laws so if there is anything I can do to help please let me know who I should talk to or how I should go about doing that. This is my first interim NCOIL Zoom meeting separate from the NCOIL national conferences. Rep. Rowland stated that Mr. Melofchik will reach out to Rep. Nuccio to provide direction.

Mr. O'Brien stated that to my good friend from NY, Asm. Cahill, we look forward to seeing your proposal and working with you on it. We may have a different point of view but that is what the NCOIL process should be. I do ask just as a point of calcification – Asm. Cahill mentioned that the model would be put in and taken up in due course with the rules of NCOIL. I would assume that in order for it to be introduced in Las Vegas the 30-day rule would need to be waived but it sounds like the sponsor is intending for this to be taken up in due course which would be an intro in Las Vegas and then initial consideration at the summer meeting. Asm. Cahill stated that his perspective is to be as cooperative and deliberative as possible, so we won't be asking to waive the 30-day rule. Cmsr. Considine stated that as a point of clarification, the 30-day rule impacts items on which a vote is scheduled so there is no 30-day rule for simply the introduction of a model. Rep. Rowland thanked Cmsr. Considine and stated that he will defer to Cmsr. Considine and Mr. Melofchik in terms of how to go about the timing of introduction and discussion. I know we have a full agenda in Las Vegas so if this needs to be introduced during an interim call or at the summer meeting maybe that would be better but I'll defer to staff as to how to handle that.

Stacey Coleman, Executive Director of the National Canine Research Council (NCRC) and the Animal Farm Foundation (AFF), stated that NCRC focuses on reliable and methodologically sound dog bite data and AFF is an advocacy group for people who have dogs in their families. I just wanted to speak up and say I am so glad that you all are here today having this conversation, but I also wanted to emphasize that I don't know that any of us who are working on this issue want to follow up with legislation on a state by state manner because that takes forever but we have been left with no other options because working directly with the insurance companies has left us nowhere. The insurance companies do not have the data to justify excluding dogs based on a breed label. They don't have the data to justify excluding dog owners based on their zip code or their race or what is presumed about them because they own a dog of a particular label. What needs to happen and what will make this process so much easier is that if insurance is honest about where it's getting its information and is truthful about the data that they have. I know that in the times we have encountered public conversations with insurance representatives they have cited unreliable and debunked science and if we can just resolve that issue and if an insurer wants to exclude particular dog owners, they can it's their choice but they need to be honest about why and stop putting the blame on what the dog looks like.

Mr. Kirkner stated that there are two things that should not go unanswered in the comments that were just made. Number one, if the NCRC is supposed to be a repository of data, I would very much appreciate them not making comments about

insurers excluding on the basis of race or being dishonest about the information they are providing without bringing data to the table. I think that's inappropriate for the discourse at NCOIL. That's a threshold matter. As for the bill, we understand that there are some states considering legislation about what breed information insurers can or cannot use. I want to be clear with the group here, there is not some massive groundswell on the ground. I believe there are six states although I'm certainly open to anything that happened today in terms of states that have adopted legislation. There are others that are considering it but to the extent that there is an inference that there is a groundswell and others are considering this, I would rebut that. I would also note that there has been no evidence presented to NCOIL or in the state discussions that I'm aware of that would indicate an availability problem.

The nation's largest homeowners and renter's insurer in the country does not ask you about dog breed instead they ask about the history of the dog. Now that is their prerogative, and they should be allowed to do that. Other companies, if their claims data and external studies and actuarial science tells them that certain dog breeds are in fact dangerous then they should be able to use that information to make underwriting and rating decisions. With complete respect to Asm. Cahill, we have a fundamental disagreement about what the role of legislators should be in a competitive insurance marketplace. It's our view that in a competitive insurance marketplace when the nation's largest homeowners and renters' carriers and two of the top 10 largest carriers in the country do not factor this in then availability is not a problem for consumers so we don't believe the time is right for NCOIL to act here. We'll certainly participate in the process and hopefully provide a counterbalance to some of the information that's been provided here today and in the future.

Susan Riggs, Senior Director of State Legislation at the American Society for the Prevention of Cruelty to Animals (ASPCA) stated that I'd like to start by thanking Asm. Cahill for his willingness to take this up as a model for a future NCOIL meeting. I just wanted to respond quickly to Mr. Kirkner as I think the issue is not the availability of insurance but it's the transparency and accuracy of the underwriting standards and I think as many of you probably have seen the data that was produced out of Massachusetts from property insurers and clearly there is a dearth of rationale for the underwriting standards that are utilizing breed at this point. I would encourage everyone to go back and look at that data and I'm happy to provide it if you would like as its public data provided by the insurance companies and I think you will clearly see the relationship that's being asserted by the insurance companies is lacking in the data provided.

INTRODUCTION AND DISCUSSION ON NCOIL INSURANCE UNDERWRITING TRANSPARENCY MODEL ACT

Rep. Matt Lehman (IN), NCOIL Immediate Past President and sponsor of the Insurance Underwriting Transparency Model Act (Model) stated that I'm proud to sponsor this Model and I'd like to provide some background and context on it before proceeding. As you likely know, NCOIL formed a Special Committee on Race in Insurance Underwriting towards the end of 2020. At the Committee's final meeting in July of last year, the Committee, in meeting its charges and therefore sunsetting, adopted a series of resolutions, two of which referred certain issues to NCOIL standing policy committees. One of the resolutions was titled "Resolution Regarding Insurance Score Transparency"

and it referred the issue of developing an Insurance Score Transparency Model Law to this Committee.

For a bit of background, I was talking to a group the other day and I said I've been in this business for 30 years and I think if you look at the past everything was tangible. If you came in for a quote, I ran your motor vehicle record (MVR), Comprehensive Loss Underwriting Exchange (CLUE) report and more recently your credit and then if there was a problem at renewal or even at issuance I had something tangible to cite like a DUI or five accidents or bad credit and this is what you need to work on to get a better rate or a policy. Over the past couple of years, the trend has been more into data collection, telematics, predictive modeling and it's not that those things are bad but it brings up this issue of what is in my rate that is creating either that increase I'm getting or maybe denial of coverage.

So, I began to work on some language here in Indiana on a bill that I have now effectively pulled back because I want to focus on NCOIL and where it's going to go with this because I think it's a national issue and not just a state issue. And for some data points I did meet with our department of insurance and I asked them I'm going down this path of where is the good balance of public policy in disclosing what's in the box and matrix that's used and what at the same time keeps a competitive marketplace so that we're not sharing confidential or proprietary information and it is a tough balance because there is a lot of data that's being used that they have some concerns with and we saw what happened in Washington with Cmsr. Mike Kreidler saying the pendulum is going this way and we are just going to ban this and I'm trying to find a place where I think NCOIL needs to go which is to show how that data is processed and then provide that to the client.

A good example is I asked the department of insurance yesterday about the Lemonade issue of collecting 5,000 data points and the department of insurance said we just had a filing in Indiana where a company came in with 1,000 elements to use on a personal home and auto policy and the actuaries looked at it and found some things that were discriminatory and some things that were proxy discrimination which is what we addressed a couple of years ago and then found some things they could use and it went from 1,000 down to 70 and as I looked at that I thought to myself what were those 930 pieces of data that was asked to be used but were denied and it's not that it should be shared but it really sheds light on the issue of a lot of data is being collected on people to be used scientifically and through these algorithms to create a rate so what I want to focus on with a model is to say if you are going to use this data there is no prohibition but if I ask you what are the factors that go into my rate you have to give to me maybe the top 10 things that you use and they would very likely include the MVR, CLUE report and other things that we have traditionally found to be normal but if we start to use artificial intelligence maybe that starts to bring up some things that people would have some concerns with.

And then if it's an adverse action of denying or raising my rate than the trigger would be the carrier would be required to disclose that so I think some of the concern from carriers, and we've had really good discussions, is that we're getting into the area of it really is very nuanced to what might be the issue on my policy is different than the issue in Rep. Rowland's policy and if I have to disclose that it's going to be a lot of data that's unique to a client and now I have to somehow process that. So, I understand there are

some issues there and my pushback a little bit is we have the staff to create the box so I think we have the staff to push that data out.

I'm looking forward to a robust discussion as we start this process because I think the bottom line is I asked the department of insurance yesterday if there have been any complaints around this path we're heading down and they said there have been a couple of complaints around I got a rate increase and no one could explain it to me – my agent couldn't explain it as my MVR and CLUE were the same and the agent reached out to the carrier and they said its proprietary and can't say so he filed a complaint with the department of insurance and they said you don't have any grounds because we've approved them to use this data so they are looking to us as policymakers as what's good public policy and as we begin to go down this path there are things that we can say maybe its good public policy to use such as the fact that I wear glasses or have gray hair and there are issues that maybe cause some concern of should that be used for data. That's where this is at, and I think I want this to be a good path to get us to where we have transparency to the consumer and the carriers can help us get there. I'm happy to answer questions and I look forward to Las Vegas to start this process.

Asm. Cooley stated that I'll say in a very general way and in encouragement of the path that Rep. Lehman wants to pursue, in CA we had a single payer bill that came to the floor and it didn't have the votes to get off the floor and that was a little surprise as it was a colossal bill and was short in double digits so it didn't advance but it caused a lot of us to think about the nature of being a legislator and its sort of like as lawmakers our process is all about four things – someone may present what is a new or wild idea; that triggers a conversation about the pros and cons and downsides of where the wheels come off and what are criticisms; a good lawmaker and good colleague will listen to the criticisms and try to figure out how to style those issues; and de-risk the idea so you can introduce change without totally disrupting things; and all of that takes time so we have our process and hear ideas and learn about them and massage.

I just sort of see that's the issue Rep. Lehman is introducing on how we work with data and how we make it work and I want to say in this time there is nothing more basic to lawmaking than starting with a wild idea, understanding what are the criticisms and how to de-risk and afford yourself some time and that speaks to the strength of NCOIL as inviting the 50 states and gathering to have these conversations. I look forward to following the conversation and it's what we do as lawmakers in terms of listening to what are some different ways to understand an issue and serve our constituents.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Cahill and seconded by Asm. Cooley the Committee adjourned at 1:00 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Insurance Underwriting Transparency Model Act

Draft as of February 2, 2022 based on Indiana HB 1238

To be discussed by the NCOIL Property & Casualty Insurance Committee on March 5, 2022.

Sponsored by Rep. Matt Lehman (IN) – NCOIL Immediate Past President

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Insurance Underwriting Transparency Act."

Section 2. Definitions

"Adverse Action" means a denial or cancellation of, an increase in a charge for, or a reduction or other adverse or unfavorable change in the terms of coverage or amount of insurance in connection with the underwriting of a personal insurance policy.

"External Consumer Data" means data or information that is obtained from an external source and used by an insurer to supplement traditional underwriting.

Section 3. Transparency Requirements

(a) If an insurer[1] uses external consumer data to underwrite and rate risks, the insurer, upon a written request, whether delivered electronically or hard copy, by a consumer, must disclose to the consumer all primary factors, up to a maximum of ten (10), of those most heavily weighed, that the insurer uses in calculating a premium.

(b) If an insurer takes an adverse action based on external consumer data, the insurer must provide written notice, whether delivered electronically or hard copy, to the consumer explaining the reason for the adverse action. The notice must include:

(1) sufficiently clear and specific language so the consumer is able to identify the basis for the insurer's decision to take an adverse action; and

(2) all factors, up to a maximum of ten (10), that were the primary influences on the adverse action.

Section 4. Penalties

A violation concerning external consumer data shall constitute a violation of [*insert citation to state unfair trade practices statute*].

Section 5. Rules

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act.

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

Section 6. Effective Date

This Act shall be effective in six (6) months for all applications, renewals, and declinations thereafter.

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[1] Terms such as "insurer" are intentionally not defined in this Model so that the specific definitions of each state's insurance code shall govern.

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National Council of Insurance Legislators (NCOIL)

Fairness for Responsible Drivers Model Act

***Sponsored by Sen. Shawn Vedaa (ND)**
***Draft as of March 16th, 2021.**
***To be discussed during the Property & Casualty Insurance Committee on March 5, 2022.**

Table of Contents

Section 1. Title

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

Section 2. Application

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

Section 3. Definitions

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

(1) Physical and emotional pain and suffering.

(2) Physical impairment.

(3) Emotional distress.

(4) Mental anguish.

(5) Loss of enjoyment.

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

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

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

(1) Treatment and rehabilitation.

(2) Medical expenses.

(3) Loss of economic or educational potential.

(4) Loss of productivity.

(5) Absenteeism.

(6) Support expenses.

(7) Accidents or injury.

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

Section 4. Prohibition on Recovery of Noneconomic Damages

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

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

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

Section 5. Exceptions

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

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

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

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

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

Section 6. Effective Date

This Act shall take effect _____.

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 18, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at The Westin Kierland Hotel in Scottsdale, Arizona on Thursday, November 18, 2021 at 1:45 p.m.

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

Other members of the Committee present were:

Sen. Keith Ingram (AR)
Sen. Mathew Pitsch (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Derek Lewis (KY)
Rep. Brenda Carter (MI)
Asm. Ken Blankenbush (NY)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Deborah Ferguson (AR)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Rachel Roberts (KY)
Rep. Bart Rowland (KY)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Mike McLendon (MS)
Sen. Walter Michel (MS)
Rep. Hank Zuber (MS)
Sen. Charles Younger (MS)
Sen. Jim Burgin (NC)
Sen. George Lang (OH)
Rep. Warren Kitzmiller (VT)
Del. Moore Capito (WV)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH), and seconded by Sen. Mathew Pitsch (AR), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Del. Steve Westfall (WV), and seconded by Asm. Ken Blankenbush (NY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 16, 2021 meeting in Boston, MA.

CONSIDERATION OF NCOIL REMOTE NOTARIZATION MODEL ACT (Model)

Rep. Jordan, sponsor of the Mode, stated that we first discussed this issue in our December meeting of last year an example of how certain ways of doing business have changed in light of the pandemic. And I'm proud to sponsor this Model as it simply provides states some guidance who are looking to enact remote notarization legislation. This Model appears in your binders on page 80 and there's been widespread support for this Model since it was first introduced. One change I made along the way is in section D regarding the number of years in which the recordings must be retained as it has been lowered from ten years to seven years. And for those of you who are familiar with this, I think this is in line with most states record retention requirements for attorneys.

So, we wanted to have it consistent with those requirements and it still follows the spirit of the Model. We've heard from a lot of interested persons on this issue including the National Notary Association and at our last meeting we were able to see a live demo of a remote notarization take place. Hearing no questions or comments no questions or comments, upon a Motion made by Rep. Tom Oliverson, M.D. (TX) and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to adopt the Model.

CONSIDERATION OF NCOIL UNIFORM CAPTIVE INSURER MODEL ACT (Model)

Rep. Jordan stated that I will now turn it over to Sen. Jason Rapert (AR), NCOIL Immediate Past President, who is the sponsor of the Model.

Sen. Rapert thanked Rep. Jordan and stated that I'll be brief as we've already discussed this issue at length in our previous meetings. As you all know, I'm a strong supporter of captive insurers in general and I'm proud that NCOIL has decided to take a stance and support them as well. We had great introductory discussions at our April meeting and then in our last meeting in July we heard from several representatives from Vermont and it's good to have Rep. Warren Kitzmiller (VT) here today for this discussion from Vermont as well. And obviously Vermont is very highly regarded in the captive insurance arena. They are first globally in captive premium written and I believe third in the number of active captive insurance companies that are domiciled there.

I'm very glad that we heard from them because as global leaders they were able to point out how the Model that we were discussing could be improved. And what I've decided to do after working with them and others is to provide a substituted version of the Model which is borrowing much of the language from what they've done in Vermont with their captive insurance statute. And that first version was really a compilation that we had put together for many of our different states as we got this started and it was really just to start the discussion. And as we got further on in discussions and listened to many of the stakeholders that are involved, all of them have told me that they seem pleased with where we're at in this position and we can reach some uniformity in all of this.

You all have the completed Model before you and one minor technical change that I want to make, and this has been discussed with the stakeholders before we started the meeting as well, is in section 11 titled Reinsurance, where it says in the parenthesis "state specific" that is meant to refer to each states credit for reinsurance statute. Accordingly, when this is adopted and finalized ultimately that technical drafting change will be made. So, I want to thank everyone for their time and reiterate that this Model

can end up providing states guidance when they're looking to develop a captive insurer statute and can send a signal to those states that captive insurance is something that NCOIL does support provided there is an appropriate statutory framework in place.

Hearing no comments or questions, upon a Motion made by Sen. Pitsch and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the Model as amended during the meeting.

INTRODUCTION AND DISCUSSION OF NCOIL INSURANCE REGULATORY SANDBOX MODEL ACT (Model)

Rep. Jordan stated that I will now turn it over to Rep. Bart Rowland (KY), who is the sponsor of the Model, for brief remarks.

Rep. Rowland stated that as I noted at our last meeting in July I support the concept of insurance regulatory sandboxes. And as you'll hear from the speakers today, the main goal of such sandboxes is to reduce regulatory hurdles for companies that want to introduce new concepts and products at the same speed as insurance technology develops. My home state of Kentucky has an insurance regulatory sandbox that has been in effect since 2019. And I'm proud to sponsor the NCOIL Model alongside my colleague from Pennsylvania Rep. Wendi Thomas. The Model is in your binders and it's on page 98. As noted at the top of the Model, the first draft is based on the Kentucky sandbox law. But that is just a starting point and I'm certainly open to hearing suggestions as to what should be added or removed from the Model. We're actually having suggestions already in Kentucky on tweaks that may be needed to our Kentucky sandbox. I'm interested in hearing from the speakers we have here today to hear how they have interacted with other state sandboxes. And I also encourage anyone with suggested changes to the Model to reach out to myself and NCOIL staff.

The Honorable Evan Daniels, Director of the Arizona Department of Insurance and Financial Institutions, thanked the Committee for the opportunity to speak and stated that the reason I'm here is because before I was appointed Director, one of the jobs I had at the Arizona Attorney General's Office was to stand up and run the nation's first regulatory sandbox program for Fintech which is quite a bit different than insurance of course and the products that we saw and a lot of the ideas that we heard about going into it were not necessarily tailored for what ultimately became the Arizona sandbox. In fact, I was reminiscing with Wade Eyerly, Founder & CEO of Degree Insurance, who will speak after me, before this meeting about a conversation that we had about his product and whether that would be a fit for the Arizona sandbox.

Generally, I don't think that the subject matter necessarily is really what's important here. I am a proponent of the program and of sandboxes generally and really any programs that are designed to open up channels of communication between stakeholders and regulators I think are a positive thing. They don't necessarily have to be sandboxes. But in my experience the Arizona sandbox was a great way to facilitate that kind of open communication and bring new ideas to the forefront of the regulators mind to help us understand what was going on in the marketplace. One thing I will say in support of sandboxes is that as a regulator I often feel like I'm behind when I'm trying to understand what's going on in the marketplace. And I'm sure that's not all that different at times from what you as members of your respective state legislatures encounter. The marketplace moves a whole lot faster than we can respond to it and I think it behooves

us to create structures that enable open communication. It's much better to understand what might be happening and the things that are developing in the marketplace so that we can be part of that development as policymakers, as regulators, whatever your role may be.

So, I'm generally supportive of sandbox ideas. I'm happy to address how it worked in Arizona. I think it's safe to say we're the most successful sandbox program in the country. By the time I left and was appointed to my current role we had approved 10 businesses doing various types of things, whether it was payment related or lending related. Obviously as I said earlier, those were very different things from what you might see in an insurance sandbox even if maybe there are some technical aspects and some technology platforms perhaps that would look very similar. But, all that said I'm very proud of the success that we had here in Arizona with the sandbox program. I know there are several places, Kentucky being one, where insurance sandboxes are now in effect and I'm interested to see what those programs produce and I'm happy to answer whatever questions you might have about our experience here in Arizona about how that worked and how we approached it from a regulatory perspective.

Mr. Eyerly stated that Degree Insurance (Degree) is licensed in nine states now. We have created a novel type of insurance where we guarantee the salary that a student earns five years after they graduate college. So, we think it's an important product but what's important about it for this audience is that's a type of insurance that was never considered when the regulations were written. So, we're going to guarantee a student's salary for five years after they finish. A school's going to buy that product to cover their students, and then that student's going to go to school for three to six years, finish their degree and then for five years send us their tax returns which means we don't pay a claim for eight years. So, as an example of the type of regulatory hurdles we run against, the way that seasoning is interpreted matters a lot to us. If seasoning starts when we file and become licensed in your state, then we're going to be fine. If it doesn't work until we pay claims, I'm eight years away from paying the first claim. What a sandbox lets us do is open up opportunities for us to begin to innovate with products like ours in small ways in states where the current regulatory framework just frankly didn't consider a product like ours before. So, it unlocks the opportunity for us to try things in a very small targeted way, prove that it works, prove that it's safe, and then expand from there.

So, we haven't used a regulatory sandbox but we would love to. We'd love to see one that worked that addresses the specific challenges that we have, things like seasoning, things like statutory requirements that on a micro-level may exceed what's reasonable, that's so far beyond a risk based capital requirement that again, things like what we're doing just likely weren't considered when those regulations were written. So, the sandbox gives a state the free hand to help promote innovation in very important ways and we're big fans of the concept.

Jeff Klein, Esq., stated that you usually see me here with McIntyre & Lemon, PLLC, representing the American Bankers Association, but I wanted to contribute to this effort in my personal capacity. I live in Charlotte, North Carolina, and thanks to Sen. Jim Burgin (NC) who is here today along with many others from NC, we passed what probably is the latest regulatory sandbox. It was a three-year effort, I handled it pro bono. For those of us that've done property- casualty work and done auto and homeowners and workers comp for so many years, this is a fresh start. It's very forward

looking and it's great that NCOIL is considering this. So, I wanted to share some quick thoughts with you about the North Carolina law. And in conjunction with other innovative efforts that the National Association of Insurance Commissioners (NAIC) and you are looking at such as rebating reform and the like, it's really helping put the insurance industry, and the banking industry in the twenty-first century.

The bill was North Carolina House Bill 624, it was enacted and signed by Governor Cooper on October 15th, 2021 and it was passed by the Republican led House 111-0 with similar margins in the Senate. It creates the North Carolina Financial Services sandbox covering both insurance and banking. We thought it was important in our state, as in Arizona and others, where North Carolina is kind of at the cross section of financial services and technology industries to make sure our state was not left behind. And we hope it'll contribute to economic development. We wanted to make a couple of points about this. It covers both Insurtech and Fintech. We preserve many consumer protection laws, as I'll say later in the presentation. There are references to several North Carolina statutes on lending and mortgage that have been controversial in the past. And some insurance statutes as well. We wanted to allay everyone's concerns that those consumer protection principles were adhered to. So, that's something you want to look at in adopting any legislation.

We created an Innovation Council which is fairly unique, composed of representatives of the Insurance Department, Office of Commissioner of Banks, Secretary of State, Attorney General and public members. There were two reasons for that. In Arizona, the Attorney General runs the program. In North Carolina we have the Democratic Attorney General and Republican General Assembly, so we didn't want to house it in just one individual. And there's something about economies of scale. By having different agencies sitting together on a fairly new and controversial area, there's kind of safety in numbers. And as we speak, there are nominations being proposed by the Senate President, the Governor, and others for the Council.

It has two key roles, one is to assign an application that comes in from a participant to the relevant state agency. In this case, it's initially the Office of Commissioner of Banking or the Insurance Department. The other role is to issue guidelines, prompt trends and help promote innovation on a larger scale, although it does not have regulatory authority per se. Another key feature is that there are several non-profits in North Carolina, such as the North Carolina Block Chain Initiative and the Carolina Fintech Hub that I've done work for and they have a role in helping participants navigate through the regulatory process and giving them technical assistance to design products and services. And we thought having an express reference to them in the legislation would be fair and helpful.

A couple of words to the wise, as you look at this in your states, this is a new and emerging issue. We wanted to make sure that we engage with a number of interested parties and partners and not leave anybody out of the discussion because that would have been fatal. So, we had meetings on several occasions with the North Carolina Department of Insurance, the Center for Responsible Lending and the North Carolina Justice Center, two of the more active consumer groups in Raleigh. The Commissioner of Banks, The Secretary of State and last but not least the North Carolina Bankers Association and the Insurance Federation were also involved to make sure that they didn't feel that the sandbox would create competitive problems. I note that there are some provisions in the North Carolina Act that we think would be helpful in the Model.

There are some extensive consumer disclosures, such as the fact that the product is not covered by the Guaranty Association, and that the state doesn't necessarily, or any agency, endorse the product.

A consumer can go to the Attorney General as they can now with any complaints. We have an extended beta test period. The North Carolina law like some of the others that it's modeled on has a two-year pilot project – a period for testing a product with a one year extension. I think the Model's a little shorter than that. So, you might want to consider that. As I mentioned before, there's a direct reference to non-governmental partners and also to future use of blockchain technology, which is kind of a shared general ledger that both states and private entities could use to share data. Maybe most importantly of any of these provisions, we drafted reciprocity provisions so that someone entering a sandbox in another state could operate in North Carolina, and the state could enter into agreements with federal agencies and there would be all sorts of reciprocal protections to make sure that this wasn't just a one domicile organization. Thank you for your time, and please don't hesitate to reach out with any questions.

J.P. Weiske, representing the American InsurTech Council, stated that I am a recovered regulator from Wisconsin who actually dealt directly with a number of Insurtech entities and we ran through a similar sandbox process. Wisconsin's law actually dates back to the 1970's allowing the Insurance Commissioner with a finding to waive any insurance law and any insurance regulation. And I think the practices that you're looking at inside this proposed Model, and we'll have some specific comments later, reflect the actual day to day work that we did in Wisconsin when we formalized that process. The idea is that you're looking at a company who has a unique and innovative idea. You have a conversation with the entity, look at the issues that they want to waive. In a number of cases, when we met with companies, we found they in fact did not need a waiver to do what they wanted to do. So, they were able to go through the normal process. In other cases, they certainly did, and we had a conversation. A lot of those dealt with filing inexperience around the filing issues. So, for example, we had a company that wanted to use slider technology to adjust deductibles and coverages all the way through. And they needed to experiment with the consumer experience to make sure that functionally worked. And in another cases, we had some new products similar to Degree that were coming in the marketplace and they wanted to see whether or not there was in fact a market for it. In one case, they found there was no market for it – apparently people wouldn't buy that type of travel insurance. In other cases, they certainly did, and those products are out and available in the market now.

So, there are some products that went through that process and got priced. And you go through it by hand, you make an agreement, and again I think the key thing about this version of the Model is that it reflects a good consistent process that companies can go through to understand what they need to do and what needs to be waived. And in a number of cases there are pieces that will remain confidential. If there's a requirement from a consumer protection standpoint, that the money be returned at the end, it's not useful from a marketing standpoint for the consumer to know that they're going to the money back as that upsets your market experiment. So, a number of cases are confidential pieces, which this provides for as well.

Hearing no comments or questions, Rep. Jordan thanked everyone and stated that he looks forward to further discussing this at future meetings.

DISCUSSION ON UNIFORM ELECTRONIC TRANSACTIONS ACT (UETA) DEVELOPMENTS STEMMING FROM COVID-19

Karen Melchert, Regional Vice President of State Relations at the American Council of Life Insurers (ACLI), thanked the Committee for the opportunity to speak and stated I just wanted to take a couple minutes to update you on what's happening mostly on the regulatory side with respect to regulatory accommodations following what we discovered during COVID-19 and what accommodations needed to be made stemming really from stuff we had been doing prior to the pandemic. In 2017, the NAIC created the Innovation and Technology Taskforce to address technological advances and the innovative use of technology across all lines of insurance to really take a look at what regulatory changes might need to be made. Following the pandemic, they created an E-commerce Working Group to see what was done that could be made permanent. Most of these accommodations were done on an emergency basis and were tied to the declaration of an emergency related to COVID-19. Some have been made permanent, others have not. And that's something that industry collectively, not just the life insurance industry, but others, have been looking at and talking to the NAIC about.

A lot of this is based on UETA and e-sign which had already been adopted in most states. I think there's three states that adopted their own version of UETA, but across the country some form of UETA is in place. And the four pillars of UETA include: a record or signature may not be denied legal effect or enforceability simply because it's an electronic form; a contract cannot be denied legal effect just because part of it included an electronic transaction; if a law requires a record to be in writing, an electronic record satisfies; and conversely, if a law requires a signature, an electronic signature satisfies. So, even with that though there are certain non-electronic delivery requirements that remain in insurance and we discovered that during the pandemic. For example, a lot of our laws require first class mail delivery of documentation. Obviously, you can't do that electronically. That was waived under a few accommodations that were issued by departments mostly relating to filings that companies are required to make. You're supposed to make quarterly filings with NAIC and then you're supposed to deliver paper copies of those to your regulator. Many states allowed those to be filed electronically provided you kept the paper form and then submitted them as soon as you were able to get back into the office and create those records.

Some states are looking to make that more permanent. So, other accommodations include signature requirements were waived; remote notarization, which led to the recently adopted NCOIL Model; and remote regulatory exams and remote proctor producer examinations. These and other accommodations actually enhanced consumer experience and in fact we're seeing consumers are increasingly showing a preference for electronic access to records in lieu of paper mailings. Benefits to that include flexibility, speed, simplicity, cost sharing, mobility and expanded access. The experience that we had during the pandemic illustrates that regulatory accommodations worked extremely well and they should be made permanent. One example is the producer licensing requirements, including continuing education and examinations, not necessarily having to be in person but can be proctored remotely. And also online continuing education classes - a lot of states have requirements that the continuing education portion of producer licensing has to be live and in person. And we're seeing changes to that and several states have adopted changes to that since the pandemic when we realized that wasn't particularly necessary anymore.

There may be some clarification around e-delivery that is needed but right now it's not clear that we need any statutory changes. And what we have been focused on is developing a handbook for the NAIC Innovation and Technology Taskforce that will look at the regulations that need to be updated and give guideline for that. There may come a time where we're going to have to come back to the legislature for changes such as with e-signature for opt-in for paper delivery versus opt-out for paper delivery. Right now, to receive something electronically you have to opt into that, as opposed to making that the norm that you get electronic delivery, and you have to opt out of that to receive a paper communication. So, that may be something that needs to be changed in state laws. I think 28 to 30 states have taken the e-sign statute and baked it into the insurance code separate and apart from e-sign which applies to all industries. So that may be something we'll need to address down the line to do the opt-in versus the opt-out for paper delivery.

The other thing I think that's important to note as we continue to develop these things is we just really wanted to keep you up to speed on what we were doing. We appreciate the partnership that NCOIL and NAIC have and I think you're going to hear tomorrow about the creation of a new letter committee at NAIC, the H Committee, which will include focus on innovation, artificial intelligence and cybersecurity. We have been told that the Innovation Technology Task Force and the subsequent working group that was formed after, they'll be folded into that Committee as well. And in a way that's great because there's been a lot of different work streams at the NAIC and it'd be better if it's all under one committee so that we can share information and make sure we're not going against each other and what we're saying and how we're developing things going forward.

It's important that regulatory and legislative efforts are continued to make sure that our state based system keeps pace with technology advances and our evolving insurance systems. We're a little slow when it comes to advances in technology in the insurance industry. We've never been quick to embrace those but that seems to be changing and it's certainly changed a lot during the last year and during the pandemic. So, we just really appreciate the ability to come to you with what we're doing and just put a place marker in case we need to come back and ask for support for legislative action on your behalf and to keep an eye out as you see proposals come before you in the next session or two. If there's anything related to electronic delivery or the like, make sure that the insurance industry is included so that we're brought up to speed like everyone else.

CONSIDERATION OF RE-ADOPTION OF MODEL LAW

Rep. Jordan stated that, lastly, we'll consider the readoption of the NCOIL Identity Theft Protection Model Act. This was originally adopted back in 2003 and has been readopted three times, the last time being in November of 2016.

Upon a Motion made by Rep. Rowland and seconded by Del. Westfall, the Committee voted without objection by way of a voice vote to re-adopt the Model.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Rapert and seconded by Sen. Hackett, the Committee adjourned at 3:00 p.m.

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National Council of Insurance Legislators (NCOIL)

Insurance Regulatory Sandbox Model Act

Draft as of October 19, 2021 and based on KY HB 386, signed into law on March 26, 2019.
To be discussed during the Financial Services & Multi-Lines Issues Committee on Saturday, March 5, 2022.

Sponsored by Rep. Bart Rowland (KY)
Rep. Wendi Thomas (PA) – Co-sponsor

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Insurance Regulatory Sandbox Act."

Section 2. Definitions

(1) "Applicant" means a person that has filed an application under Section 3 of this Act;

(2) "Beta test" means the phase of testing of an insurance innovation in the regulatory sandbox through the use, sale, license, or availability of the insurance innovation by or to clients or consumers under the supervision of the department;

(3) "Client" means a person, other than a consumer, utilizing a participant's insurance innovation during a beta test to carry on some activity regulated by the department;

(4) "Director" means the director of insurance innovation;

(5) "Extended no-action letter" or "extended letter" means a public notice setting forth the conditions for an extended safe harbor beyond the beta test under which the department will not take any administrative or regulatory action against any person using the insurance innovation described in the extended no-action letter;

(6) "Innovation's utility" means an evaluation by the commissioner of the insurance innovation's ability to adequately satisfy factors set forth in subsection (1)(b)1. of Section 3 of this Act;

(7) "Insurance innovation" or "innovation" means any product, process, method, or procedure relating to the sale, solicitation, negotiation, fulfilment, administration, or use of any product or service regulated by the department:

> (a) That has not been used, sold, licensed, or otherwise made available in this [State] before the effective filing date of the application, whether or not the product or service is marketed or sold directly to consumers; and
>
> (b) That has regulatory and statutory barriers that prevent its use, sale, license, or availability within this [State];

(8) "Limited no-action letter" or "limited letter" means a letter setting forth the conditions of a beta test and establishing a safe harbor under which the department will not take any administrative or regulatory action against a participant or client of the participant concerning the compliance of the insurance innovation with [State] law so long as the participant or client abides by the terms and conditions established in the limited no-action letter;

(9) "Participant" means an applicant that has been issued a limited no-action letter under Section 5 of this Act; and

(10) "Regulatory sandbox" or "sandbox" means the process established under this Act by which a person may apply to beta test and obtain a limited no-action letter for an innovation, potentially resulting in the issuance of an extended no-action letter.

Section 3. Application Process

(1) Except as provided in subsection (2) of this section, on or before [date], a person may apply to the department for admission to the sandbox by submitting an application in the form prescribed by the commissioner, accompanied by the following:

(a) A filing fee of [xxxxx]);

(b) A detailed description of the innovation, which shall include:

1. An explanation of how the innovation will:

a. Add value to customers and serve the public interest;

b. Be economically viable for the applicant;

c. Provide suitable consumer protection; and

d. Not pose an unreasonable risk of consumer harm.

2. A detailed description of the statutory and regulatory issues that may prevent the innovation from being currently utilized, issued, sold, solicited, distributed, or advertised in the market;

3. A description of how the innovation functions and the manner in which it will be offered or provided;

4. If the innovation involves the use of software, hardware, or other technology developed for the purpose of implementing or operating it, a technical white paper setting forth a description of the operation and general content of technology to be utilized, including:

a. The problem addressed by that technology; and

b. The interaction between that technology and its users;

5. If the innovation involves the issuance of a policy of insurance, a statement that either:

a. If the applicant will be the insurer on the policy, that the applicant holds a valid certificate of authority and is authorized to issue the insurance coverage in question; or

b. If some other person will be the insurer on the policy, that the other person holds a valid certificate of authority and is authorized to issue the insurance coverage in question; and

6. A statement by an officer of the applicant certifying that no product, process, method, or procedure substantially similar to the innovation has been used, sold, licensed, or otherwise made available in this [State] before the effective filing date of the application;

(c) The name, contact information, and bar number of the applicant's insurance regulatory counsel, which shall be a person with experience providing insurance regulatory compliance advice;

(d) A detailed description of the specific conduct that the applicant proposes should be permitted by the limited no-action letter;

(e) Proposed terms and conditions to govern the applicant’s beta test, which shall include:

1. Citation to the provisions of [State] law that should be excepted in the notice of acceptance issued under subsection (6) of Section 4 of this Act; and

2. Any request for an extension of the time period for a beta test under subsection (1) of Section 6 of this Act and the grounds for the request;

(f) Proposed metrics by which the department may reasonably test the innovation's utility during the beta test;

(g) Disclosure of all:

1. Persons who are directors and executive officers of the applicant;

2. General partners of the applicant if the applicant is a limited partnership;

3. Members of the applicant if the applicant is a limited liability applicant;

4. Persons who are beneficial owners of ten percent (10%) or more of the voting securities of the applicant;

5. Other persons with direct or indirect power to direct the management and policies of the applicant by contract, other than a commercial contract for goods or nonmanagement services; and

6. Conflicts of interest with respect to any person listed in this paragraph and the department;

(h) A statement that the applicant has funds of at least [xxxxx dollars] available to guarantee its financial stability through one (1) or a combination of any of the following:

1. A contractual liability insurance policy;

2. A surety bond issued by an authorized surety;

3. Securities of the type eligible for deposit by authorized insurers in this [State];

4. Evidence that the applicant has established an account payable to the commissioner in a federally insured financial institution in this [State] and has deposited money of the United States in an amount equal to the amount required by this paragraph that is not available for withdrawal except by direct order of the commissioner;

5. A letter of credit issued by a qualified United States financial institution as defined in [citation to appropriate State statute]; or

6. Another form of security authorized by the commissioner; and

(i) A statement confirming that the applicant is not seeking authorization for, nor shall it engage in, any conduct that would render the applicant unauthorized to make an application under subsection (2) of this section.

(2) (a) The following persons shall not be authorized to make an application to the department for admission to the sandbox:

1. Any person seeking to sell or license an insurance innovation directly to any federal, state, or local government entity, agency, or instrumentality as the insured person or end user of the innovation;

2. Any person seeking to sell, license, or use an insurance innovation that is not in compliance with subsection (1)(b)5. of this section;

3. Any person seeking to make an application that would result in the person having more than five (5) active beta tests ongoing within the [State] at any one (1) time; and

4. Any person seeking a limited or extended no-action letter or exemption from any administrative regulation or statute concerning:

a. Assets, deposits, investments, capital, surplus, or other solvency requirements applicable to insurers;

b. Required participation in any assigned risk plan, residual market, or guaranty fund;

c. Any licensing or certificate of authority requirements; or

d. The application of any taxes or fees.

(b) For the purposes of this subsection, "federal, state, or local government entity, agency, or instrumentality" includes any county, city, municipal corporation, urban-county government, charter county government, consolidated local government, unified local government, special district, special purpose governmental entity, public school district, or public institution of education

Section 4. Director of Insurance Innovation

(1) There shall be a director of insurance innovation within the department, responsible for administering Sections 2 to 9 of this Act. The director shall be appointed by the [xxxxx] with the approval of the Governor in accordance with [citation to appropriate State law].

(2) The director shall review all applications for admission to the sandbox.

(3) (a) Unless extended as provided in paragraph (b) of this subsection, the commissioner shall issue a notice of acceptance or rejection in accordance with this section within sixty (60) days from the date an application is received.

(b) The commissioner may extend by not more than thirty (30) days the period provided in paragraph (a) of this subsection if he or she notifies the applicant before expiration of the initial sixty (60) day period.

(c) An application that has not been accepted or rejected by a notice of acceptance or rejection issued by the commissioner prior to expiration of the initial sixty (60) day period, or if applicable, the period provided in paragraph (b) of this subsection, shall be deemed accepted.

(4) The commissioner may request from the applicant any additional material or information necessary to evaluate the application, including but not limited to:

(a) Proof of financial stability;

(b) A proposed business plan;

(c) Pro-forma financial statement; and

(d) Executive profiles on the applicant and its leadership demonstrating insurance or insurance-related industry experience and applicable experience in the use of the technology.

(5) The commissioner shall review the application to:

(a) Identify and assess:

1. The potential risks to consumers, if any, posed by the innovation; and

2. The manner in which the innovation would be offered or provided; and

(b) Determine whether it satisfies the following requirements:

1. The application satisfies the requirements of Section 3 of this Act;

2. The application proposes a product, process, method, or procedure that meets the definition of innovation under Section 2 of this Act;

3. Approval of the application does not pose an unreasonable risk of consumer harm;

4. The application identifies statutory or regulatory requirements that actually prevent the innovation from being utilized, issued, sold, solicited, distributed, or advertised in this [State]; and

5. The application proposes an innovation that is not substantially similar to an innovation:

a. That has been previously beta tested; or

b. Proposed in an application that is currently pending with the department.

(6) Upon review of the application, the commissioner shall, in his or her discretion, issue one (1) of the following:

(a) If the commissioner determines that the application fails to satisfy any of the requirements under subsection (5)(b) of this section, he or she shall:

1. Issue a notice of rejection to the applicant; and

2. Describe in the notice of rejection the specific defects in the application; or

(b) If the commissioner determines that the application satisfies the requirements of subsection (5)(b) of this section, he or she shall issue a notice of acceptance to the applicant. The notice of acceptance shall:

1. Set forth the terms and conditions that will govern the applicant's beta test, which shall include, at a minimum:

a. Requiring the applicant to:

i. Abide by all [State] law, except where explicitly excepted;

ii. Utilize the insurance innovation within this [State]; and

iii. Report any change in the disclosures made pursuant to subsection (1)(g) of Section 3 of this Act;

b. Notice of the licenses required to be obtained prior to the commencement of the beta test;

c. Monthly reporting obligations structured to determine the progress of the beta test;

d. Consumer protection measures deemed necessary by the commissioner to be employed by the applicant;

e. The level of financial stability required to be in place for the beta test. The commissioner may increase, decrease, or waive the requirements for financial stability required under subsection (1)(h) of Section 3 of this Act, commensurate with the risk of consumer harm posed by the insurance innovation;

f. Duration of the beta test, including any extension authorized under Section 6 of this Act;

g. Permitted conduct under the limited letter;

h. Any limits established by the commissioner on the:

i. Financial exposure that may be assumed by an applicant during the beta test;

ii. Number of customers an applicant may accept; and

iii. Volume of transactions that an applicant or its clients may complete during the beta test; and

i. Metrics the commissioner intends to use to determine the innovation's utility; and

2. Provide that the notice of acceptance shall expire unless:

a. It is accepted by the applicant in writing; and

b. The acceptance is filed with the department within sixty (60) days of the issuance of the notice.

(7) An applicant may request a hearing pursuant to [citation to appropriate State stutate] on:

(a) A notice of rejection; and

(b) A notice of acceptance, if the request is made prior to its expiration.

Section 5. Limited No-Action Letter

(1) Within ten (10) days following the timely receipt of an acceptance pursuant to subsection (6)(b)2. of Section 4 of this Act, the commissioner shall issue a limited no-action letter that:

(a) Sets forth terms and conditions for the participant that are the same as those set forth in the notice of acceptance issued under subsection (6) of Section 4 of this Act; and

(b) Provides that so long as the participant and any clients of the participant abide by the terms and conditions set forth in the letter, no administrative or regulatory action concerning the compliance of the insurance innovation with [State] law will be taken by the commissioner against the participant or any clients during the term of the beta test.

(2) If the application is deemed accepted under subsection (3)(c) of Section 4 of this Act, the proposed limited no-action letter included with the application shall be deemed to have the effect of a limited letter issued by the commissioner.

(3) The safe harbor of the limited letter shall persist until the earlier of:

(a) The early termination of the beta test under Section 6 of this Act;

(b) The issuance of an extended no-action letter; or

(c) The issuance of a notice declining to issue an extended no-action letter.

(4) A limited no-action letter issued by the commissioner under this section shall be exempt from the application of [inert citation to appropriate State statute] .

(5) The commissioner shall publish any limited letter issued pursuant to this section on the department's Web site.

Section 6. Beta Rest Requirements

(1) The time period for a beta test shall be one (1) year. The time period may be extended by the commissioner in the notice of acceptance for a period that is not longer than one (1) year if a request is made in accordance with subsection (1)(e) of Section 3 of this Act.

(2) During the beta test, the participant and any clients of the participant shall:

(a) Comply with all terms and conditions set forth in the limited no-action letter; and

(b) Provide the department with all documents, data, and information requested by the commissioner.

(3) (a) For any violation of the terms or conditions set forth in the limited letter, the commissioner may:

1. Issue an order terminating the beta test and the safe harbor of the limited letter before the time period set forth in the limited letter has expired; and

2. Impose a fine of not more than [xxxxx] dollars per violation.

(b) The commissioner may also issue an order under paragraph (a)1. of this subsection if, following receipt of information or complaints, the commissioner determines the beta test is causing consumer harm.

(4) (a) The commissioner may issue an order requiring a client to cease and desist any activity violating the terms or conditions set forth in the limited letter.

(b) The issuance of a cease and desist order to one (1) client shall not otherwise impact the ability of the participant or any other clients to continue activities relating to the innovation in a manner compliant with the requirements of the limited letter.

(5) A participant or client may request a hearing on any order issued under this section pursuant to [insert citation to appropriate State law].

Section 7. Beta Test Review

(1) (a) Within sixty (60) days of completion of the beta test, unless the time period is extended up to thirty (30) days upon notice from the commissioner, the commissioner shall issue an extended no-action letter or a notice declining to issue an extended no-action letter.

(b) The participant may continue to employ the insurance innovation pursuant to the terms and conditions of the limited letter during the period between the completion of the beta test and the issuance of either an extended no action letter or a notice declining to issue an extended no-action letter.

(2) The commissioner shall review the results of the beta test to determine whether the innovation satisfies the following requirements:

(a) The data presented demonstrates that the innovation's utility was meritorious of an extension;

(b) Regulatory and statutory barriers prevent continued use of the innovation within this [State];

(c) The innovation provided a benefit to [State] consumers; and

(d) The issuance of an extended no-action letter:

1. Presents no risk of unreasonable harm to consumers or the marketplace; and

2. Serves the public interest.

(3) Upon review of the results of the beta test, the commissioner shall, in his or her discretion, issue one (1) of the following:

(a) If the commissioner determines that the innovation fails to satisfy any of the requirements under subsection (2) of this section, he or she shall:

1. Issue a notice declining to issue an extended no-action letter;

2. Describe in the notice the reasons for the declination;

3. Notify the participant for the innovation of the notice; and

4. Publish the notice on the department's Web site; or

(b) If the commissioner determines that the innovation satisfies the requirements under subsection (2) of this section, he or she shall issue an extended no action letter. An extended no-action letter issued by the commissioner shall include:

1. A description of the insurance innovation and the specific conduct permitted by the extended letter in sufficient detail to enable any person to use the innovation or a product, process, method, or procedure not substantially different from the innovation within the safe harbor of the extended letter;

2. Notice of any certificate of authority, license, or permit the commissioner determines is necessary to use, sell, or license the innovation, or make the innovation available, in this [State];

3. An expiration date not greater than three (3) years following the date of issuance;

4. Notice that the extended no-action letter may:

a. Only be modified by:

i. Promulgation of an administrative regulation, if the safe harbor addresses a requirement established by administrative regulation; or

ii. An act of the General Assembly; and

b. Be rescinded prior to its expiration if the commissioner receives complaints and determines continued activity poses a risk of harm to consumers;

5. Clarification of required procedures related to the issuance and cancellation of any policies of insurance, if applicable, due to the expiration period; and

6. Notice that, upon expiration, all persons relying on the extended no action letter shall cease and desist operations related to the innovation unless changes have been made to [State] law to permit the innovation by:

a. The promulgation of an administrative regulation, if the safe harbor address a requirement established by administrative regulation; or

b. An act of the General Assembly.

(4) A hearing on a notice of declination may be requested in accordance with [insert appropriate citation to State statute].

(5) An extended no-action letter issued by the commissioner pursuant to this section shall be:

(a) Exempt from the application of [insert citation to appropriate State statute]; and

(b) Published on the department's Web site.

Section 8 Confidentiality

(1) All documents, materials, or other information in the possession or control of the department that are created, produced, obtained, or disclosed in relation to this Act and that relate to the financial condition of any person shall be confidential and shall not be subject to public disclosure pursuant to the [State] Open Records Act, [citation].

(2) Notwithstanding any law to the contrary, the commissioner may disclose in an extended no-action letter any information relating to the insurance innovation necessary to clearly establish the safe harbor of the extended letter.

Section 9. Reports

(1) One hundred twenty days (120) days prior to the start of the 20xx, 20xx, 20xx, 20xx, and 20xx regular sessions of the General Assembly, the commissioner shall submit a written report to the Committees with jurisdiction over insurance issues in each Chamber that meets the requirements of subsection (2) of this section. Thereafter, the commissioner shall submit the report annually, upon request.

(2) The report shall include the following:

(a) The number of:

1. Applications filed and accepted;

2. Beta tests conducted; and

3. Extended letters issued;

(b) A description of the innovations tested;

(c) The length of each beta test;

(d) The results of each beta test;

(e) A description of each safe harbor created under Section 7 of this Act;

(f) The number and types of orders or other actions taken by the commissioner or any other interested party under this Act;

(g) Identification of any statutory barriers for consideration of amendment by the General Assembly following successful beta tests and the issuance of extended letters; and

(h) Any other information or recommendations deemed relevant by the commissioner.

(3) The commissioner shall also provide the Committees with jurisdiction over insurance issues in each Chamber a detailed briefing, upon request, to discuss and explain any report submitted under this section.

Section 10. Rules

The Commissioner is authorized to promulgate rules and regulations necessary to effectuate the purposes of this Act.

Section 11. Effective Date

This Act shall take effect [xxxxxxx].

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 18, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at The Westin Kierland Hotel in Scottsdale, AZ on Thursday, November 18, 2021 at 10:00 a.m.

Assemblywoman Pam Hunter, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Sen. Mathew Pitsch (AR)
Sen. Jason Rapert (AR)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Jonathan Carroll (IL)
Rep. Thaddeus Jones (IL)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Derek Lewis (KY)
Rep. Bart Rowland (KY)
Rep. Cherlynn Stevenson (KY)
Rep. Susan Westrom (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Sen. Charles Younger (MS)
Sen. Michael McLendon (MS)
Asm. Kevin Cahill (NY)
Sen. Pamela Helming (NY)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. James Kaufman (AK)
Rep. Doug Gutwein (IN)
Sen. Travis Holdman (IN)
Sen. Beverly Gossage (KS)
Rep. Rachel Roberts (KY)
Sen. Robert Mills (LA)
Rep. Kyra Bolden (MI)
Rep. Kevin Coleman (MI)
Sen. Lana Theis (MI)
Sen. Walter Michel (MS)
Rep. Hank Zuber (MS)
Sen. Jim Burgin (NC)
Asm. Ken Blankenbush (NY)
Sen. Jay Hottinger (OH)
Sen. Eric Nelson (WV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Bob Hackett (OH), and seconded by Rep. Deborah Ferguson (AR), Vice Chair of the Committee, the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Del. Steve Westfall (WV), and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2021 meeting in Boston, MA.

DISCUSSION ON 340B DRUG PRICING PROGRAM

Asw. Hunter stated that, in general, the 340B drug pricing program (program) was created by Congress to help certain categories of healthcare providers, referred to as covered entities, purchase covered outpatient drugs at a reduced price. And over the years we have seen problems arise with the program and some states have taken action. In New York, I actually used to work for a federally qualified health center and the program really was instrumental and the rebates that the health centers were able to keep really helped with their operational costs. Obviously, the states want that money back for themselves and we were able to push it off for a year but next year that money is going to be going towards the state. I note that today is just a preliminary conversation and there's no model in front of us or any language. We just want to get started because we will have an enhanced conversation about this at our next meeting.

Jeremey Crandall, Director of Federal and State Policy at the National Association of Community Health Centers (NACHC), thanked the Committee for interest in this topic. I know that you have a lot of competing topics that you have to consider each and every meeting so we deeply appreciate you considering this one. Before we discuss the program itself I just want to tell you a little bit about NACHC and the Community Health Centers. We are the National Membership Organization for FQHCs, federally qualified health centers. There are approximately 1,400 health centers total in the United States across 15,000 sites. They are in all 50 U.S. states and territories and in nearly every U.S. Congressional District. I found out yesterday that there's one or two that we are not in. And ultimately we serve 29 million patients, all of whom live in medically underserved communities. Finally, and most importantly, it is our mission and our mandate under federal law that we have to serve every patient that comes through our door regardless of ability to pay or their insurance status. And I really emphasize that last point because it has a direct link to the issue that we're going to talk to you about here today – the program.

It is no overstatement how much I can emphasize the extent to which program providers, they're called covered entities, health centers, as well as others rely on the program both to reduce the cost of prescription drugs and to fund and sustain core services. I'm going to touch on a little bit of the background about the program itself. It was established in 1992 as a part of the Federal Public Health Service Act. Specifically, the program enables certain safety net providers, community health centers, Ryan White HIV AIDS clinics, certain critical access in disproportionate share hospitals that treat a high number of low income patients, the ability to purchase prescription drugs, certain outpatient drugs, for its patients at significantly reduced cost.

At the time Congress created the program they specifically stated it's intention was to enable eligible providers to "stretch scarce federal resources as far as possible; reaching more eligible patients and providing more comprehensive services." In practice here's how it works. Drug manufacturers that participate in Medicare and Medicaid are required under federal law to provide discounts on certain drugs to program providers. For

insured patients whether on public or private plans they pay their normal co-pay that they otherwise would and their insurer reimburses the pharmacy at their normal payment. But that delta between the reimbursement and what program covered entity ultimately pays for the drug, that savings ultimately goes to that provider and then program providers use these savings to fund core services.

There are several constructs of the program that I want to share with you that I think are really important. Number one, only providers that serve a large number of low income patients, or those in rural areas, are even eligible to participate in the program. Number two, all participants operate under strict federal guidelines governing the program itself. This includes registration, annual recertification, being subject to federal audits, specific rules about avoiding duplicate discounts if a program drug also has Medicaid rebate attached to it, and then finally, appropriate use of the savings itself. I said a moment ago how critical the program is and I thought it was really important for you to not hear from me but also hear directly from health centers themselves. One element that health centers pride themselves on is the ability to deliver both core and wraparound services that enable us to treat the whole patient.

And so, I asked for a couple of snapshots about what the program means. From a health center in western Michigan: “The 340(b) program is essential not only to keep the pharmacy afloat but it enables us to hire additional community health workers to go into neighborhoods to promote healthy living and ensure patients are keeping their appointments and we are also able to offer pregnancy centering programs for expectant mothers. We even use some of the savings to help purchase a mobile medical unit.” From Shenandoah Community Health in West Virginia: “340(b) is enabling us to subsidize additional care services including mammography, prescription delivery and Hepatitis C treatment.”

I just want to leave you with a couple final thoughts. First of all, specific to community health centers we are required under both federal law and regulation to reinvest every penny of program savings that we have directly back into patient care. That’s in the Health Resources and Services Administration (HRSA) Compliance Manual that is our regulator essentially for FQHC’s. Second, there are significant conversations happening right now at the federal level about this program, what it’s going to look like now and into the future. We are a part of those conversations, 340(b) and they’re very important and we think they need to continue. But ultimately, the reason we’re here is that you all do have significant levers at your disposal to protect this program as well and that’s why we’re here to talk to you today.

Maureen Testoni, President and CEO of 340(b) Health, thanked the Committee for the opportunity to speak and said that our association represents hospitals that participate in the program. We represent almost 1,500 hospitals all over the country. We only focus on the program as that is our key hospital focus. Just to give you a little bit of background on what hospitals do with the program, I have some statistics to share with you. Program hospitals are responsible for about 60% of the uncompensated hospital care provided in this country. They are also responsible for 75% of hospital Medicaid inpatient care in this country. This is to give you a sense of their contribution to treating people with low income. Also, an important aspect of the program are the critical access hospitals. The rural hospitals that participate and many of them say the program is what really helps them keep their doors open. There’s also a lot of services that do not technically qualify as uncompensated care because they’re not traditionally reimbursed by insurers or by

Medicare and program hospitals also have a very high rate of providing services like transportation, translation and things like that.

So, over the last several years, we have seen some actions by payers to reduce reimbursement to program providers and some actions have specifically targeted program providers for things like lower reimbursement but also different types of claims identification or even potentially trying to sway patients to go to certain types of providers. It's a big concern for the hospitals we represent because it really takes a lot of the savings that are intended for these kinds of safety net providers and diverts them to other types of organizations. Fundamentally, what the program is really about and the intent of the program is to subsidize these providers, these safety net providers that really focus on providing care to low income and rural individuals. So, it is a big concern when we see that there is a diversion of those savings to organizations that don't have those kinds of strict federal requirements to focus on care for low income people.

So, states have started to take action here and I've just listed some of them just to give a sense of the types of things that states are getting active in around the program. So, they're prohibiting the discriminatory actions by pharmacy benefits managers (PBM's) and payors like lower reimbursement, claims identifications, keeping program entities out of networks and that type of thing. And the reason that they're doing this is because there's no federal law that exists right now that really addresses reimbursement and those types of things for commercial insurance. There's just nothing there at all. And so, as a result the federal government has said that they can't step in right now when there's discriminatory actions, so states have had to do so. So far at least 14 states have enacted legislation to prohibit discriminatory actions by PBM's and other payors and a number are also considering passing such laws. So, there's a lot of activity and we get contacted regularly by states asking us what other states are doing and how it's working. We get contacted a lot also by providers that are active in advocacy in their state. So, we see this as something that has really grown just even over the past two to three years. So, that just gives you an overview on it and there is my contact information and we keep a lot of information on state actions on what they're doing in this area that we're always happy to share with you as well.

Melodie Shrader, Vice President of State Affairs at the Pharmaceutical Care Management Association (PCMA), stated that I want to start with where I'm going to end, which is that PCMA supports the original goal of the program to be a safety net for the vulnerable and uninsured patients and we're neutral on any proposed legislation on the program except in instances where it erodes any of the PBM tools that we use to help keep the costs low for our clients. And I think as the two speakers before me have said, the program is a federal program and a lot of these issues are going to lie with the federal government. But with that being said, the program is a complex program and we are very appreciative of being invited here today to be a part of the beginning of this conversation and we appreciate the fact that NCOIL is committed to education and a longer conversation.

So, many of you know, but I'll start with what a PBM is - we are a company that contracts with plan sponsors, insurers, labor unions, that remit programs, etc. They hire us, we're a vendor that performs a variety of services to ensure for the cost effective and efficient delivery of prescription drugs to consumers. There are a number of PBM's in the marketplace today, over 66 in the US and they vary in size and footprint, and offering, and expertise in the market. We negotiate manufacturer rebates and that is one of the

key components of the way we keep drug costs low when it comes to manufacturers. And at this time, there's not an alternative to that as far as the manufacturers set the drug price and we negotiate those rebates in order to keep that price low. And that is going to be I think a part of this conversation as we go forward.

The speakers have already talked about the program but I think it's important that we do understand that it was indeed started to stretch those federal resources and the two speakers before me have already said that. And PhRMA has to participate in that if they are going to actually participate in the Medicaid program and there's a couple of important terms that we're going to be using over and over again and I think as you all go forward with this conversation it's important that we really focus on those two terms which is covered entity and contract pharmacy. I think we'll be using those terms a lot as we continue with this conversation. The covered entity is as the two speakers before mentioned it is a nonprofit hospital or the community health programs or the Ryan White clinics. But the contracted pharmacies are ones that you're also going to be talking a lot about. Covered entities actually contract with pharmacies in your community. And the next slide that I'm going to show you begins to see how complex it gets and anything in healthcare, as you all know, gets very complicated.

And as we continue this conversation and we walk down this road together, I think we're going to see that there's a lot of complexities here and I think it's really great that you're asking experts to come and talk to you about this because it really does start to get complex. And as I started to try to understand this, I realized in my own community in Kentucky, I live in a small community of about 35,000 and the total in our county is about 50,000. Our hospital is owned by a larger hospital system from southern Indiana and it is a program entity. It has 11 hospitals in their system, they cover three states and they have over 500 doctors in their system. In our community, they have probably 20 doctors in their system.

When we talk about a covered entity, our hospital is a program hospital. To be a program prescription, it just has to be written by that covered entity. So, all of a sudden my community, most of the prescriptions written in our community is written by that program entity. So, it becomes very complex in our community and it becomes a very big conversation. So, I really appreciate the fact that you all are taking on this conversation. When we talk about the contracted pharmacies, I looked it up last night and I had no idea the Walmart, the two Walgreens, the Rite Aid and the two largest independent pharmacies are all contracted pharmacies in our community. So, therefore, most of the prescriptions in our community are probably written by the covered entity. And most of the prescriptions are filled at one of those contracted pharmacies. So, it's a pretty big conversation in just my little community so I think we really look forward to this conversation and look forward to being a part of this conversation and we really appreciate this opportunity. As I said at the beginning, I'll end where I started. PCMA supports the original goal of the program as it is a safety net for the vulnerable and uninsured. PCMA is neutral on legislative proposals on the program except in the instances where it erodes the PBM tools to help protect our commercial clients. And any changes to the program are probably going to have to be a discussion at the federal government level but we appreciate the opportunity to be part of this conversation.

Rep. Tom Oliverson, M.D. (TX) stated that he really appreciates this timely conversation and this has sort of got on my radar screen recently as well. One of the things I wanted to hear from each of you or whoever wants to comment on this is there seems to be

some data out there and some studies now that seem to indicate that there's enhanced profitability for not for profit hospitals that are operating in the program compared to those not in the program and there's allegations that there are prescriptions being filled simultaneously under both Medicaid and the program, which is sort of double dipping and it is my understanding is not lawful to do. And at the same time, some of these facilities actually provide less charity care then non contracted program entities, so as we look to these things, as we look at this program, I know obviously this is a safety net program and this is not a program designed to make people money or make people profitable. This is designed to help the most in need. I'm a huge advocate for FQHCs and I think they do yeoman's work in my community and in medically underserved communities across the state of Texas. Many of our rural areas, which are hard to get healthcare resources to are covered by FQHCs but it concerns me when I read things about enhanced profitability for not for profit entities and the possibility that these programs are being abused. So, I was wondering if you all could comment on that.

Ms. Testoni stated that I'm happy to at least start since I'm representing 340(b) hospitals. So, you raised a number of important points. Let me just start by saying my organization and others outside of my organization have done a lot of research on this issue of what is going on with the program in hospitals. And I think the focus has been on the hospitals because they are the biggest users of the program. They have the most patients, they do the most expensive services such as cancer treatment and lots of things like that. So, we have a lot of research now to be able to show exactly what is going on with the program.

On the issue of profitability, we find that program hospitals have lower profit margins than non program hospitals across the board. So, we compare big hospitals to big hospitals, small hospitals to small hospitals and across the board we see they have lower profit margins. For small rural hospitals, like critical access hospitals, a lot of them will say they are what helps us keep the doors open. So, from the perspective of how the program works, it is a situation where you pay less for the drug and you get paid like the regular price, as if you didn't get that discount and so that does go towards helping to fund your services. So, it's just critical, especially for those rural hospitals, as it does help them keep their doors open, there's no question. In terms of double dipping, that is something that is not permitted under federal law and we don't see a lot of it under fee for service Medicaid because the federal government has set up some rules for how to prevent that that providers have to follow. That doesn't apply for Medicaid Managed Care as that's a situation where the states are not allowed to get rebates if a drug has gone through the program. So, it's not so much that it's double dipping per se, but it's a situation where the manufacturer, if a drug is purchased by the program and the state seeks a rebate, then they're basically paying it twice. The hospital doesn't profit or get anything extra that way at all but the states are actually prohibited from engaging in that as they are not supposed to be getting those rebates.

And then third a comment that you made was about charity care. Charity care is one part of a bigger calculation in that a lot of what they use in the federal law is our compensated care, not just charity care since that's one piece. But even on charity care, it is very rare that you would find a hospital to have higher charity care generally than program hospitals. That's definitely not the norm. But then when you put in all of the other things, the uncompensated care which is, like underpayment by Medicaid, tremendous for hospitals that are providing 75% of the Medicaid care, there's just no

question that program hospitals again, across every category, when you compare big hospitals to big hospitals, small to small, in every category program hospitals are providing more of that type of care than the non program hospitals. And I would be thrilled if you were interested, to at least show you know some of the studies that we've done. We've paid for other people to do them independently outside of us and then others have done it just all on their own and published that as well.

Mr. Crandall stated that for FQHCs, we're very aggressive in making it clear to FQHCs that they essentially run a very tight ship with their 340(b) programs, especially on avoiding the duplicate discounts. It's not perfect but they very much understand that they have to be very tight on duplicate discounts because we are regulated very closely by the Health Resources and Services Administration.

Sen. Bob Hackett (OH) stated that in Ohio I'm probably known as the program legislator. I've fought for the FQHCs and I actually carried related legislation in Ohio. An issue which really surprises me is why the history of the program wasn't provided because when the program was originally started, it was the expansion in the hospitals by President Obama that really brought in all these additional hospitals. And then regarding the profit issue, there were really strict guidelines of how they can use the money. I was on a board of a hospital, and hospitals are primarily non profit and deal with non profits. So, they know how to work the system probably as good as anybody in the world so the issue of the expansion of the hospitals into the program has somewhat created the problem. The FQHCs and the veterans and other hospitals have been there from the beginning and they were the ones that we wanted to protect. So the issues that we deal with is the additional hospitals that came into the program and I'm not criticizing that, because during COVID they were the great players in Ohio. They worked with us and they did everything the state asked them and they were really good. And so, we have kind of protected the hospitals but that's an issue and it's not a state issue, it's a federal issue if that's going to get changed. But we have to protect our FQHCs.

Ms. Testoni thanked Sen. Hackett for his support of the program and stated that what happened under President Obama with the expansion of the program was it expanded to rural hospitals. So, those included rural referral centers, sole community hospitals and by far the biggest group were critical access hospitals which frankly about doubled the number of hospitals in the program. But according to HRSA, those hospitals are responsible for maybe 10% of the total program because they are so small. So, there's looking at the number of hospitals, then there's looking you know at other aspects of the program. And it is true that they did double the number of hospitals but they are really tiny hospitals that came into the program and they're in more isolated rural communities. So, it limits how much actual impact that they would be having on the program from that perspective.

There's definitely been allegations that the program has grown since it started in 1992, and there's no question that it has. In terms of the number of claims that go through the program, the number of claims for which manufacturers have to provide a discount is much bigger now than it was in 1992. A lot of that though I believe comes from the big shift that we've seen since 1992 from inpatient settings to outpatient settings. And I think that is one of the biggest things that we have seen. So, you know, chemotherapy in 1992 often was provided in the inpatient setting. And now, it's provided in the outpatient setting. And sometimes, it's not even provided at the hospital. There's now chemotherapy pills that people can pick up at their pharmacy and do in their own home.

So, we've seen a real shift in how care is provided. We've seen a lot of growth in outpatient drugs. That's where a lot of the big patents are going into outpatient drugs. And that is something that was not the case when the program was started, and then now there's been these changes. So, we are definitely seeing more claims go through but another part of the growth is the high price of prescription drugs. The program is built so that if a manufacturer increases it's drugs higher than inflation, there's a penalty. That increases the discount that manufacturers have to give. So, we're definitely seeing more in discounts. But a lot of that is because of manufacturers raising the prices. And there's been some research that shows that the program because of that inflationary penalty it's actually had an impact on keeping prices lower than they would otherwise be, even for non program drugs but obviously it's not enough to really keep the prices way down.

Sen. Hackett stated that we did the legislation in Ohio because the PBMs basically said, "Hey fine, don't use us for this one drug thing." But you must realize that PBMs, if you pull out some of the big players you're creating deserts in Ohio. The program is going to conflict at times with your formula of the way PBMs operate and that's what they did in Ohio - they backed out. They were going to come in and say, "Hey if you don't want to deal with us, don't deal, we'll pull this one drug company." I don't know if it was Walmart or Walgreens which one it was. But we needed that across the state because it would have created deserts so you have to realize when you look at FQHCs, you know they need to have outlets where their people need to be able to get the prescriptions filled and if you come in and say, "Hey it conflicts with our formula to protect our clients" you've got to realize you're going to kill the FQHCs. So, you have to work with the FQHCs and that's the way the federal law was there. So, that's why we did the legislation in Ohio. I didn't think we needed it. But then the PBMs came in and tried to fight us. And we just said, "Hey we're going to pass legislation to allow the PBM's to do it." So, you know I don't know how you want to comment on that but by nature you're going to have that conflict between your formula and how FQHCs operate cause they need those pharmacies to be able to have their people to go to them.

Asw. Hunter stated that there is going to be a more extensive conversation on this in March and if there are any comments, questions or concerns please send them to NCOIL staff and we'll make sure that the panel that we choose is reflective of the conversation that you all want to have.

CONSIDERATION OF NCOIL TELEMEDICINE AUTHORIZATION AND REIMBURSEMENT MODEL ACT (Model)

Asw. Hunter thanked everyone for their work and input on this Model. I'm proud to have sponsored this. We've worked on this for a lengthy period of time over the past year. I'm proud that the organization has been involved with such an important issue during an important time. Telemedicine certainly didn't start with the COVID-19 pandemic but I do think that it showed us all it definitely will be more frequently utilized in years to come.

If you would please in your binder take a look on page 41. I note that since our last meeting in July I've made a couple of changes to the Model, in the form of a new section six titled Network Adequacy and Limitation. If you recall, last meeting we had a conversation about network adequacy. Thanks to my colleague, Asm. Kevin Cahill (NY), NCOIL Treasurer, for pointing out the issue that needed to be addressed in the Model. The new language will state "an insurer shall not use telemedicine or telehealth to satisfy network adequacy requirements with regard to a healthcare service." And I'd like to

thank America's Health Insurance Plans (AHIP) for pointing out that the language could be interpreted as prohibiting insurers from using telemedicine or telehealth at all in meeting network adequacy requirements. But that certainly is not the intent and it's certainly not meant to be incomprehensible as AHIP contended in a letter forwarded to our office. Accordingly though, I agree with AHIP's suggestion to simply add the word "solely." So it will read, "an insurer shall not solely use telemedicine or telehealth to satisfy network adequacy requirements with regard to a healthcare service."

The other new language you see is also straightforward and also addresses an issue that I know the Vice Chair of this Committee, Rep. Deborah Ferguson (AR) feels strongly about. The language simply states that "an insurer shall not limit coverage only to services delivered by select third-party telemedicine or telehealth organizations." If a patient's existing doctor provides telemedicine services the patient should not be forced to use a totally different service with a one-time provider he or she has never seen before and will never see again. Last but certainly not least, I would be remiss if I did not again mention the issue of payment parity. As the sponsor of this Model and Chair of this Committee I am again stating that the Model does not require dollar for dollar payment parity. I understand that concerns have been raised, mainly by AHIP that the language should be changed to ease their concerns but I don't know much clearer I can be than saying the Model does not require payment parity. If a state adopting the Model wants to alter the language that is certainly okay and frankly encouraged as the NCOIL philosophy with model laws is that they should be adapted to meet states needs and marketplace realities. But as sponsor of the Model and Chair of the Committee I am comfortable with the language as is. With that said I know that AHIP would like to make a few final comments and then I will open it up for questions or comments from legislators before we move forward to vote on the Model.

Miranda Motter, Senior Vice President pf State Affairs at AHIP, thanked the Committee for the opportunity to speak and stated that I appreciate this Committee's work on telehealth. This Committee is certainly working to advance the strides that we have made during COVID. Asw. Hunter you talked about the strides that were made during COVID and I think health plans are now laser focused on how we can continue those strides and advancements and so I applaud you for that work.

Let me first say, we have talked to some of you about our concerns about the new section. And we certainly appreciate the intention in terms of the language to make sure that telehealth can be utilized and brought in as we think about telehealth moving forward. I also appreciate the comments relative to payment parity that we have had some concerns around that. We certainly appreciate the intent and the recognition that the language is not intended to require payment parity. I would say that to the extent that you are willing, but certainly understand the statements, any sort of clarification to that would also be appreciated. But in closing let me say again, we appreciate this Committee's work as telehealth is an incredibly important service. We know that it's been an incredibly important service during COVID and it will be moving forward as we look to make sure that it is clinically appropriate and provided to Americans as they need it.

Sen. Lana Theis (MI) stated that she appreciates the comments about reimbursement as well but the way that I'm reading this language implies to me financial parity. So, I do have a concern with that.

Ms. Motter stated that I think we have a difference of interpretation in terms of how those words on the page can be read. As many of you know, this issue has been debated in states all across the country even down to the detail of an exact word and exact comma. Our interpretation is that it could be interpreted to mean reimbursement parity but again, we want to recognize the multiple comments made in this Committee that the intent is not to require payment parity. As I said, as a result we would love to see the language with that intent done through a drafting note or done through a simple statement in the policy section. But again, I hear the intent that it is not intended to be payment parity but this issue is really being debated as we look forward to make sure that telehealth is being brought into the healthcare system in a way that is providing clinically appropriate care, that is providing affordable care and making sure that individuals that don't have access can continue to access those critically important services.

Asm. Cahill stated that I think our intention, if I'm not mistaken, is to encourage the development of telehealth and to make it available to the people we represent in our various states where it is appropriate to be used, but not to create a path towards substitution of telemedicine, telehealth for brick and mortar healthcare. My concern is twofold. First, to allay concerns about the issue of parity, parity is not the same as equality. Equality would mean if you pay a doctor $5 for a visit, you'd pay a doctor on telemedicine $5 for a visit, even if the nature of the visit was not necessarily qualitatively equal. Parity, in my understanding, is that all things being equal that the reimbursement would be also equal. But if all things are not equal then of course it shouldn't be.
I can envision many instances where telehealth could be more valuable than an in person visit. If you have the opportunity for example, to talk to the leading specialist in the country on a specific area, you may want to pay that specialist more than you would a community specialist who you know practices in just your own community. On the other hand, if we are using it as is often the case with the early COVID stuff, the preliminary to an actual visit, it might end up being just something that raises cost without raising quality.

So, I think it is a complex issue and one that needs to be delved into. I do want to specifically focus on section six and the proposed language change by AHIP to insert the word solely. All due respect, I think that's the camel's nose in the tent. I think that's the beginning of allowing health plans to substitute telehealth inappropriately where brick and mortar healthcare is what we prefer. I think it will have a dramatic negative effect on the development of networks, particularly in our rural areas as we go forward. And I would suggest a word other than solely. I think it was suggested informally that the word predominantly would perhaps better express the sentiment of this Committee and of this body than the word solely. Solely is a pretty low bar. If a health plan comes forward with a network that has one provider where it is more appropriate to have five in person providers and then also has a telehealth component that's not solely anymore. So, they've complied with that standard. I would ask for consideration of using a different word. Or leaving the section as it is written in our book.

Rep. Stephen Meskers (CT) stated that I think the intent of the bill in telemedicine and beginning of the regulation oversight is important. I think the question of parity and the question of equity are valuable questions. But I sit both on the finance committee in the state of Connecticut and in the insurance committee and I think the problem becomes either a state issue for the state employee plans and tax payer issue or a consumer issue as a purchaser of insurance policies. We sit here in the regulatory function at the state level with the ultimate goal of regulating the industry but also providing the industry

with the adequate tools to control costs for the delivery of services in the state. And some large part the problems are regulatory and at the federal level. When I looked at the chart from the PBM and I've been looking at charts for 35 years, I couldn't figure out which way the cash was flowing on that model and I always worry if I can't figure out the cash flow. Here it looks like, what we're trying to do is figure out how to allocate telemedicine. In the onset of the pandemic all of our business models were broken down in terms of remote work and telemedicine And I think we're at the beginning phase of figuring how to adequately use telemedicine as a component of our healthcare. I'd prefer to see a relatively generous interpretation to allow the industry to wrestle with our hospitals and our pharmaceutical companies to figure out how we deliver this service, and whether we can do it in an effective way. So, I appreciate the changes to the bill, I appreciate the work that the committee's done in drafting it. So, I'm a little confused about whether I want parity or equity but I'm looking for lower cost pricing, and if this helps us get there I'm in support.

Rep. Tammy Nuccio (CT) stated that looking at this from the perspective of cost in healthcare, I know I had a lot of encounters with constituents during the COVID period where doctors were requiring them to do a telehealth visit prior to coming into the office. Which then brings me to the case of inflating healthcare costs by doing a telehealth visit and then saying, "You know we can't really help you with that and now you need to come into the office." So, from the parity perspective I think we need to be cognizant of the fact that we're recognizing the differences in service between a telehealth call and in in patient brick and mortar payment scheme here to make sure that we're adequately covering it.

They are definitely services I think we can cover from a telehealth perspective that will help reduce the cost of healthcare but if it's simply being put in as an option, and reading this very quickly I didn't see a mention in here to double visits, or consumer protection to make sure that people aren't being directed to do a telehealth call and then have to go in and do a subsequent office visit. So, if there was some kind of way to say, if this does not generate an office visit within X amount of period of time, maybe you would change the coding at that point to a telehealth call to a brick and mortar but not having the ability to do both or double dip. I think we need to be cognizant that this is a new model and make sure that we are regulating how it's being used so we're not just seeing increases to healthcare cost across the board as a new way to bill.

Rep. Matt Lehman (IN), NCOIL President, stated that I hate to disagree with my fellow officer and good friend from New York, Asm. Cahill, but I do think not adding the word solely actually creates more problems and I think solely is not a low bar, I think it can be a high bar. Because coming from a rural area, I think if you could interpret this as a prohibition, then I get no telemedicine which I need in my rural areas. If we put solely in, it says you're going to give me some options with brick and mortar and telehealth. So, solely I think in this case is a high bar. I would support the Chair in saying that I think the change of this to solely does make this a better amendment.

Hearing no further comments or questions, Asw. Hunter stated that we are going to move forward with a motion to vote on the amendment and I just want to state again that a state adopting a model, if they want to alter the language it's certainly ok for them to do that. This is a model for you to take back to states and integrate into the fabric of your state's needs. Upon a Motion made by Rep. Ferguson and seconded by Rep. Lehman, the Committee voted by way of a voice vote to adopt the amendment introduced today.

Then, upon a Motion made by Rep. Lehman and seconded by Rep. Joe Fischer (KY), NCOIL Secretary, the Committee voted by way of a voice vote to adopt the model as amended.

CONSIDERATION OF NCOIL MODEL ACT REGARDING AIR AMBULANCE PATIENT PROTECTIONS (Model)

Asw. Hunter stated that we are moving forward to consideration of the air ambulance Model on page 46 in your binders. I'll start off by saying thank you to everyone that has worked on the model. Notably, Del. Steve Westfall (WV) is prime sponsor and Representatives Thaddeus Jones (IL), Deanna Frazier (KY) and Tom Oliverson, M.D are co-sponsors. This model, I must tell you has been one of the most contentious models I've worked as my time as Health Committee Chair. And I must say, things really escalated in these last couple of weeks. Prior to that, we were having a respectful exchange of ideas on an important issue of insurance public policy but that really changed when an email was sent out to certain members of this committee.

I know Del. Westfall will have further comments on this but I'll just say that I, as Chair, am disappointed in the behavior of the opponents of this model. NCOIL is a respected National Legislative Organization that is always willing to have open and frank discussions on insurance public policy issues. NCOIL is not the forum for sending inaccurate emails out to only a select group within a committee which encourages constituents to reach out to us based on false information they have been provided. So, I'd like to turn this over to Del. Westfall for a few words.

Del. Westfall stated that I'll start by noting that the changes to the model since our last meeting are largely intended to avoid any threat of federal preemption and uphold the state's right to regulate the business of insurance. The new purpose section illustrates that intent and makes clear that the model is intended to help preserve the longstanding jurisdiction that states have to regulate the business of insurance as expressly established by the McCarran-Ferguson Act and to affirm the ability of states to regulate the business of insurance without threat of federal obstruction. I note since the model was distributed in the 30-day materials that purpose section has been redrafted to make it stronger, and the language appears in a separate document before you.

Before closing, I would like to make a couple points on the email referred to by Asw. Hunter. In that email the opponent to this model states that the model would eliminate consumers' ability to obtain their air ambulance membership. This is totally false. Some states have indeed tried that approach i.e. banning the sale of air ambulance memberships. The model does not do that. Rather it clarifies such memberships as insurance products and provides the state insurance department the authority to regulate them to protect consumers in their states. The email also intentionally mislabeled the title of the model. The email referred to the model as the Air Ambulance Membership Plan Model Act. As you can see before you the title of the model is the Model Act Regarding Air Ambulance Patient Protections. It's certainly not a mistake that the opponents of the model decided to remove the words patient protections from the title and instead invent their own title.

Lastly, the email states that an alternative model has been offered that is consumer friendly rather than focusing on picking sides between competitors and that there has been no response to that alternative which is concerning. Again, this completely

misrepresents the model and the actions that have gone on over the past several months. A document with the names of the opponent lobbyists on it containing several suggestions and ideas for the model were sent to Asw. Hunter who then forwarded to NCOIL staff. NCOIL staff then reached out with some questions, but staff did not receive a response. That can hardly be characterized as either an alternative being offered or that there has been no response.

Rep. Jones thanked Asw. Hunter for the opportunity to speak and stated that when a similar bill came before us in Illinois it was nasty and contentious as well. And there were several issues that were raised one of which does the legislature have the authority to make sure that we can regulate this business and the products. And part of our contention in Illinois was that we do have the right to regulate this business and we wanted to make sure that we were at the forefront of this. The bill was HB 317 that passed the House but then got stalled. And part of what we said was that the legislation did nothing to prohibit the sale of air ambulance memberships as that was the key contention but it was also that it provides much needed help to consumers and that's what our sole obligation is to our consumers in Illinois and around states who want to address this issue. So, I feel that it's important that we not only address this but it's no surprise that this issue is contentious here because it is strongly contentious in Illinois and I'm looking forward to supporting it and looking forward to hearing concerns today about it.

Rep. Oliverson thanked Asw. Hunter and stated that he has profound appreciation for Del. Westfall for doing the yeoman's work on this and getting this going, as well as his fellow cosponsors. This is an important issue and I would have to say unfortunately I was not terribly surprised by the email. You may recall that we had an episode in Texas where a company was essentially fabricated and presented to our committee feigning outrage which ends up not being a legitimate registered to do business company in our state. So the whole thing was a essentially a ruse to destroy the work product that we were working on Texas. I have also been very dissatisfied and really unhappy with the way in which stakeholders have approached their opposition to this. Rather than work together towards a model which I think allows for consumer protections, which ultimately is the responsibility of every lawmaker sitting here, they seem to be more interested in just winning at all costs I guess and I just want to say I'm terribly frustrated.

So, I'm looking forward to passing the model and I believe that this will withstand legal scrutiny. I look forward to that and I think it's much needed. People should know what they're getting into and they should know that and perhaps they may or may not actually need a product like this and they should be informed about it. And I think that is our responsibility, so congratulations to Del. Westfall, and I look forward to seeing this become model policy and I appreciate everyone's strong efforts, including Asw. Hunter because I know this has been a contentious difficult issue to preside over and referee on and I appreciate your patience with all of us on this.

Asw. Hunter stated that we will next hear from The Honorable Nat Shapo, Partner at Katten Muchin Rosenmann, LLP and former Director of the Illinois Department of Insurance. At our last meeting in July the opponents of the model had hired Professor Dan Schwarcz of the University of Minnesota Law School to prepare a report laying out the reasons why they believe the model if adopted by states would be subject federal preemption. Dir. Shapo has been hired by the proponents of the model to respond to the conclusions Prof. Schwarcz made in his report and in his testimony to this committee at

our last meeting. A copy of Dir. Shapo's report was previously emailed to the committee by NCOIL staff and is also on the conference app and the NCOIL website.

Dir. Shapo thanked Asw. Hunter for the introduction and for her leadership on the committee on this and all other issues. And I also wanted to acknowledge Rep. Jones who is well known at home in Illinois for his commitment to strong and effective regulation and his remarks earlier I thought were quite consistent with that. I've been retained by Air Methods Corporation to review and offer my analysis of Prof. Schwarcz's prior presentation. His basic conclusion was, that it is virtually certain that federal courts will continue to conclude that the sale of air ambulance subscriptions does not constitute the business of insurance under the McCarran-Ferguson Act. I won't go into all the details of preemption and reverse preemption but that is the essential question before you - whether the regulated activity here is the business of insurance under McCarran.

I respectfully disagree with Professor Schwarcz's conclusions. He's an eminently credentialed professor and a thoughtful scholar but I do respectfully but strongly disagree with his conclusion of virtual certain preemption here. The hook for his report were the opinions in West Virginia and North Dakota. I -went through those and I've concluded those are highly distinguishable. They're much different substantively as North Dakota's was a ban and West Virginia's was essentially a delegation to the regulator and it didn't have the same kind of level of detail and substantive work that the model has. Also, it's clear and for instance in the West Virginia opinion that the court there had an issue with the fact that there had been prior litigation in the case and this was the next litigation. The court literally quoted the famous Yogi Berra quote, "It's déjà vu all over again." The core model would come to a court and probably receive a more kind of balanced review. I note in my report that you've had four extensive hearings over a year and there's twenty-something pages of minutes that demonstrate the substance behind this which I think complies nicely with the standard under Fabe that McCarran laws are protected when they possess the end intention or aim of adjusting, managing or controlling the business of insurance.

And getting to that standard, the Fabe case is a so-called first clause case in McCarran and the standard there is a state law would be reviewed under the standard that McCarran established of Congress' primary objective of granting the states broad regulatory authority over the business of insurance. There's kind of a skirmish as to whether or not the standard that I just quoted would be applicable here under the so-called first clause versus second clause. You can read about that in my report if you'd like but I think the language in the controlling Fabe opinion is clear that the broad language that I just quoted will be an overlay over any review of the state law.

The Pireno case has three factors and I address them in length and the most important factor is the first factor of whether the law regulates a practice that is effectively transferring or spreading policyholders risk. Even the language in Prof. Schwarcz's report is very clear that that's the case here. With the second and third factors under Pireno, I think something that was missed in the earlier report was that the review is of the "particular practice" that's being regulated. This model regulates the particular practice of the subscriptions, which Prof. Schwarcz's report itself concedes do transfer and spread risk.

The model is not regulating and not going behind the curtain and it's not getting into balance billing questions for instance. In the Pireno case, the issue was chiropractic peer

reviews that control costs. This case is not like that. This case only regulates the transferring of risk issue which is the subscriptions. So, the particular practice here under the second and third prongs is the subscriptions which transfer risk. The model does not get into controlling the costs on the other side and does not get into the health insurance questions. So, I believe under the second and third prongs you'd be protected. And therefore, I think as the guardians of McCarran, as the people who are responsible for meeting the broad standard in Fabe, Congress' overriding interest in protecting the states' ability to regulate the business of insurance, that if you feel this is a risk transfer practice that needs consumer protections than you'd be within your boundaries of pursuing it and you would not be irresponsibly passing something that's virtually certain to be preempted.

Christopher Hall, Program Director of Gov't Affairs and Industry Relations at PHI Health LLC, thanked the Committee for the opportunity to speak and stated that PHI is headquartered in Phoenix, Arizona and we've been providing air ambulance services through our lines of business which is PHI Air Medical and Air Evac Services. Air Evac Services has served the citizens of Arizona for over 50 years. We also offer PHI Cares membership service. Our membership has two aspects. It allows members of a community to take action to support the availability of air ambulance services in their community and it provides a means for consumers to pre-pay any patient cost sharing imposed on them by their insurance companies.

I'd like to speak first to the former aspect of our membership which is community support. I've not always worked for PHI Health. In my career I worked for a hospital based air ambulance service in Miami, Florida, for a private ground ambulance service in Oregon and as a transporting paramedic and firefighter for an all resources department in a municipal department in Oregon. However, my first job as a paramedic was for the oldest private non-profit air and ground ambulance service in our country, Mercy Flights Incorporated, in Southern Oregon. A little bit about Mercy - it started in 1949 which is coincidentally when PHI pioneered the use of helicopters in Southern Louisiana. Mercy began when an air traffic controller from Oregon witnessed the needless death of friends and family traveling to Portland, Oregon for Polio treatments. At the time the road system in Oregon was a patch work of pavement and dirt road requiring between six to eight hours depending on road conditions and weather to travel by what we consider a primitive ground ambulance from Medford to Portland. Many Polio patients died on that ride prompting the man to begin providing air ambulance service for safe transportation by air. Unfortunately, the man didn't own a plane, and he didn't have the means to buy one. He recognized the need but did not have the financial resources to address the need.

Asw. Hunter stated that I appreciate all of your commentary but we need to be able to let our colleagues ask some questions so is there anything specific to the model that you'd like to make a statement about?

Mr. Hall stated that I think what you're dealing with here is this has come down to a matter of two competing business models: membership versus non-membership. And this goes well beyond AMC versus GMR. There are membership services across this country in Ohio and Louisiana and in the pacific northwest that are there so that their citizens can help support the availability of the service being there. And they have the benefit of being able to pre-pay costs imposed on them by insurers. What you have now in front of you is what could not pass in the last two years based on its merits and has

now been turned into a battle of states rights. It doesn't need to be. The shared goal here is consumer protection and transparency. We can do that. That's something we can all rally behind and we can all support because that's what we want is informed consumers. Pitching this into a states battle breeds one contentious battle after another contentious battle after another contentious battle. And I would encourage this body to not adopt this model legislation in its current form but to focus on the consumer transparency and education that we all are seeking.

Hearing no further comments or questions, upon a Motion made by Asm. Cahill and seconded by Del. Westfall, the Committee voted by way of a voice vote to adopt the revised purpose section. Then, upon a Motion made by Asm. Cahill and seconded by Rep. Lehman, the Committee voted by way of a voice vote to adopt the Model as amended.

CONSIDERATION OF NCOIL ACCUMULATOR ADJUSTMENT PROGRAM MODEL ACT (Model)

Asw. Hunter stated that Model is on page 49 in your binders. Asw. Hunter thanked everyone who's worked on this model as it has clearly struck a chord since several states have recently introduced such legislation and several states I'm told have plans to do so next year. That's why I feel it's very important that we adopt this model so that states have an NCOIL model to look at when they consider their own bills. Before we go any further, I'd like to offer the prime sponsor of the model Sen. Jason Rapert, NCOIL Immediate Past President, the opportunity to say a few words.

Sen. Rapert thanked Asw. Hunter for all of her work on this and for allowing him to comment. Sen. Rapert stated that he is proud to sponsor this model law as it closely resembles a piece of legislation that I sponsored in Arkansas that was signed into law earlier this year. As noted by Asw. Hunter, this type of legislation has been enacted in several states the past couple of years. I'm hopeful that states looking to enact such laws during their upcoming legislative sessions can look to the NCOIL model for guidance. As a reminder and for those who may not have been present during past committee meetings, the issue that such legislation like this model deals with is that it seeks to prohibit accumulator adjustment programs which prevent copayment assistance that helps patients pay for high cost prescription drugs from counting towards their annual deductible or maximum out of pocket costs.

Accordingly, the model and the laws across the county simply state that no matter who is paying for these funds, whether it's pharmaceutical manufacturers, copay systems, even a go fund me page, or an aunt or an uncle, those funds and third party payment should be counting towards the patient's cost sharing requirements. What's great about this issue as I've noted before is that it truly is bipartisan. Both red states and blue states have enacted legislation on this issue and I'm thrilled that my colleagues and committee members from both sides of the aisle have joined me in sponsoring this model. I also want to acknowledge that obviously with my schedule being as it is there were some folks that had contacted me about amendments to this. I wanted to make sure that those amendments had an opportunity to be heard and so I deferred on those amendments on adding them directly to the model before today. But obviously, Asw. Hunter, you have been able to step up and offer those amendments.

And I appreciate the membership and also the staff for understanding that by my deferring I think it gave everybody a chance to make their case and get all of that heard as we've neared the end of this. And I'm proud of the fact that we're now approaching the end of this so as I leave with my comments for now before making a motion, I just want to say Asw. Hunter that I appreciate what you've done on this with the amendments that will get us closer to putting this to rest.

Asw. Hunter stated that as noted, I do have some proposed co-sponsor amendments to the model which have been distributed to everyone in a separate document. The amendments I believe make this model much stronger and even more consumer friendly and I'll briefly walk through them. First, section 2(I) is proposed to be deleted simply because I don't believe there was or is any evidence in the record to support that assertion. Next, several additions to section 4 have been made. The first deals with limiting accumulator adjustment programs to covered drugs that have no other lower cost alternative. This type of language appears in several state accumulator laws and I think it makes sense as the original language was very broad and could have been read as applying to third-party payments for all drugs, services or devices and used to bypass a formulary.

The second change, new section 4(B), requires that: a person that pays any amount on behalf of an enrollee for a covered prescription must notify the enrollee prior to the acceptance of the financial assistance of the total amount of assistance available and the duration for which it is available; and may not condition the assistance on enrollment in a specific health plan or type of health plan to the extent permitted under federal law. I believe this is a very consumer friendly amendment and makes sense as it simply requires more information about the assistance to be provided to the consumer and removes any unnecessary conditions for the assistance to apply. Lastly, new section 4(C) addresses the issue of those with health savings account (HSA's). This amendment simply ensures that the model would not disqualify an otherwise qualified state resident from funding an HSA to help manage her or his out of pocket medical costs. Several states have included this type of language in their accumulator laws.

Brendan Peppard, Regional Director of State Affairs at AHIP, thanked the Committee for the opportunity to speak and stated that it's nice to actually see all of you in person instead of as a box on Zoom. This is my first travel in about a year and a half and it's really nice to actually be here. I had a whole set of prepared comments but I think I'm going to skip them and just say thank you for all of the work that has been done on this. We still have concerns with the model as we don't think it's exactly what we would like to see but we do believe it has been made stronger. One point I will make on what we've been calling the fair and equitable amendment which was referenced as new section 4(B) - we believe that you incorporated two of the three points we had in there. We think that all three are very important and we would urge you to consider also including the provision that requires that any assistance be provided through the entire year. But other than that we really appreciate all the work that's gone into this.

Steven Schultz, Director of State Legislative Affairs at The Arthritis Foundation and Co-chair of the All Copays Count Coalition, stated that the Coalition has helped worked on these types of bills and has created model language around this. I want to just say thank you to the Chair, the Vice Chair, Sen. Rapert, and the co-sponsors of this Model for your continuous work on it. Also, thank you to the staff of NCOIL for your work on it. I think Sen. Rapert did a great job of outlining the issue and the amendments were covered in

detail. I think for the most part I just want to say thank you to the numerous members of this committee that have voted on this language across the states where it's been introduced in thirty plus states and enacted in twelve.

Like Asw. Hunter said, and Sen. Rapert said, it's likely to be introduced in a vast majority of states next year. So, I acknowledge that NCOIL model language will only assist in guiding legislators as they prepare for that. Also, I would like to thank Del. Westfall who has helped enact this legislation in WV. As for the amendments, two of them are pretty straightforward and solving issues that have come up throughout this process. And that would be the amendment around the generic equivalent which is something that I often call the Arizona language and is a very common sense kind of way to meet in the middle on the issue. And the second one is the HSA amendment which we hope solves this issue for the states that hopefully have enacted this already and move forward to enact this that would cover it and ease concerns from Departments of Insurance across the country and any legislators that might have concerns about the language. The third amendment that AHIP just acknowledged, the one thing I'll say about it is that, in the thirty plus states that we've seen this introduced, that amendment hasn't been included in any of them. So, there's just concerns about the fact that this hasn't been introduced and had that day in the hearing rooms to discuss and work through it throughout the process in the states. And so, we're talking about model language that would be something that I would just acknowledge some concerns about. But the other two are pretty straightforward and agreed upon absolutely.

Kevin McKechnie of the American Bankers Association (ABA) HSA Council, thanked the Committee for the opportunity to speak and for the chance to explain ourselves in Boston and for the work that went on between then and now. And thank you to the sponsor for working so closely with our team. And thank you to NCOIL staff for doing the best you could. In the interest of time, I'll stop and just say I'm here to answer any questions you might have and I think we can move forward.

Rep. Lehman stated that I'm going to voice one concern on this entire process. Not relating to process - on the bill. And that is while I agree with Sen. Rapert that we're allowing all these entities to provide towards that deductible, we're now introducing an entity that controls the cost of those drugs. And I think that to me begins this process of okay, so if right now it costs $600 for a drug they're going to give me a $400 or $500 coupon - I pay $100 out of my deductible, out of my own pocket and the entity provides that $500. It now becomes a $600 credit. If that drug becomes a $1,500 credit, or drug and now a $1,400 credit, now I pay a $100 but now my deductible's been met to the tune of $1,500, not $600. So, my only concern moving forward is, we're introducing not grandma and grandpa helping out Junior with his deductible, but we're actually bringing into the formula the people who set the price of the drug. And I just think that opens up a potential for a long term discussion of that we kind of went down this path with the PBMs. We bring them in as the fixer of this problem and now they're part of the problem in a way. So, I just want to say cautionary that while I agree with conceptually in a way what we want to do is help people, I think it's a little bit concerning to me that we're now bringing in an entity that I have some concerns with being the payor or partial payor of the deductible.

Rep. Meskers stated that I want to echo those comments, and my concerns as I look at the bill, I'm glad we've addressed the issue relating to high deductible plans and the potential for the HSA impact on the IRS. I'm glad we're addressing that. I want to salute

the drafters of the bill, in terms of its intent, and I have the same concerns. The intent is to provide access to people to high cost drugs and provide them with a coupon that gets them there. In terms of their deductibles it provides the savings directly. But both drugs are part of the formulary and there's a perverse incentive on the coupon to pick the more expensive drug over the generic. And eventually, when the coupon disappears, it's going to end up in the baseline cost of our healthcare, and we're going to socialize the cost because the consumers are going to demand that it be included and push for a different formula on the deductible. So, I have the same concern that we're allowing the pharmaceutical companies to dictate the coupon policies that the consumer's going to receive in their mailbox and apply directly for their benefit. And we may be distorting a process and ultimately increasing our overall healthcare cost. But I'm not in opposition to the bill as it stands, I'll probably vote in support. But I think there may be a question of review as we move forward and to get testimony from the insurance companies about you know what's the percentage of uptake of non-generic drugs by couponing. And I think the suggestion of a twelve month cycle along with the formulary that the drug has covered raises the cost of the coupon to the pharmaceutical company, and maybe we can see some accuracy versus a bait and switch or pushing to force the insurance companies to cover it at a better rate, a very expensive drug.

Sen. Beverly Gossage (KS) stated that both comments that were just made were part of my comments, so I will just finish by saying I've been a health insurance agent for 19 years, my company is HSA Benefits Consulting as I helped pioneer HSAs, so I appreciate the addition and the amendment to clarify for HSA's.

Rep. Nuccio stated I too appreciate the amendments but do find value in the one that was left out regarding providing it for the full year. I think what we're going to see here is there is definitely a drive to go to these higher cost prescriptions. And then as Rep. Meskers said, people come to say, this is the prescription that works best for me, when I guess we need to determine our intent. Is our intent to handle the financial aspect of this or is the intent to drive down the cost of healthcare? Because, if we're driving down the cost of healthcare then we should be driving people towards the equivalent generics that cost significantly less and you don't need a coupon for.

The other part of this too is where my weariness comes in with the accumulator bills here is that we are kind of going around the bush on insurance in general. An insurance policy is provided by an employer to an employee, it's a contract to provide services. And part of that with a high deductible health plan is that the cost of the care is going to be split between the employer and the employee. A high deductible health plan is a cheaper premium plan than a lower deductible health plan because the assumption is that the employee's going to assume that risk. When we inflate what people are paying and apply coupons when they're not actually paying out of pocket, you are fulfilling that copay requirement quicker which means the employer has to start paying a higher portion of the expenses quicker, which means you're just inflating the cost of healthcare. Because as the employer pays out quicker their cost is going to increase and then the premium is going to go up. So, the snake is continuously eating its tail here. Either we're going to push people toward generics and lower cost of a product or we're going to continue to drive with PhRMA having high cost drugs and us finding ways to supplement it, which is then just going to increase the cost of healthcare. So, I guess my frustration is we're looking at legislation to help the consumer without addressing the underlying issue. So, I'm not quite sure where I stand on it just from an overall perspective but we

definitely need the language in here for the HSAs because we're seeing across the board if you're going to pass this you need to account for the IRS regulations.

Sen. Hackett stated that the only thing I can say is, the proponents always say it won't drive up the cost of healthcare, that's what they've said for everything that's been involved in healthcare for the last 40 years. And everything drives up the cost of healthcare. But I just want to thank Asw. Hunter as the amendment really helps the patients and it expands more to make more people eligible for the rebates. But I agree that we have to be really careful that we're not driving up the cost of healthcare.

Rep. Ferguson stated that I think the whole generic argument is a little moot because by the time a patient is offered a coupon the doctor has already decided what to prescribe, whether to prescribe a biologic or some drug instead of a generic. So, that's a little bit of a moot issue. But I do have a question for Mr. Schultz - you said you had some concerns about one of the amendments and reacting to the plans so can you sort of expand on that and explain to us your concerns with that amendment.

Mr. Schultz stated that I think that the biggest element of it has been that this is an amendment that really hasn't been in place in any state. Like I said, there's been thirty states that have introduced this language and none of them have added that language, even into a bill that didn't get passed. So, there hasn't been that opportunity for the insurers and patient groups to sit down in a state and kind of say, "Hey, what's going on right now?" And to talk about the elements of what happens when a patient does get on this assistance program, what information is disclosed to them, and sent to them by the manufacturer or the third-party. I think that's the biggest concern that I would have as far as I think the other amendments are ones that we've have seen in other states, whereas this one it may take a little bit more time and it may be worthwhile to have a little bit more discussion especially as we may see it in states moving forward so we have that opportunity to have those stakeholder meetings around that type of language. And I appreciate your comments around the generic equivalent. These types of assistance programs only come into play once the patient has been approved for the medication and the new language kind of solves the generic equivalent language because it really requires the patient having gone through any generic equivalent, being approved by the health plan to get on that higher cost maybe biologic before any cost sharing or assistance programs comes into play. So, I think that hopefully we'll ease some concerns of some folks.

Sen. Rapert stated that I appreciate all the comments and I will say that at this point it's interesting to me that we get to a point where all of the people that have been involved in the amendment process have stated their amendments. That doesn't mean we still can't have questions, and that's important to remember that. That's a part of the process. I do want to restate a couple of very important things about this issue. Number one, even in the minutes from the last meeting, this model deals with seeking to prohibit accumulator adjustment programs which prevent copayment assistance that help patients for high cost prescription drugs from counting towards their annual deductibles and maximum out of pocket costs. And as you all know, one of the great things about this organization is that we come from many different angles. I'm very well known for my conservatism. But it's a compassionate conservatism. And we've worked very, very hard here to make sure that we remember that we aren't just moving around bullet points and bits and pieces for the sake of argument. These are real people. And when I sit down, it's not often that I've been able to sit down and have the American Medical Association, The American

Cancer Society Action Network, The AIDS Institute, The National Hemophilia Foundation, The Cancer Support Community, the American Kidney Fund and so many others that have said, we need this legislation. And we heard that in Arkansas and some of you have done it in your other states. And what I would remind everybody on this, is that the people that were at the table that said that they had issues have now said that they have agreed. So, I would ask the body and the committee to move forward.

And the last comment is that you never know what a day would bring. I didn't know that just before this meeting that I would get a phone call from my wife, that my oldest daughter was headed to an emergency room back home. I've called to check on her, she's stable. But they're doing rounds of tests, they don't yet know what's wrong with her. And again, I don't want to over-dramatize it to make it an emotional vote. But I want to tell you that we've dealt with a lot of loss in this nation over the last few years. We've seen costs, we've seen stresses, but what I hope that we can remember as legislators is that yes this is policy that affects people. And when you have one of those couples at home who have a child with hemophilia that are paying tens of thousands of dollars, I am not going to withhold from them the opportunity for a coupon. Which by the way, the doctor doesn't seek someone in order to use a coupon. The doctor makes a diagnosis, prescribes what the doctor thinks is appropriate and then the coupon may or may not come into play.

So, I would ask this body today, to make a vote that helps the individual moms and dads that are out there as they take care of their families. And with that I would make a motion for adoption of all of your amendments as stated, Asw. Hunter. And then we can vote on the model itself.

Asm. Cahill seconded the Motion made by Sen. Rapert. The Committee then voted by way of a voice vote to adopt the amendments. Then, upon a Motion made by Sen. Rapert and seconded by Del. Westfall, the Committee voted by way of a voice vote to adopt the Model with the amendments.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Ferguson and seconded by Sen. Hackett, the Committee adjourned at 11:30 a.m.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

A Model Act Regarding Air Ambulance Insurance Claims

Adopted by the NCOIL Health, Long-Term Care & Health Retirement Issues Committee on October 13, 2017
Sponsor's Technical Amendments adopted by the NCOIL Health, Long Term Care & Health Retirement Issues Committee on November 18, 2017
Adopted by the NCOIL Executive Committee on November 19, 2017

To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on March 6, 2022.

Sponsored by Assemblyman Will Barclay (NY)

Section 1. Legislative findings, purpose and scope.

(A) The legislature finds that:

(1) Air ambulance services provide a necessary, and sometimes lifesaving, means of transporting medical patients in both emergency and non-emergency situations;
(2) Adequate access to air ambulance services is essential;
(3) In some cases, the difference between charges assessed by out-of-network air ambulance service providers and reimbursements by consumers' health plans have resulted in high balance bills to consumers; and
(4) The Federal Airline Deregulation Act ("ADA") preempts states from enacting any law related to a price, route, or service of an air carrier, which has been interpreted by some courts as applying to air ambulance service provider charges.

(B) The purpose of this legislation is to protect consumers who are covered by commercial insurance from overall disproportionate financial responsibility and liability for using out-of-network air ambulance services instead of in-network air ambulance services in an emergency situation, including balance bills from out-of-network air ambulance service providers in a manner that is not preempted by the Employee Retirement Income Security Act of 1974 ("ERISA") or the ADA.

(C) This legislation applies to all health plans licensed, operating or otherwise doing business in this state, and registered air ambulance service providers.

Section 2. Definitions.

(A) A "registered air ambulance service provider" is an air ambulance service provider licensed by the [insert appropriate state EMS agency] that has registered with the Department of Insurance to participate in the voluntary dispute resolution process established hereunder, as provided in Section 5(B).

(B) A "covered person" is an individual covered by a health plan licensed, operating or otherwise authorized to do business in this state.

(C) A "health plan" provides coverage for health benefits to residents of this state and is licensed, operating or otherwise authorized to do business in this state. "Health plan" includes health insurers as well as self-funded health benefit plans. "Health plan" does not include:

(1) Medicaid managed care programs operated under [Insert Applicable State Statute];
(2) Medicaid programs operated under [Insert Applicable State Statute];
(3) the state child health plan operated under [Insert Applicable State Statute];
(4) Medicare; or
(5) "excepted benefit" products as defined under 42 U.S.C. 300gg-91(c).

(D) "Balance bill" or "balance billing" refers to the difference between (i) the amount charged by an air ambulance service provider and (ii) any amount paid by a health plan plus the covered person's copayment, deductible or coinsurance amount applicable to a specific air ambulance transport.

(E) "Disputed air ambulance service provider charge" means the amount remaining after payment by a health plan of the amount set forth in Section 4.

Section 3. Network Adequacy; Medical Necessity.

(A) A health plan that does not have an adequate network of air ambulance service providers in this state may not use an allowed amount for air ambulance reimbursement that is less than the applicable average rates published by registered air ambulance service providers. The Department of Insurance will determine such average rates on an annual basis.

(B) For purposes of this [chapter], a patient transport shall be deemed to be medically necessary by health plans if (i) requested by a neutral third party licensed or certified medical professional or first responder and (ii) determined by that neutral third party licensed or certified medical professional or first responder to be conducted by an air ambulance service provider without regard to the patient's ability to pay.

Section 4. Hold harmless.

(A) If a covered person, after being picked up in the state, receives services from a

registered air ambulance service provider that is not part of the covered person's health plan's network, the health plan shall assume the covered person's responsibility for amounts charged by such registered air ambulance service provider other than any applicable copayments, coinsurance, and deductibles.

(B) A health plan that has assumed a covered person's responsibility as required pursuant to Section 4(A) shall notify the air ambulance service of that assumption no later than the date the health plan issues payment under Section 4(D).

(C) If a registered air ambulance service provider receives notice pursuant to Section 4(B), with the exception of amounts owed for applicable copayments, coinsurance, and deductibles, the registered air ambulance service may not:

(1) bill, collect, or attempt to collect from the covered person for the responsibility assumed under Section 4(A); or
(2) report to a consumer reporting agency that the covered person is delinquent for the amount assumed by the health plan under Section 4(A); or
(3) obtain a lien on the covered person's property in connection with the amount assumed by the health plan under Section 4(A); or
(4) take any other action adverse to the covered person with regard to the amount covered by the health plan pursuant to Section 4(A).

(D) (1) Subject to the provisions of the covered person's health plan contract, a health plan is responsible for payment directly to the air ambulance service provider or denial of a claim for air ambulance services within 30 days after receipt of a proof of loss. Within such timeframe, the health plan shall notify the covered person and the registered air ambulance service provider of the amount of deductible, coinsurance, or copayment that is the covered person's responsibility to pay.

(2) The health plan responsible under Section 4(A) shall make payment based on:

(a) the billed charges of the registered air ambulance service;
(b) another amount negotiated with the registered air ambulance service; or
(c) the maximum amount the health plan would pay to an in-network air ambulance service provider for the services performed, unless Section 3(A) is applicable, in which case the average amount as determined by the Department of Insurance.

(E) If after payment is made under Section 4(D)(2) the health plan or registered air ambulance service provider disputes the reasonableness of that payment, the health plan or registered air ambulance service provider shall invoke the independent dispute resolution process established hereunder, if good-faith settlement negotiations fail to resolve the dispute.

Section 5. Independent Dispute Resolution.

(A) A program of Independent Dispute Resolution ("IDR") for disputed air ambulance service charges shall be established and administered by the Department of Insurance

("DOI").

(1) The DOI shall promulgate rules, forms and procedures for the implementation and administration of the IDR program.

(2) The DOI may charge such fees as necessary to cover its costs of implementation and administration.

(3) The DOI shall maintain a list of qualified reviewers.

(B)Registration, Waiver and Reporting.

(1) (a) By January 1 of each year, air ambulance service providers wishing to participate in the IDR program established hereunder shall register with the DOI on such forms, in such manner and providing such information as required by the DOI.

(b) This registration shall automatically renew quarterly unless the registered air ambulance service provider gives notice to the DOI of its intent to not renew its registration not less than 30 days prior to the end of the quarter.

(c) All disputed charges incurred during the quarter of a registered air ambulance service provider's registration shall be subject to IDR.

(2) By registering, a registered air ambulance service provider acknowledges that, notwithstanding the ADA, it is voluntarily agreeing to participate in the IDR program as established hereunder, and such voluntary agreement constitutes a waiver of the air ambulance service provider's ability to challenge the IDR program based on the ADA with respect to disputed charges as provided in Section 5(B)(1)(c).

(3) As a further condition of participation in the IDR program, the registered air ambulance provider agrees (a) to publish the air ambulance transport rates charged by it in this state and(b) to provide de-identified, itemized billings for each of its transports in this state.

(4) The DOI shall keep and maintain records of each IDR proceeding.

(5) The DOI shall analyze the results of the IDR proceedings, as well as the information submitted pursuant to Section 5(B)(3) each year, and issue a report annually, the contents of which shall include, but not be limited to:

(a) the overall aggregate statistics of the IDR program for the year;

(b) the deidentified results of all disputes decided by each independent reviewer through the IDR program;

(c) the number of disputes settled between the parties;

(d) an analysis of financial and market trends of the air ambulance service provider claims; and,

(e) recommended changes to improve the IDR program

(6) The report shall be made public through, at minimum, posting on the website of the DOI.

(C) The sole issue to be considered and determined in a IDR proceeding is the reasonable charge for the air ambulance service provided. The basis for this determination shall include, but not be limited to, the overall fixed and variable cost for providing the air ambulance services including:

(1) Costs of maintaining aircraft, hangar and crew facilities;
(2) Compensation for pilots and flight crew (taking into consideration training and qualifications);
(3) Overhead;
(4) Insurance;
(5) Fuel;
(6) Costs attributable to any medical services provided in-flight;
(7) Costs associated with 24/7/365 readiness;
(8) The cost of uncompensated care and undercompensated care; and
(9) A reasonable profit.

Section 6. Independent Dispute Resolution Procedures.

(A) Either the registered air ambulance service provider or the health plan may request adjudication of a disputed charge by submitting a request for IDR on such forms or in such manner as prescribed by the DOI, and shall include the amount in dispute and a brief description of the service provided. The requesting party shall copy the other party on its submission to the DOI.

(B) The insurance commissioner shall establish an application process and fee schedule for independent reviewers.

(C) If the parties have not designated an independent reviewer by mutual agreement within 30 days of the request for IDR, the insurance commissioner shall select an independent reviewer from its list of qualified reviewers.

(D) To be eligible to serve as an independent reviewer, an individual must be knowledgeable and experienced in applicable principles of contract and insurance law and the healthcare industry generally.

(1) In approving an individual as an independent reviewer, the insurance commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an independent dispute resolution procedure. A conflict of interest includes but is not limited to current or recent ownership or employment of either the individual or a close family member in a health plan, a health care provider, or an air ambulance service provider that may be involved in an independent dispute resolution procedure.
(2) The insurance commissioner shall immediately terminate the approval of an independent reviewer who no longer meets the requirements to serve as an independent reviewer.

(E) Either party to a IDR proceeding may request an oral hearing.

(1) If no oral hearing is requested, the independent reviewer shall set a date for the submission of all information to be considered by the independent reviewer.
(2) Each party to the IDR shall submit a "binding award amount"; the independent reviewer must choose one party's or the other's "binding award

amount" based on which amount the independent reviewer determines to be closest to the reasonable charge for air ambulance services provided in accordance with Section 5(C), with no deviation.

(3) If an oral hearing is requested, the independent reviewer may make procedural rulings.

(4) There shall be no discovery in IDR proceedings.

(5) The independent reviewer shall issue his or her written decision within ten (10) days of submission or hearing.

(F) Unless otherwise agreed by the parties, each party shall:

(1) Bear its own attorney fees and costs, and

(2) Equally bear all fees and costs of the independent reviewer.

(G) The decision of the independent reviewer is final and shall be binding on the parties. The prevailing party may seek enforcement of the independent reviewer's decision in any court of competent jurisdiction.

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National Council of Insurance Legislators (NCOIL)

OUT-OF-NETWORK BALANCE BILLING TRANSPARENCY MODEL ACT

Adopted by the Health, Long Term Care, and Health Retirement Issues Committee on November 18, 2017 and by the NCOIL Executive Committee on November 19, 2017
Sponsored by Sen. James Seward (NY)

****To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on March 6, 2022.***

Section 1. Title

This Act shall be known as the Out-of-Network Balance Billing Transparency Act.

Section 2. Purpose

The purpose of this Act is to protect consumers from unexpected medical bills that result from their receiving care from out-of-network providers. Improved disclosures by health benefit plans, providers, and facilities, and a procedure for appealing out-of-network referral denials will help consumers better navigate the insurance processes and reduce the incidence of costly, surprise bills.

Section 3. Applicability

A. Except as provided in subsection B, this Act applies to any health benefit plan, provider, and health care facility as defined in Section 4.

B. This Act does not apply to:
1. Medicaid managed care programs operated under [Insert Applicable State Statute];
2. Medicaid programs operated under [Insert Applicable State Statute];
3. the state child health plan operated under [Insert Applicable State Statute];
4. Medicare; or
5. “excepted benefit” products as defined under 42 U.S.C. 300gg-91(c).

Section 4. Definitions

A. "Balance billing" means the practice by a provider, who does not participate in an

enrollee's health benefit plan network, of charging the enrollee the difference between the provider's fee and the sum of what the enrollee's health benefit plan pays and what the enrollee is required to pay in applicable deductibles, co-payments, coinsurance or other cost-sharing amounts required by the health benefit plan.

B. "Carrier" or "health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services. Carriers include a health insurance company, HMO, a hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

C. "Emergency services" includes any health care service provided in a health care facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

1. placing the patient's health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

D. "Enrollee" means an individual who is eligible to receive medical care through a health benefit plan.

E. "Facility-based provider" means an individual or group of health care providers:

1. to whom the health care facility has granted clinical privileges; and
2. who provides services to patients treated at the health care facility under those clinical privileges.

F. "Health benefit plan" means a policy, contract, certificate or agreement entered into, offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of [physical, mental, and/or behavioral] health care services.

G. "Health care facility" means a hospital, emergency clinic, outpatient clinic, birthing center, ambulatory surgical center, or other facility providing medical care, and which is licensed by [Insert appropriate state agency].

Drafting Note*: States may wish to consider including a specific number of beds that a "health care facility" must have to be included within this definition in order to account for varying geographical settings*

H. "Network" means the providers and health care facilities who have contracted to provide health care services to the enrollees of a health benefit plan. This includes a network operated by or that contracts with a health maintenance organization, a preferred

provider organization, or another entity (including an insurance company) that issues a health benefit plan.
I. “Network plan” means a health benefit plan that uses a network to provide services to enrollees.

J. “Out-of-network facility” means a health care facility that has not contracted with a carrier to provide services to enrollees of a health benefit plan.

K. “Out-of-network provider” means a health care provider who has not contracted with a carrier to provide services to enrollees of a health benefit plan.

L. “Out-of-network referral denial" means a denial by a health benefit plan of a request for an authorization or referral to an out-of-network provider on the basis that the health benefit plan has an in-network provider with appropriate training and experience to meet the particular health care needs of the enrollee and who is able to provide the requested health service.

M. “Provider” means an individual who is licensed to provide and provides medical care.

N. “Usual, customary, and reasonable (UCR) rate” shall mean the eightieth percentile of all charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported in a benchmarking database maintained by a nonprofit organization specified by the commissioner. The nonprofit organization shall not be financially affiliated with an insurance carrier.

Section 5. Determination of Network Adequacy

A. A health benefit plan that contracts with a network of health care providers shall ensure that the network is adequate to meet the health needs of insureds and provide an appropriate choice of providers at each in-network health care facility sufficient to render the services covered by the health benefit plan.

B. The commissioner of [insert applicable state agency] shall review the network of health care providers for adequacy at the time of the commissioner’s initial approval of a health insurance policy or contract; at least every three years thereafter; and upon application for expansion of any service area associated with the policy or contract.

C. To the extent that the network has been determined by the commissioner to meet the standards set forth in [insert applicable section law], such network shall be deemed adequate by the commissioner.

D. Nothing in this subsection shall limit the commissioner’s authority to establish minimum standards for the form, content, and sale of health benefit plans, to require additional coverage options for out-of-network services, or to provide for standardization and simplification of coverage.

Section 6 Coverage Option Mandate

A. A carrier that issues a comprehensive group health benefit plan that covers services provided by out-of-network providers shall make available and, if requested by the policyholder or contract holder, provide at least one option for coverage for at least eighty percent of the UCR rate of each service provided by an out-of-network provider after imposition of a deductible or any permissible benefit maximum.

B. If there is no coverage available pursuant to subparagraph (A) of this section in a rating region, then the commissioner may require a carrier issuing a comprehensive group health benefit plan in the rating region, to make available and, if requested by the policyholder or contract holder, provide at least one option for coverage of eighty percent of the UCR rate of each service provided by an out-of-network provider after imposition of any permissible deductible or benefit maximum. The commissioner may, after considering the public interest, permit a carrier to satisfy the requirements of this paragraph on behalf of another carrier, corporation, or health maintenance organization within the same holding company system. The commissioner may, upon written request, waive the requirement for coverage of services provided by out-of-network providers to be made available pursuant to this subsection if the commissioner determines that it would pose an undue hardship upon a carrier.

C. This section shall not apply to emergency care services in health care facilities or prehospital emergency medical services as defined by [insert applicable section of state law].

D. Nothing in this subsection shall limit the commissioner's authority to establish minimum standards for the form, content, and sale of health benefit plans and subscriber contracts, to require additional coverage options for services provided by out-of-network providers, or to provide for standardization and simplification of coverage.

Section 7. Emergency Services Provided by Out-of-Network Provider

When an enrollee in a health benefit plan that covers emergency services receives the services from an out-of-network provider, the health benefit plan shall ensure that the enrollee shall incur no greater out-of-pocket costs for the emergency services than the enrollee would have incurred with an in-network provider.

Section 8. Health Benefit Plan Notice to Enrollees

A. Where applicable, and through its website, a health benefit plan must give to an enrollee:

1. notice
    a. that the enrollee may obtain a referral or preauthorization for services from an out-of-network provider when the health benefit plan does not have in its network a provider who is geographically accessible to the

enrollee and has the appropriate training and experience to meet the particular health care needs of the enrollee; and
b. the procedure for requesting and obtaining such referral or preauthorization;

2. notice
a. that the enrollee with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and
b. the procedure for requesting and obtaining such a standing referral;

3. notice
a. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request a specialist responsible for providing or coordinating
the enrollee's medical care; and
b. the procedure for requesting and obtaining such a specialist;

4. notice
a. that the enrollee with a life-threatening condition or disease, or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time may request access to a specialty care center; and
b. the procedure for requesting and obtaining such access may be obtained;

5. notice that an enrollee shall have direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such annual examinations, and treatment of acute gynecologic conditions, from a qualified provider of such services of her choice from within the plan or for any care related to a pregnancy.

6. a listing of providers in the health plan network, pursuant to Section 14.

7. with respect to out-of-network coverage:
a. a clear description of the methodology used by the carrier to determine reimbursement for out-of-network health care services;
b. a description of the amount that the carrier will reimburse under the methodology for out-of-network health care services set forth as a percentage of the UCR rate for out-of-network health care services; and
c. examples of anticipated out-of-pocket costs for frequently billed out-of-network health care services; and
d. information that reasonably permits an enrollee to estimate the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the

health benefit plan will reimburse for out-of-network health care services and the UCR rate for out-of-network health care services

B. Upon request of an enrollee and no later than 48 hours after the enrollee has been pre-certified to receive non-emergency services at a facility, a health benefit plan shall provide by electronic or written correspondence, information on:

1. whether the enrollee's provider is a participating provider in the health benefit plan network;
2. whether proposed non-emergency medical care is covered by the health benefit plan;
3. what the insured's personal responsibility will be for payment of applicable copayment or deductible amounts; and
4. if applicable, coinsurance amounts owed based on the provider's contracted rate for in-network services or the insurer's UCR rate for out-of-network services.

Section 9. Provider Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

B. Verbally at the time an appointment is scheduled and in writing or through a website prior to providing services, a health care provider or the provider's representative shall disclose to the enrollee in writing or through an internet website, the health benefit plans in which the provider participates and the hospitals with which the provider is affiliated.

C. If a provider does not participate in the enrollee's health benefit plan network, the provider shall:

1. prior to providing services, inform the enrollee that the amount or estimated amount the provider will bill the enrollee for health care services is available upon request; and

2. Upon request, provide the enrollee with a written amount or estimated amount the provider anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.

3. Nothing in subsection (C) shall apply to emergent or unforeseen conditions or circumstances discovered during a procedure.

D. When services rendered in a provider's office require referral to, or coordination with, an anesthesiologist, laboratory, pathologist, radiologist, and/or assistant surgeon, the provider or provider's representative initiating the referral or coordination shall give to the enrollee, the following information in writing about the aforementioned who will be providing services to the enrollee: (1) name, practice name, mailing address, telephone number, and (2) how to determine in which health benefit plan networks each

participates. The information shall be provided to the enrollee at the time of the referral or commencement of the coordination of services.

E. At the time a provider or the provider's representative is scheduling an enrollee to receive services at a health care facility, that provider or provider's representative shall give to the enrollee, the following information in writing about any anesthesiologist, laboratory, pathologist, radiologist and/or assistant surgeon who will also be providing services to the enrollee: (1) name, practice name, mailing address, telephone number, and (2) how to determine in which health benefit plan networks each participates.

Section 10. Health Care Facility Notice to Enrollees

A. This section applies to the provision of non-emergency services only.

B. A health care facility shall establish, update and make public through posting on its website, to the extent required by federal guidelines, a list of the facility's standard charges for items and services provided by the facility, including for diagnosis-related groups established under section 1886(d)(4) of the federal Social Security Act.

C. A health care facility shall post on its website:

1. the networks in which the health care facility is a participating provider;

2. a statement that:

    a. provider services provided in the health care facility are not included in the facility's charges;

    b. providers who provide services in the facility may or may not participate with the same health benefit plans as the facility;

    c. if an enrollee in a health benefit plan receives services in the facility that is in that health benefit plan's network, but receives those services from a provider who is not in that network, the enrollee may be billed for the amount between what the provider charges and what the enrollee's health benefit plan pays that provider, including any co-pays, co-insurance, and/or deductibles that are the enrollee's responsibility; and

    d. the enrollee should check with the provider arranging for the enrollee to receive services in the facility to determine whether that provider participates in the enrollee's health benefit plans network.

3. as applicable, the name, mailing address and telephone number of the facility-based providers and facility-based provider groups that the facility has employed or contracted with to provide services including anesthesiology, pathology, and/or radiology, and

instructions about how to determine in which health benefit plan networks each participates.

D. In registration or admission materials provided in advance of non-emergency services, a health care facility shall:

1. advise the enrollee to check with the provider arranging for the services to determine the name, practice name, mailing address and telephone number of any other provider who is reasonably anticipated to be providing services to the enrollee while in the health care facility, including but not limited to providers employed by or contracting with the health care facility; and

2. inform the enrollee about how to timely determine in which health benefit plan networks the providers referenced in Section 10 C 3 participate.

E. Upon request, a facility shall provide the enrollee with a written amount or estimated amount that the facility anticipates billing the enrollee for planned services absent unforeseen medical circumstances that might arise when the services are provided.

Section 11. Independent Dispute Resolution

(A) A program of Independent Dispute Resolution ("IDR") for disputed out-of-network charges, including balanced bills, shall be established and administered by the Department of Insurance ("DOI").

(1) The DOI shall promulgate rules, forms and procedures for the implementation and administration of the IDR program.

(2) The DOI may charge the parties participating in the IDR program such fees as necessary to cover its costs of implementation and administration.

(3) The DOI shall maintain a list of qualified reviewers.

(B) The sole issue to be considered and determined in a IDR proceeding is the reasonable charge for the medical services provided to the individual. The basis for this determination shall include, but not be limited to:

(1) whether there is a gross disparity between the fee charged by the health care facility or provider for services rendered as compared to:

(a) fees paid to the involved health care facility or provider for the same services rendered by the health care facility or provider to other patients in health care plans in which the health care facility or provider is not participating, and

(b) in the case of a dispute involving a health care plan, fees paid by the health care plan to reimburse similarly qualified providers for the same services in the same region who are not participating with the health care plan;

(2) the level of training, education and experience of the provider;

(3) the health care facility or provider's s usual charge for comparable services with regard to patients in health care plans in which the health care facility or provider is not participating;

(4) the circumstances and complexity of the particular case, including time and place of the service;

(5) individual patient characteristics; and

(6) the usual, customary and reasonable rate of the service.

Section 12. Independent Dispute Resolution Procedures.

(A) A health carrier or nonparticipating provider may initiate an independent dispute resolution process to determine reimbursement for health care services provided by a nonparticipating provider. Failure to respond within fifteen days to the initiation of the independent dispute resolution process constitute acceptance of the initiating party's submission.

(B) The insurance commissioner shall establish an application process and fee schedule for independent reviewers.

(C) If the parties have not designated an independent reviewer by mutual agreement within 30 days of the request for IDR, the insurance commissioner shall select an independent reviewer from its list of qualified reviewers.

(D)To be eligible to serve as an independent reviewer, an individual must be knowledgeable and experienced in applicable principles of contract and insurance law and the healthcare industry generally.

(1) In approving an individual as an independent reviewer, the insurance commissioner shall ensure that the individual does not have a conflict of interest that would adversely impact the individual's independence and impartiality in rendering a decision in an independent dispute resolution procedure. A conflict of interest includes but is not limited to current or recent ownership or employment of either the individual or a close family member in a health plan, or a health care provider that may be involved in an independent dispute resolution procedure.

(2) The insurance commissioner shall immediately terminate the approval of an independent reviewer who no longer meets the requirements to serve as an independent reviewer.

(E) Either party to a IDR proceeding may request an oral hearing.

(1) If no oral hearing is requested, the independent reviewer shall set a date for the submission of all information to be considered by the independent reviewer.

(2) Each party to the IDR shall submit a "binding award amount"; the independent reviewer must choose one party's or the other's "binding award amount" based on which amount the independent reviewer determines to be closest to the reasonable charge for services provided in accordance with Section 11(B), with no deviation.

(3) If an oral hearing is requested, the independent reviewer may make procedural rulings.

(4) There shall be no discovery in IDR proceedings.

(5) The independent reviewer shall issue his or her written decision within ten (10) days of submission or hearing.

(F) Unless otherwise agreed by the parties, each party shall:

(1) Bear its own attorney fees and costs, and

(2) Equally bear all fees and costs of the independent reviewer.

(G)The decision of the independent reviewer is final and shall be binding on the parties. The prevailing party may seek enforcement of the independent reviewer's decision in any court of competent jurisdiction.

Section 13. Balance Billing

A. If an out-of-network provider bills an enrollee for non-emergency medical care, requesting payment on the balance of the provider's charge that is not related to copays, coinsurance payments, or deductible payments and is not covered by the health benefits plan, the billing statement from that provider must contain:

1. an itemized listing of the non-emergency medical care provided along with the dates the services and supplies were provided;

2. a conspicuous, plain-language explanation that:

a. the provider is not within the health plan network; and

b. the health benefit plan has paid a rate, as determined by the health benefit plan, which is below the facility-based provider's billed amount;

3. a telephone number to call to discuss the statement, provide an explanation of any acronyms, abbreviations, and numbers used on the statement, or discuss any payment issues;

4. a statement that the enrollee may call to discuss alternative payment arrangements;

5. a notice that:

a. the enrollee may file complaints with the [Insert State Medical Board] and includes the [Insert State Medical Board] mailing address and complaint telephone number; and

b. the enrollee may initiate an IDR proceeding to dispute the billing statement in the same manner as a health carrier or non-participating provider pursuant to Section 12. The notice shall include the contact information at the DOI for such initiation, including the mailing address and telephone number.

6. a notice that if an enrollee owes more than $200 to the provider (over any applicable co-payments, co-insurance, or deductibles and insurance payments) and the enrollee agrees to a payment plan

a. the provider will not furnish adverse information to a consumer reporting agency if the enrollee substantially complies with the terms of the payment plan (1) within six months of having received the medical services or (2) within 30 days of receiving the first billing statement that reflects all insurance payments and the final amount owed by the enrollee; and

b. a patient may be considered by the provider to be out of substantial compliance with the payment plan agreement if payments in compliance with the agreement have not been made for a period of 45 days.

Section 14. Out-of-Network Referral Denials

A. An out-of-network referral denial under this subsection does not constitute an adverse determination.

B. The notice of an out-of-network referral denial provided to an enrollee shall include information regarding how the enrollee can appeal the denial, including but not limited to what information must be submitted with the appeal.

C. Appeals

1. An enrollee or enrollee's designee may appeal an out-of-network referral denial by submitting a written statement from the enrollee's attending physician, who must be a licensed, board certified or board eligible physician qualified to practice in the specialty appropriate to treat the enrollee for the health service sought, provided that:

a. the in-network provider or providers recommended by the health benefit plan do not have the appropriate training and experience to meet the particular health care needs of the enrollee for the health service; and

b. the attending physician recommends an out-of-network provider with the appropriate training and experience to meet the particular health care needs of the enrollee, and who is able to provide the requested health service.

2. If an out-of-network referral denial has been upheld by the health benefit plan's internal appeals process and the enrollee wishes to pursue an external appeal, the external appeal agent shall

a. review the utilization review agent's health benefit plan's final adverse determination; and

b. make a determination as to whether the out-of-network referral shall be covered by the health benefit plan, provided that such determination shall:

i. be conducted only by one or a greater odd number of clinical peer reviewers;

ii. based upon review of the (1) training and experience of the in-network health care provider or providers proposed by the plan, (2) the training and experience of the requested out-of-network provider, (3) the clinical standards of the plan, (4) the information provided concerning the insured, (5) the attending physician's recommendation, (6) the insured's medical record, and (7) any other pertinent information; and

iii. be subject to the terms and conditions generally applicable to benefits under the evidence of coverage under the health care plan;

iv. be binding on the plan and the insured; and

v. be admissible in any court proceeding.

c. Upon reaching its decision, the external appeals agent shall submit to the enrollee and the health benefit plan, a written statement that:

i. the out-of-network referral shall be covered by the health care plan either when the reviewer or a majority of the panel of reviewers determines that (1) the health plan does not have a provider with the appropriate training and experience to meet the particular health care needs of an insured who is able to provide the requested health service, and (2) that the out-of-network

provider has the appropriate training and experience to meet the particular health care needs of an insured, is able to provide the requested health service and is likely to produce a more clinically beneficial outcome. or

ii. the external appeal agent is upholding the health plan's denial of coverage.

Section 15. Prior Authorization

A. A health benefit plan shall make a utilization review determination involving health care services which require pre-authorization and provide notice of that determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within three business days of receipt of the information necessary to make the determination. To the extent practicable, such written notification to the enrollee and the enrollee's health care provider shall be transmitted electronically, in a manner and in a form agreed upon by the parties. The notification shall identify:

1. whether the services are considered in-network or out-of-network;

2. whether the enrollee will be responsible for any payment, other than any applicable co-payment, co-insurance or deductible;

3. as applicable, the dollar amount the health benefit plan will pay if the service is out-of-network; and

4. as applicable, information explaining how an enrollee can determine the anticipated out-of-pocket cost for out-of-network health care services in a geographical area or zip code based upon the difference between what the health benefit plan will reimburse for out-of-network health care services and the UCR rate for out-of-network health care services

Section 16. Provider Directories

A. A carrier shall provide a provider directory on both the carrier's website and in print format.

1. The carrier shall annually audit at least a reasonable sample size of its provider directories for accuracy and retain documentation of such an audit to be made available to the insurance commissioner upon request.

2. The directory on the carrier's website and in print format shall contain the following general information in plain language for each network plan:

a. a description of the criteria the carrier has used to build its network;

b. if applicable, a description of the criteria the carrier has used to tier providers;
c. if applicable, how the carrier designates the different provider tiers or levels in the network and identifies for each specific provider, hospital or other type of facility in the network which tier each is placed, for example by name, symbols or grouping, in order for a covered person or a prospective covered person to be able to identify the provider tier;
d. if applicable, a statement that authorization or referral may be required to access some providers;
e. what provider directory applies to which network plan, such as including the specific name of the network plan as marketed and issued in this state;
f. a customer service email address and telephone number or electronic link that enrollees or the public may use to notify the carrier of inaccurate provider directory information.

B. Regarding the directory posted online, the carrier shall

1. update the provider directory at least monthly;

2. ensure that the public is able to view all of the current providers for a plan through a clearly identifiable link or tab and without creating or accessing an account or entering a policy or contract number;

3. make available in a searchable format the following information for each network plan:

a. For health care professionals: name; gender; participating office location(s); specialty, if applicable; medical group affiliations, if applicable; facility affiliations; if applicable; participating facility affiliations, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients.
b. For hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); participating hospital location; and hospital accreditation status; and
c. For facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s).

4. make available the following information in addition to the information available under Subsection B 3:

a. for health care professionals: contact information; board certification(s); and languages spoken other than English by clinical staff, if applicable;
b. for hospitals: telephone number; and
c. for facilities other than hospitals: telephone number.

C. Regarding the provider directory in print format, the carrier shall include a disclosure that the directory is accurate as of the date of printing and that enrollees and prospective enrollees should consult the carrier's electronic provider directory on its website or call [insert appropriate customer service phone number] to obtain current provider directory information.
D. Upon request of an enrollee or a prospective enrollee, the carrier shall make available in print format, the following provider directory information for the applicable network plan:

a. for health care professionals: name; contact information; participating office location(s); specialty, if applicable; languages spoken other than English, if applicable; and whether the provider is accepting new patients;
b. for hospitals: hospital name; hospital type (i.e., acute, rehabilitation, children's, cancer); and participating hospital location and telephone number; and
c. for facilities, other than hospitals, by type: facility name; facility type; types of services performed; and participating facility location(s) and telephone number.

Section 17. Effective Date

This Act shall take effect on [insert months] following enactment.

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act Banning Fee Schedules for Uncovered Dental Services

Adopted by the NCOIL Executive Committee on November 21, 2010, and by the NCOIL Health, Long-Term Care & Health Retirement Issues Committee on November 20, 2010. Re-adopted by the Health, Long-Term Care & Retirement Issues Committee on March 3, 2017, and by the Executive Committee on March 5, 2017.

****To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on March 6, 2022.***

Section I. Summary

This Act would prohibit a dental insurance plan from requiring a dentist who provides services to its subscribers to accept a fee set by the plan for any services except covered services.

Section II. Definitions

A. "Covered services" means dental care services for which a reimbursement is available under an enrollee's plan contract, or for which a reimbursement would be available but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, alternative benefit payments, or any other limitation.

B. "Dental plan" shall include any policy of insurance which is issued by a health care service contractor which provides for coverage of dental services not in connection with a medical plan.

Section III. Contracts With Providers For Dental Services

A. No contract of any health care service contractor that covers any dental services, and no contract or participating provider agreement with a dentist may require, directly or indirectly, that a dentist who is a participating provider provide services to an enrolled participant at a fee set by, or at a fee subject to the approval of, the health care service contractor unless the dental services are covered services.

Drafting Note: Concerns exist that dental plans may react by adopting a strategy of covering all services at a nominal or de minimus fee. Such a strategy by dental benefit plans, to adopt or impose a deductible, co-payment, co-insurances or any other requirement in such a way as to provide de minimus reimbursement and avoid the impact of this model bill is contrary to the spirit and intent of this model legislation. States should consider setting a threshold of what payment would constitute; for example, "50 percent of the dentists' prevailing fee, administered consistently with policies traditionally governing covered services."

B. A health care service contractor or other person providing third party administrator services shall not make available any providers in its dentist network to a plan that sets dental fees for any services except covered services.

Section IV. Penalties

Penalties provided for in [Insert Applicable State Statute Concerning Dental Plan Contracts] shall apply to any violation of this Act.

Section V. Severability

If any section, clause, or provision of this chapter shall be held either unconstitutional or ineffective in whole or in part to the extent that it is not unconstitutional or ineffective, it shall be valid and effective and no other section, clause or provision shall on account thereof be termed invalid or ineffective.

Section VI. Effective Date

This Act shall take effect immediately.

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

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Patient Safety Model Act

Readopted by the NCOIL Health, Long-Term Care & Health Retirement Issues Committee on March 5, 2011, and Executive Committee on March 6, 2011. Adopted by the NCOIL Property-Casualty and Health Insurance Committees on November 18, 2005, and Executive Committee on November 19, 2005. Re-adopted by the Health, Long-Term Care and Retirement Issues Committee on March 3, 2017 and by the Executive Committee on March 5, 2017.

To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on March 6, 2022.

Sponsored by Rep. George Keiser (ND) and Assem. Nancy Calhoun (NY)

Table of Contents

Subpart 2. Annual department summary
Subpart 3. Best practices report and department summary
Subpart 4. Confidentiality
Subpart 5. Report to legislature
Subpart 6. Gifts, grants, and donations
Subpart 7 Whistleblower protection
Subpart 8. Administrative penalty
Subpart 9. Notice; request for hearing
Subpart 10. Hearing; order
Subpart 11. Notice and payment of administrative penalty; judicial review; refund
Subpart 12. Expiration
Subpart 13. Effective dates

Part II. Hospital Infections Disclosure (based on a combination of NY State chapter amendments 284 and 239 (2005)).

Section A. Definitions
Section B. Hospital reports
Section C. Privacy
Section D. Whistleblower protection
Section E. Penalties
Section F. Regulatory oversight
Section G. Amendments

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Purpose.

The purpose of this Act is to establish programs to:

A. promote public accountability through the detection of statewide trends in the occurrence of certain medical errors by:

1. requiring hospitals, ambulatory surgical centers, and mental hospitals to report errors
2. providing the public with access to statewide summaries of the reports
3. requiring hospitals, ambulatory surgical centers, and mental hospitals to implement risk-reduction strategies

B. require reporting of hospital infection statistics in order to improve patient safety

[Drafting Note: A further purpose of the Act is to reduce the rising medical liability insurance premiums that are charged to medical professionals and that reflect, in part, the costs of medical errors.]

Short Title.

This act may be called the Patient Safety Model Act.

Part I. Patient Safety Program.

Section A. Hospitals

Subpart 1. Duties of Department

(a) The department shall develop a patient safety program for hospitals. The program must:

(1) be administered by the hospital licensing program within the department

(2) serve as an information clearinghouse for hospitals concerning best practices and quality improvement strategies

(b) The department shall group hospitals by size for the reports required by this Part as follows:

(1) less than 50 beds

(2) 50 to 99 beds

(3) 100 to 199 beds

(4) 200 to 399 beds

(5) 400 beds or more

(c) The department shall combine two or more categories described by Subsection (b) if the number of hospitals in any category falls below 40.

Subpart 2. Annual report

(a) On renewal of a license under this chapter, a hospital shall submit to the department an annual report that lists the number and frequency of occurrences at the hospital or at an outpatient facility owned or operated by the hospital of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient

(2) a perinatal death unrelated to a congenital condition in an infant with a birth weight greater than 2,500 grams

(3) the suicide of a patient in a setting in which the patient received care 24 hours a day

(4) the abduction of a newborn infant patient from the hospital or the discharge of a newborn infant patient from the hospital into the custody of an individual in circumstances in which the hospital knew, or in the exercise of ordinary care should have known, that the individual did not have legal custody of the infant

(5) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility

(6) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities

(7) a surgical procedure on the wrong patient or on the wrong body part of a patient

(8) a foreign object accidentally left in a patient during a procedure

(9) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a) of this section.

Section B. Ambulatory Surgical Centers

Subpart 1. Duties of department

The department shall develop a patient safety program for ambulatory surgical centers. The program must:

(a) be administered by the ambulatory surgical center licensing program within the department

(b) serve as an information clearinghouse for ambulatory surgical centers concerning best and quality improvement strategies

Subpart 2. Annual report

(a) On renewal of a license under this chapter, an ambulatory surgical center shall submit to the department an annual report that lists the number and frequency of occurrences at the center or at an outpatient facility owned or operated by the center of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient

(2) the suicide of a patient

(3) the sexual assault of a patient during treatment or while the patient was on the premises of the center or facility

(4) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities

(5) a surgical procedure on the wrong patient or on the wrong body part of a patient

(6) a foreign object accidentally left in a patient during a procedure

(7) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a).

Section C. Mental Hospitals

Subpart 1. Duties of department

The department shall develop a patient safety program for mental hospitals licensed by the department. The program must:

(a) be administered by the licensing program within the department

(b) serve as an information clearinghouse for hospitals concerning best practices and quality improvement strategies

Subpart 2. Annual report

(a) On renewal of a license under this chapter, a mental hospital shall submit to the department an annual report that lists the number and frequency of occurrences at the hospital or at an outpatient facility owned or operated by the hospital of each of the following events during the preceding year:

(1) a medication error resulting in a patient's unanticipated death or major permanent loss of bodily function in circumstances unrelated to the natural course of the illness or underlying condition of the patient

(2) the suicide of a patient in a setting in which the patient received care 24 hours a day 5

(3) the sexual assault of a patient during treatment or while the patient was on the premises of the hospital or facility

(4) a hemolytic transfusion reaction in a patient resulting from the administration of blood or blood products with major blood group incompatibilities

(5) a patient death or serious disability associated with the use or function of a device designed for patient care that is used or functions other than as intended

(b) The department may not require the annual report to include any information other than the number of occurrences of each event listed in Subsection (a) of this section.

Section D. General Requirements

Subpart 1. Root cause analysis and action plan

(a) In this section, "root cause analysis" means the process that identifies basic or causal factors underlying a variation in performance leading to an event listed in Subparts 2 of Sections A, B, or C and that:

(1) focuses primarily on systems and processes

(2) progresses from special causes in clinical processes to common causes in organizational processes

(3) identifies potential improvements in processes or systems

(b) Not later than the 45th day after the date a hospital, ambulatory surgical center, or mental hospital becomes aware of an event listed in Subparts 2 of Sections A, B, or C, the facility shall:

(1) conduct a root cause analysis of the event

(2) develop an action plan that identifies strategies to reduce the risk of a similar event occurring in the future

(c) The department may review a root cause analysis or action plan related to an event listed in Subparts 2 of Sections A, B, or C during a survey, inspection, or investigation of a hospital, ambulatory surgical center, or mental hospital.

(d) The department may not require a root cause analysis or action plan to be submitted to the department.

(e) The department or an employee or agent of the department may not in any form, format, or manner remove, copy, reproduce, redact, or dictate from all or any part of a root cause analysis or action plan.

Subpart 2. Annual department summary

(a) The department annually shall compile and make available to the public a summary of the events reported by mental hospitals as required by Subpart 2 of Sections A, B, or C of this part. The summary shall identify events by specific hospital, ambulatory surgical center, or mental hospital but shall not directly or indirectly identify:

(1) an individual, or

(2) a specific reported event or the circumstances or individuals surrounding the event

Subpart 3. Best practices report and department summary

(a) A hospital, ambulatory surgical center, or mental hospital shall provide to the department at least one report of best practices and safety measures related to a reported event.

(b) A hospital, ambulatory surgical center, or mental hospital may provide to the department a report of other best practices and the safety measures that are effective in improving patient safety.

(c) The department by rule may prescribe the form and format of a best practices report. The department may not require a best practices report to exceed one page in length. The department shall accept, in lieu of a report in the form and format prescribed by the department, a copy of a report submitted by a hospital, ambulatory surgical center, or mental hospital to a patient safety organization.

(d) The department periodically shall:

(1) review the best practices reports

(2) compile a summary of the best practices reports determined by the department to be effective and recommended as best practices

(3) make the summary available to the public by posting it on the Department's Web site and distributing its availability to interested parties as widely as practical

(e) The summary shall identify best practices by specific hospital, ambulatory surgical center, or mental hospital but shall not directly or indirectly identify:

(1) an individual, or

(2) a specific reported event or the circumstances or individuals surrounding the event

Subpart 4. Confidentiality

The provisions of this section regarding the confidentiality of information or materials compiled or reported by a hospital, ambulatory surgical center, or mental hospital in compliance with or as authorized under this part do not restrict access, to the extent authorized by law, by the patient or the patient's legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records.

Subpart 5. Report to legislature

(a) Not later than [insert practical date], the commissioner of public health shall:

(1) evaluate the patient safety program established under Subpart 3 and

(2) report the results of the evaluation and make recommendations to the legislature

(b) The commissioner of public health shall conduct the evaluation in consultation with hospitals, ambulatory surgical centers, or mental hospitals licensed under [insert reference to licensing statute].

(c) The evaluation must address:

(1) the degree to which the department was able to detect statewide trends in errors based on the types and numbers of events reported

(2) the degree to which the statewide summaries of events compiled by the department were accessed by the public

(3) the effectiveness of the department's best practices summary in improving patient care

(4) the impact of national studies on the effectiveness of state or federal systems of reporting medical errors

(5) the Department shall publicize the report and its availability as widely as practical to interested parties, including, but not limited to, hospitals, providers, media organizations, health insurers, health maintenance organizations, purchasers of health insurance, organized labor, consumer or patient advocacy groups, and individual consumers. The annual report shall be made available to any person upon request.

Subpart 6. Gifts, grants, and donations

The department may accept and administer a gift, grant, or donation from any source to carry out the purposes of this part.

Subpart 7. Whistleblower Protection

(a) No employer shall take retaliatory action against any employee because the employee does any of the following:

(1) Discloses or threatens to disclose to any person or entity any activity, policy, practice, procedure, action, or failure to act of the employer or agent of the employer that the employee reasonably believes is a violation of any law or that the employee reasonably believes constitutes improper quality of patient care

(2) Provides information to, or testifies before, any public body conducting an investigation, a hearing, or an inquiry that involves allegations that the employer has violated any law or has engaged in behavior constituting improper quality of patient care

(3) Objects to or refuses to participate in any activity, policy, or practice of the employer or agent that the employee reasonably believes is in violation of a law or constitutes improper quality of patient care

(b) Subdivisions (a)(1) and (3) of this section shall not apply unless an employee first reports the alleged violation of law or improper quality of patient care to the employer, supervisor, or other person designated by the employer to address reports by employees of improper quality of patient care, and the employer has had a reasonable opportunity to address the violation. The employer shall address the violation under its compliance plan, if one exists. The employee shall not be required to make 8 a report under this Subsection if the employee reasonably

believes that doing so would be futile because making the report would not result in appropriate action to address the violation.

Subpart 8. Administrative penalty

(a) The department may assess an administrative penalty against a person who violates this part or a rule adopted under this part.

(b) The penalty may not exceed $1,000 for each violation. Each day of a continuing violation constitutes a separate violation.

(c) In determining the amount of an administrative penalty assessed under this section, the department shall consider:

(1) the seriousness of the violation

(2) the history of previous violations

(3) the amount necessary to deter future violations

(4) efforts made to correct the violation

(5) any hazard posed to the public health and safety by the violation

(6) any other matters that justice may require

(d) All proceedings for the assessment of an administrative penalty under this Subpart are considered to be contested cases under [insert reference to state administrative procedure act].

Subpart 9. Notice; request for hearing

(a) If, after investigation of a possible violation and the facts surrounding that possible violation, the department determines that a violation has occurred, the department shall give written notice of the violation to the person alleged to have committed the violation. The notice shall include:

(1) a brief summary of the alleged violation

(2) a statement of the amount of the proposed penalty based on the factors set forth in Subpart 8(c) of this section

(3) a statement of the person's right to a hearing on the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty

(b) Not later than the 20th day after the date on which the notice is received, the person notified may accept the determination of the department made under this section, including the proposed penalty, or make a written request for a hearing on that determination.

(c) If the person notified of the violation accepts the determination of the department, the commissioner of public health or the commissioner's designee shall issue an order approving the determination and ordering that the person pay the proposed penalty.

Subpart 10. Hearing; order

(a) If the person notified fails to respond in a timely manner to the notice 9 under Subpart 9(b) of this section, or if the person requests a hearing, the department shall:

(1) set a hearing

(2) give written notice of the hearing to the person

(3) designate a hearings examiner to conduct the hearing

(b) The hearings examiner shall make findings of fact and conclusions of law and shall promptly issue to the commissioner of public health or the commissioner's designee a proposal for decision as to the occurrence of the violation and a recommendation as to the amount of the proposed penalty if a penalty is determined to be warranted.

(c) Based on the findings of fact and conclusions of law and the recommendations of the hearings examiner, the commissioner of public health or the commissioner's designee by order may find that a violation has occurred and may assess a penalty or may find that no violation has occurred.

Subpart 11. Notice and payment of administrative penalty; judicial review; refund

(a) The department shall give notice of the order under Subpart 12(c) to the person notified. The notice must include:

(1) separate statements of the findings of fact and conclusions of law

(2) the amount of any penalty assessed

(3) a statement of the right of the person to judicial review of the order

(b) Not later than the 30th day after the date on which the decision is final as provided by [insert reference to state administrative procedure code], the person shall either:

(1) pay the penalty

(2) pay the penalty and file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty, or

(3) without paying the penalty, file a petition for judicial review contesting the occurrence of the violation, the amount of the penalty, or both the occurrence of the violation and the amount of the penalty

(c) Within the 30-day period, a person who acts under Subsection (b)(3) of this section may:

(1) stay enforcement of the penalty by:

(i) paying the penalty to the court for placement in an escrow account, or

(ii) giving to the court a supersedeas bond that is approved by the court for the amount of the penalty and that is effective until all judicial review of the order is final, or

(2) request the court to stay enforcement of the penalty by:

(i) filing with the court a sworn affidavit of the person stating that the person is financially unable to pay the amount of the penalty and is financially unable to give the supersedeas bond and

(ii) giving a copy of the affidavit to the department by certified mail

(d) If the department receives a copy of an affidavit under Subsection (c)(2) of 10 this Subpart, the department may file with the court, within five days after the date the copy is received, a contest to the affidavit. The court shall hold a hearing on the facts alleged in the affidavit as soon as practicable and shall stay the enforcement of the penalty on finding that the alleged facts are true. The person

who files an affidavit has the burden of proving that the person is financially unable to pay the penalty and to give a supersedeas bond.

(e) If the person does not pay the penalty and the enforcement of the penalty is not stayed, the department may refer the matter to the attorney general for collection of the penalty.

(f) Judicial review of the order:

(1) is instituted by filing a petition as provided by [insert reference to state administrative procedure code], and

(2) is under the substantial evidence rule

(g) If the court sustains the occurrence of the violation, the court may uphold or reduce the amount of the penalty and order the person to pay the full or reduced amount of the penalty. If the court does not sustain the occurrence of the violation, the court shall order that no penalty is owed.

(h) When the judgment of the court becomes final, the court shall proceed under this Subsection. If the person paid the amount of the penalty under Subsection (b)(2) of this Subpart and if that amount is reduced or is not upheld by the court, the court shall order that the department pay the appropriate amount plus accrued interest to the person. The rate of the interest is the rate charged on loans to depository institutions by the New York Federal Reserve Bank, and the interest shall be paid for the period beginning on the date the penalty was paid and ending on the date the penalty is remitted. If the person paid the penalty under Subsection (c)(1)(i) or gave a supersedeas bond under Subsection (c)(1)(ii) and if the amount of the penalty is not upheld by the court, the court shall order the release of the escrow account or bond. If the person paid the penalty under Subsection (c)(1)(i) and the amount of the penalty is reduced, the court shall order that the amount of the penalty be paid to the department from the escrow account and that the remainder of the account be released. If the person gave a supersedeas bond and if the amount of the penalty is reduced, the court shall order the release of the bond after the person pays the amount.

Subpart 12. Expiration

Unless continued in existence, this part expires [four years after the effective date of this act].

Subpart 13. Effective dates

[State may want to consider amount of time necessary for entities to comply with the provisions of this act.]

Part II. Hospital Infections Disclosure.

Section A. Definitions

For purposes of this act:

1. "Department" means the Department of _____ *[State may have several possible agencies to collect the data. These could be the state hospital licensing agency, state health care data collection agency, or state public health agency. This would*

minimize the state's cost to implement the bill, as the hospital-acquired infection data can be gathered in the course of collecting other patient data.]

2. "Hospital" means an acute care health care facility licensed under the Hospital Licensing Act *[insert a cross-reference and/or citation to the definition of "acute care hospital" in your state hospital licensing law. You may also consider including hospital-affiliated and freestanding outpatient surgical centers.]*

3. "Hospital-acquired infection" means a localized or systemic condition (a) that results from adverse reaction to the presence of an infectious agent(s) or its toxin(s) as determined by clinical examination and (b) that was not present or incubating at the time of admission to the hospital unless the infection was related to a previous admission to the same facility.

Section B. Hospital Reports

1 (a) Each hospital shall maintain a program capable of identifying and tracking hospital acquired infections for the purpose of public reporting under this section and quality improvement.

(b) Such programs shall have the capacity to identify the following elements: the specific infectious agents or toxins and site of each infection; the clinical department or unit within the facility where the patient first became infected; and the patient's diagnoses and any relevant specific surgical, medical or diagnostic procedure performed during the current admission.

(c) The department shall establish guidelines, definitions, criteria, standards and coding for hospital identification, tracking and reporting of hospital acquired infections that shall be consistent with the recommendations of recognized centers of expertise in the identification and prevention of hospital acquired infections including, but not limited to the National Health Care Safety Network of the Centers for Disease Control and Prevention or its successor. The department shall solicit and consider public comment prior to such establishment.

(d) Hospitals initially shall be required to identify, track and report hospital acquired infections that occur in critical care units to include surgical wound infections, central line related bloodstream infections, and ventilator associated pneumonia.

(e) Subsequent to the initial requirements identified in paragraph (d) of this subdivision the department may, from time to time, require the tracking and reporting of other types of hospital acquired infections that occur in hospitals in consultation with technical advisors who are regionally or nationally recognized experts in the prevention, identification and control of hospital acquired infection and the public reporting of performance data.

2. Each hospital shall regularly report to the department the hospital infection data it has collected. The department shall establish data collection and analytical methodologies that meet accepted standards for validity and reliability. In no case shall the frequency of reporting be required to be more frequently than once every six months, and reports shall be submitted not more than 60 days after the close of the reporting period.

3. The commissioner shall establish a state-wide database of all reported hospital acquired infection information for the purpose of supporting quality improvement and infection control activities in hospitals. The database shall be organized so that

consumers, hospitals, healthcare professionals, purchasers and payers may compare individual hospital experience with that of other individual hospitals as well as regional and state-wide averages and, where available, national data.

4. (a) Subject to paragraph (c) of this subdivision, on or before [choose date] of each year the commissioner shall submit a report to the governor and the legislature, which shall simultaneously be published in its entirety on the department's Web site, that includes, but is not limited to, hospital acquired infection rates adjusted for the potential differences in risk factors for each reporting hospital, an analysis of trends in the prevention and control of hospital acquired infection rates in hospitals across the state, regional and, if available, national comparisons for the purpose of comparing individual hospital performance, and a narrative describing lessons for safety and quality improvement that can be learned from leadership hospitals and programs.

(b) The commissioner shall consult with technical advisors who have regionally or nationally acknowledged expertise in the prevention and control of hospital acquired infection and infectious disease in order to develop the adjustment for potential differences in risk factors to be used for public reporting.

(c) (i) No later than one year subsequent to the effective date of this act, the department shall establish a hospital acquired infection reporting system capable of receiving electronically transmitted reports from hospitals. Hospitals shall begin to submit such reports as directed by the commissioner but in no case later than six months subsequent to the establishment of such reporting system.

(ii) The first year of data submission under this section shall be considered the “pilot phase” of the statewide hospital acquired infection reporting system. The purpose of the pilot phase is to ensure, by various means, including any audit process referred to in Subdivision 6 of this section, the completeness and accuracy of hospital acquired infection reporting by hospitals. For data reported during the pilot phase, hospital identifiers shall be encrypted by the department in any and all public databases and reports. The department shall provide each hospital with an encryption key for that hospital only to permit access to its own performance data for internal quality improvement purposes.

(iii) No later than 180 days after the conclusion of the pilot phase, the department shall issue a report to hospitals assessing the overall accuracy of the data submitted in the pilot phase and provide guidance for improving the 13 accuracy of hospital acquired infection reporting. The department shall issue a report to the governor and the legislature assessing the overall completeness and accuracy of the data submitted by hospitals during the pilot phase and make recommendations for the improvement or modification of hospital acquired infection data reporting based on the pilot phase, as well as share lessons learned in prevention of hospital acquired infections. No hospital- identifiable data shall be included in the pilot phase report, but aggregate or otherwise de-identified data may be included.

(iv) After the pilot phase is completed, all data submitted under this section and compiled in the statewide hospital acquired infection database established herein and all public reports derived therefrom shall include hospital identifiers.

5. Subject to Subdivision 4 of this section, a summary table, in a format designed to be easily understood by lay consumers, that includes individual facility hospital acquired infection rates adjusted for potential differences in risk factors and comparisons with regional and/or state averages shall be developed and posted on the department's Web site. The commissioner shall consult with consumer and patient advocates and representatives of reporting facilities for the purpose of ensuring that such summary table report format is easily understandable by the public, and clearly and accurately portrays comparative hospital performance in the prevention and control of hospital acquired infections.

6. To assure the accuracy of the self-reported hospital acquired infection data and to assure that public reporting fairly reflects what actually is occurring in each hospital, the department shall develop and implement an audit process.

7. For the purpose of ensuring that hospitals have the resources needed for ongoing staff education and training in hospital acquired infection prevention and control, the department may make such grants to hospitals within amounts appropriated therefor.

Section C. Privacy

(1) The provisions of this section regarding the confidentiality of information or materials compiled or reported by a hospital in compliance with or as authorized under this part do not restrict access, to the extent authorized by law, by the patient or the patient's legally authorized representative to records of the patient's medical diagnosis or treatment or to other primary health records.

(2) It is the expressed intent of the Legislature that a patient's right of confidentiality shall not be violated in any manner. Patient social security numbers and any other information that could be used to identify an individual patient shall not be released notwithstanding any other provision of law.

Section D. Whistleblower Protection

(a) No employer shall take retaliatory action against any employee because the employee does any of the following:

(1) Discloses or threatens to disclose to any person or entity any activity, policy, practice, procedure, action, or failure to act of the employer or agent of the employer that the employee reasonably believes is a violation of any law or 14 that the employee reasonably believes constitutes improper quality of patient care

(2) Provides information to, or testifies before, any public body conducting an investigation, a hearing, or an inquiry that involves allegations that the employer has violated any law or has engaged in behavior constituting improper quality of patient care

(3) Objects to or refuses to participate in any activity, policy, or practice of the employer or agent that the employee reasonably believes is in violation of a law or constitutes improper quality of patient care

(b) Subdivisions (a)(1) and (3) of this section shall not apply unless an employee first reports the alleged violation of law or improper quality of patient care to the employer, supervisor, or other person designated by the employer to address reports by employees of improper quality of patient care, and the employer has had a reasonable opportunity to address the violation. The employer shall address the violation under its compliance plan, if one exists. The employee shall not be required to make a report under this Subsection if the employee reasonably believes that doing so would be futile because making the report would not result in appropriate action to address the violation.

Section E. Penalties

A determination that a hospital has violated the provisions of this Act may result in any of the following:

1. termination of licensure or other sanctions relating to licensure under the Hospital Licensing Act *[insert name and citation of state hospital licensing act]*.
2. a civil penalty of up to $1,000 per day per violation for each day the hospital is in violation of the Act

Section F. Regulatory oversight

The Department shall be responsible for ensuring compliance with this Act as a condition of licensure under the Hospital Licensing Act and shall enforce such compliance according to the provisions of the Hospital Licensing Act. *[insert name and citation of state hospital licensing act]*.

Section G. Amendments

The Hospital Licensing Act is amended as follows: *[Amend state hospital licensing act to add that violations of the Infections Disclosure Act are grounds for license termination or sanctions under the state licensing act.]*

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

RENTAL NETWORK CONTRACT ARRANGEMENTS MODEL ACT

Adopted by the NCOIL Executive Committee on November 23, 2008, and by the Health, Long-Term Care, and Health Retirement Issues Committee on November 21, 2008. Re-adopted by the Health, Long Term Care and Retirement Issues Committee on March 3, 2017 and by the Executive Committee on Mach 5, 2017.

****To be considered for re-adoption during the Health Insurance & Long Term Care Issues Committee on March 6, 2022.***

Table of Contents **Page Numbers**

Section I. Definitions

For purposes of this Act, the following definitions shall apply:

A. "Contracting entity" means any person or entity that enters into direct contracts with providers for the delivery of health care services in the ordinary course of business.

B. "Covered individual" means an individual who is covered under a health insurance plan.

C. "Direct notification" is a written or electronic communication from a contracting entity to a provider documenting third party access to a provider network.

D. "Health care services" means services for the diagnosis, prevention, treatment, or cure of a health condition, illness, injury, or disease.

E. 1. “Health insurance plan” means any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services, whether by insurance or otherwise.

2. “Health insurance plan” shall not include one or more, or any combination of, the following: coverage only for accident, or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers’ compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; coverage similar to the foregoing as specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits; dental or vision benefits; benefits for long-term care, nursing home care, home health care, or community-based 2 care; specified disease or illness coverage, hospital indemnity or other fixed indemnity insurance, or such other similar, limited benefits as are specified in regulations; Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; or other similar limited benefit supplemental coverages.

F. 1. “Provider” means a physician, a physician organization, or a physician hospital organization that is acting exclusively as an administrator on behalf of a provider to facilitate the provider’s participation in health care contracts.

2. “Provider” does 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.

G. “Provider network contract" means a contract between a contracting entity and a provider specifying the rights and responsibilities of the contracting entity and provider for the delivery of and payment for health care services to covered individuals.

H. “Third party” means an organization that enters into a contract with a contracting entity or with another third party to gain access to a provider network contract.

Section II. Scope

A. This Act does not apply to provider network contracts for services provided to Medicaid, Medicare, or State Children’s Health Insurance Program (SCHIP) beneficiaries.

B. This Act does not apply in circumstances where access to the provider network contract is granted to an entity operating under the same brand licensee program as the contracting entity.

C. This Act does not apply to a contract between a contracting entity and a discount medical plan organization.

Drafting Note: Each state will determine whether this legislation should apply to self-funded employer-sponsored health insurance plans and/or third-party administrators operating on their behalf (as regulated under the Employee Retirement Income Security Act of 1974 [ERISA]).

Section III. Registration

A. Any person that commences business as a contracting entity shall register with the (*Appropriate State Agency*) within 30 days of commencing business in this State unless such person is licensed by the (*Appropriate State Agency*) as an insurer. Upon passage of this Act, each person, not licensed by the (*Appropriate State Agency*) as a contracting entity shall register with the (*Appropriate State Agency*) within 90 days of the effective date of this Act.

1. Registration shall consist of the submission of the following information:

(a) the official name of the contracting entity, including any d/b/a designations used in this state;

(b) the mailing address and main telephone number for the contracting entity's main headquarters; and

(c) the name and telephone number of the contracting entity's representative who shall serve as the primary contact with the Department.

2. The information required by this Section shall be submitted in written or electronic format, as prescribed by the (Appropriate State Agency).

3. The (Appropriate State Agency) may collect a reasonable fee for the purpose of administering the registration process.

Section IV. Contracting Entity Rights and Responsibilities

A. A contracting entity may not grant access to a provider's health care services and contractual discounts pursuant to a provider network contract unless:

1. the provider network contract specifically states that the contracting entity may enter into an agreement with a third party allowing the third party to obtain the

contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity; and

2. the third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

B. A contracting entity that grants access to a provider's health care services and contractual discounts pursuant to a provider network contract shall:

1. identify and provide to the provider, upon request at the time a provider network contract is entered into with a provider, a written or electronic list of all third parties known at the time of contracting, to which the contracting entity has or will grant access to the provider's health care services and contractual discounts pursuant to a provider network contract;

2. maintain an internet website or other readily available mechanism, such as a toll-free telephone number, through which a provider may obtain a listing, updated at least every 90 days, of the third parties to which the contracting entity or another third party has executed contracts to grant access to such provider's health care services and contractual discounts pursuant to a provider network contract;

3. provide the third party with sufficient information regarding the provider network contract to enable the third party to comply with all relevant terms, limitations, and conditions of the provider network contract;

4. require that the third party who contracts with the contracting entity to gain access to the provider network contract identify the source of the contractual discount taken by the third party on each remittance advice (RA) or explanation of payment (EOP) form furnished to a health care provider when such discount is pursuant to the contracting entity's provider network contract; and

5. (a) notify the third party who contracts with the contracting entity to gain access to the provider network contract of the termination of the provider network contract no later than (insert number) days prior to the effective date of the final termination of the provider network contract; and

(b) require those that are by contract eligible to claim the right to access a provider's discounted rate to cease claiming entitlement to those rates or other contracted rights or obligations for services rendered after termination of the provider network contract.

(c) The notice required under subsection IV(B)(5)(a) can be provided through any reasonable means, including but not limited to: written notice,

electronic communication, or an update to electronic database or other provider listing.

C. Subject to any applicable continuity of care requirements, agreements, or contractual provisions:

1. a third party's right to access a provider's health care services and contractual discounts pursuant to a provider network contract shall terminate on the date the provider network contract is terminated;

2. claims for health care services performed after the termination date of the provider network contract are not eligible for processing and payment in accordance with the provider network contract; and

3. claims for health care services performed before the termination date of the provider network contract, but processed after the termination date, are eligible for processing and payment in accordance with the provider network contract.

D. 1. All information made available to provider in accordance with the requirements of this Act shall be confidential and shall not be disclosed to any person or entity not involved in the provider's practice or the administration thereof without the prior written consent of the contracting entity.

2. Nothing contained in this Act shall be construed to prohibit a contracting entity from requiring the provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by the contracting entity is not used for any purpose other than the provider's direct practice management or billing activities.

Section V. Third Party Rights and Responsibilities

A. A third party, having itself been granted access to a provider's health care services and contractual discounts pursuant to a provider network contract, that subsequently grants access to another third party is obligated to comply with the rights and responsibilities imposed on contracting entities under Sections IV and VI of this Act.

B. A third party that enters into a contract with another third party to access a provider's health care services and contractual discounts pursuant a provider network contract is obligated to comply with the rights and responsibilities imposed on third parties under Section V of this Act.

C. 1. A third party will inform the contracting entity and providers under the contracting entity's provider network contract of the location of a website, toll-free number, or other readily available mechanism, to identify the name of the person or entity to which the third party subsequently grants access to the

provider's health care services and contractual discounts pursuant to the provider network contract.

2. The website will be updated on a routine basis as additional persons or entities are granted access. The website shall be updated to reflect all current persons and entities with access every 90 days. Upon request, a contracting entity shall make access information available to a provider via telephone or through direct notification.

Section VI. Unauthorized Access to Provider Network Contracts

A. It is an unfair insurance practice for the purposes of (*insert applicable reference to state insurance code unfair trade practices section)* to knowingly access or utilize a provider's contractual discount pursuant to a provider network contract without a contractual relationship with the provider, contracting entity, or third party, as specified in this Act.

B. Contracting entities and third parties are obligated to comply with Sections IV(B)(2) or V(C)(1) and (2) concerning the services referenced on a remittance advice (RA) or explanation of payment (EOP). A provider may refuse the discount taken on the RA or EOP if the discount is taken without a contractual basis or in violation of these sections. However, an error in the RA or EOP may be corrected within 30 days following notice by the provider.

C. A contracting entity may not lease, rent, or otherwise grant to a third party, access to a provider network contract unless the third party accessing the health care contract is:

1. a payer or third party administrator or another entity that administers or processes claims on behalf of the payer;

2. a preferred provider organization or preferred provider network, including a physician organization or physician-hospital organization; or

3. an entity engaged in the electronic claims transport between the contracting entity and the payer that does not provide access to the provider's services and discount to any other third party.

Section VII. Enforcement

Enforcement of this model will follow that of *(insert applicable reference to state insurance code unfair trade practices section).*

Section VIII. Effective Date

This Act shall be effective (insert date).

This bill will be introduced during the Health Insurance & Long Term Care Issues Committee on March 6, 2022 as the starting point for development of a similar NCOIL Model Act to be sponsored by Asw. Pam Hunter (NY).

A09149 Text:

STATE OF NEW YORK

_____

9149

IN ASSEMBLY

January 31, 2022

_____

Introduced by M. of A. HUNTER -- read once and referred to the Committee on Insurance

AN ACT to amend the insurance law and the social services law, in relation to requiring health insurance policies and medicaid to cover biomarker testing for certain purposes

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 11 b to read as follows:

(11-b) (A) Every policy which provides medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

(i) labeled indications for a test approved or cleared by the food and drug administration of the United States government or indicated tests for a food and drug administration approved drug;

(ii) centers for medicare and medicaid services national coverage determinations and medicare administrative contractor local coverage determinations; or

(iii) nationally recognized clinical practice guidelines and consensus statements.

(B) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(C) The covered person and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage

policy provided pursuant to the provisions of this paragraph. Such process shall be made readily accessible on the website of the insurer.

(D) As used in this paragraph, the following terms shall have the following meanings:

> **(i) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarkers include but are not limited to gene mutations or protein expression.**
>
> **(ii) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests, multi-plex panel tests, and whole genome sequencing.**
>
> **(iii) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Such statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.**
>
> **(iv) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.**

§ 2. Subsection (l) of section 3221 of the insurance law is amended by adding a new paragraph 11-b to read as follows:

(11-b) (A) Every insurer delivering a group or blanket policy or issuing a group or blanket policy for delivery in this state that provides coverage for medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

> **(i) labeled indications for a test approved or cleared by the food and drug administration of the United States government or indicated tests for a food and drug administration approved drug;**

(ii) centers for medicare and medicaid services national coverage determinations and medicare administrative contractor local coverage determinations; or

(iii) nationally recognized clinical practice guidelines and consensus statements.

(B) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(C) The covered person and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy provided pursuant to the provisions of this paragraph. Such process shall be made readily accessible on the website of the insurer.

(D) As used in this paragraph, the following terms shall have the following meanings:

(i) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarkers include but are not limited to gene mutations or protein expression.

(ii) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests, multi-plex panel tests, and whole genome sequencing.

(iii) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Such statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

(iv) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

§ 3. Section 4303 of the insurance law is amended by adding a new subsection (p-1) to read as follows:

(p-1) (1) A medical expense indemnity corporation, a hospital service corporation or a health service corporation that provides coverage for medical, major medical, or similar comprehensive-type coverage shall provide coverage for biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a covered person's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

(A) labeled indications for a test approved or cleared by the food and drug administration of the United States government or indicated tests for a food and drug administration approved drug;

(B) centers for medicare and medicaid services national coverage determinations and medicare administrative contractor local coverage determinations; or

(C) nationally recognized clinical practice guidelines and consensus statements.

(2) Such coverage shall be provided in a manner that shall limit disruptions in care including the need for multiple biopsies or biospecimen samples.

(3) The covered person and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request ab exception to a coverage policy provided pursuant to the provisions of this subsection. Such process shall be made readily accessible on the website of the insurer.
(4) As used in this subsection, the following terms shall have the following meanings:

(A) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarkers include but are not limited to gene mutations or protein expression.

(B) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests, multi-plex panel tests, and whole genome sequencing.

(C) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy.

Such statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

(D) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

§ 4. Subdivision 2 of section 365-a of the social services law is amended by adding a new paragraph (jj) to read as follows:

(jj) (i) biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a recipient's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

(1) labeled indications for a test approved or cleared by the food and drug administration of the United States government or indicated tests for a food and drug administration approved drug;

(2) centers for medicare and medicaid services national coverage determinations and medicare administrative contractor local coverage determinations; or

(3) nationally recognized clinical practice guidelines and consensus statements.

(ii) Risk-bearing entities contracted to the medicaid program to deliver services to recipients shall provide biomarker testing at the same scope, duration and frequency as the medicaid program otherwise provides to enrollees.

(iii) The recipient and participating provider shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy of the medicaid program or by risk-bearing entities contracted to the medicaid program. Such process shall be made readily accessible to all participating providers and enrollees online.

(iv) As used in this paragraph, the following terms shall have the following meanings:

(1) "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarkers include but are not limited to gene mutations or protein expression.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests, multi-plex panel tests, and whole genome sequencing.

(3) "Consensus statements" means statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Such statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

(4) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options and include recommendations intended to optimize patient care.

§ 5. This act shall take effect January 1, 2023 and shall apply to all policies and contracts issued, renewed, modified, altered or amended on or after such date.

340B Prescription Drug Program Anti-Discrimination Model Act

This draft language was submitted for discussion purposes by the National Association of Community Health Centers (NACHC) and 340B Health.

Table of Contents

Section 1. Title

This act shall be known as and may be cited as the "340B Prescription Drug Program Anti-Discrimination Model Act."

Section 2. Purpose

The Legislature hereby finds and declares that:

(A) The 340B program enables safety-net providers to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services.

(B) Section 340B of Public Health Service Act requires pharmaceutical manufacturers to provide 340B discounts in order to have their drugs covered by Medicaid and Medicare Part B.

(C) To participate in 340B, providers must meet strict eligibility criteria.

(D) 340B savings support hospitals, clinics, and health centers' care for patients who have low incomes, including those with low incomes enrolled in Medicaid and Medicare.

(E) Over the last several years, some pharmacy benefit managers and health plans have used unique 340B participation agreements or addenda when contracting with 340B providers and their contract pharmacies.

(F) Some of the agreements offer reimbursement rates below the rates paid to non-340B pharmacies, depriving providers of part or all of the financial benefit that Congress intended for them to receive when 340B was established.

(G) Payers sometimes impose 340B claim identification requirements on 340B providers that are burdensome and impede covered entities' ability to use 340B drugs.

(H) 340B providers should not be subject to payer practices that undermine the use of 340B drugs.

(I) 340B providers should not be subject to burdensome requirements for the purpose of accommodating private contractual arrangements of payers and pharmaceutical manufacturers.

(J) There is a need in the state to protect providers' 340B benefit from discriminatory payer practices in order to preserve the state's health care safety-net.

Section 3. Definitions

(A) "340B covered entity" means an entity described in section 340B(a)(4) of the "Public Health Service Act," 42 U.S.C. 256b(a)(4).

(B) "340B drug" means a drug that is—(1) a covered outpatient drug (as defined for purposes of section 340B of the Public Health Service Act); and (2) purchased under an agreement in effect under such section.

(C) "340B pharmacy" means: (1) a covered entity participating in the 340B drug discount program; (2) a pharmacy of a covered entity participating in the 340B drug discount program; or (3) a pharmacy contracting with a covered entity participating in the 340B drug discount program to dispense drugs purchased through the 340B drug discount program.

(D) "Third party" means a group health plan, a health insurance issuer offering group or individual health insurance coverage, or a pharmacy benefit manager that reimburses a 340B covered entity for drugs. Third party includes Medicaid managed care organizations, employee benefit plans under the Employee Retirement Income Security Act of 1974, or Medicare Part C or D plans. Third party does not include drugs reimbursed under Medicaid fee-for-service or a self-pay patient.

Section 4. Prohibited Actions

A third party may not discriminate against a 340B pharmacy by imposing requirements, exclusions, reimbursement terms, or other conditions on the 340B pharmacy that differ from those applied to entities or pharmacies that are not 340B pharmacies. Prohibited actions by third parties include, but are not limited to, the following:

(A) Reimbursing a 340B pharmacy for drugs at a rate lower than that paid to non-340B pharmacies or lowering reimbursement for a claim on the basis that the claim is for a 340B drug

(B) Imposing any terms or conditions on 340B pharmacies with respect to any of the following that differ from such terms or conditions applied to non-340B pharmacies on the basis that entity is a 340B pharmacy or that the drug dispensed is a 340B drugs:

(1) Fees, chargebacks, clawbacks, adjustments, or other assessments.

(2) Dispensing fees that are less than the dispensing fees for non-340B pharmacies.

(3) Restrictions or requirements regarding participation in standard or preferred pharmacy networks.

(4) Requirements relating to the frequency or scope of audits or to inventory management systems using generally accepted accounting principles.

(5) Any other restrictions, conditions, practices, or policies that are not imposed on non-340B pharmacies.

(C) Requiring identification, billing modifiers, attestation, or other indication that a drug or claim is for a 340B drug unless the drug or claim is being billed to Medicaid fee-for-service or a Medicaid managed care plan and the state requires 340B claim identification

(D) Requiring a 340B pharmacy to reverse, resubmit, or clarify a claim after the initial adjudication unless these actions are in the normal course of pharmacy business and not related to 340B drug pricing

(E) Excluding a 340B pharmacy from a network on the basis of the pharmacy's participation in 340B or refusing to contract with a 340B pharmacy for reasons other than those that apply equally to non-340B pharmacies

(F) Imposing any provision that prevents or interferes with an individual’s choice to receive a prescription drug from a 340B pharmacy, including the administration of the drug, in person or via direct delivery, mail, or other form of shipment, or creation of a restriction or additional charge on a patient who chooses to receive drugs from a 340B pharmacy

(G) Using a definition of “pharmacy” that factors in a pharmacy’s participation in 340B

(H) Requiring or compelling the submission of ingredient costs or pricing data or pertaining to drugs purchased under section 340B

Section 5. Enforcement

Upon enactment of this law, any provision of a contract that is contrary to this section is void and unenforceable. A civil monetary penalty shall be imposed on any third party that violates the requirements of this section. Such penalty shall not exceed $5,000 per violation per 340B pharmacy per day.

A violation of any provision of this article by a third party constitutes an unfair or deceptive act or practice in the business of insurance under [insert state reference] and is considered void and unenforceable.

Section 6. Rules

The [chief State insurance regulator] shall propose and adopt regulations to implement 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.

EXECUTIVE COMMITTEE MATERIAL

ND Rep. George Keiser, former NCOIL President, passed away after battling ALS the last few years.

Below please find a Resolution in Honor of Rep. Keiser that will be discussed and considered during the Executive Committee's meeting in Las Vegas.

Comments in support of the Resolution and in memory of Rep. Keiser are welcome. All comments will then be formally bound together and sent to Rep. Keiser's family along with the Resolution.

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Manasquan, NJ 08726
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Honor of Past President Representative George Keiser (ND)

To be Discussed and Considered by the NCOIL Executive Committee on March 6, 2022

Sponsored by Sen. Jerry Klein (ND); Sen. Shawn Vedaa (ND); Rep. Tracy Boe (ND); Rep. Deborah Ferguson (AR); Sen. Jason Rapert (AR); Asm. Ken Cooley (CA); Sen. Travis Holdman (IN); Rep. Matt Lehman (IN); Sen. Neil Breslin (NY); Asm. Kevin Cahill (NY); Rep. Tom Oliverson (TX)

WHEREAS, George Keiser served with distinction for nearly 30 years in the North Dakota House of Representatives, having first been elected in 1992; and

WHEREAS, George applied his experience and wisdom as a successful business owner and employer to his role as Chair of the North Dakota House Industry, Business & Labor Committee from 2003-2019; and

WHEREAS, prior to his legislative service, George served his country in the U.S. Army and as Bismarck City Commissioner; and

WHEREAS, George, the youngest of ten children, was proud to be a father and husband to his wife, Kathy, and four children, Jenny, Jeff, Sarah, and Katie; and

WHEREAS, George was a longtime active NCOIL member and leader, having served in each of the NCOIL Officer positions, culminating with his successful tenure as NCOIL President in 2011; and

WHEREAS, throughout his time at NCOIL, George was at the forefront of several important NCOIL efforts including being the sponsor of:

- Resolution in Support of the Enforcement of the Department of Defense Predatory Lending Regulation
- Resolution Concerning Best Practices for Pension De-Risking through Private Annuitization
- Accumulator Adjustment Program Model Act
- Transparency in Dental Benefits Contracting Model Act
- Patient Safety Model Act

- Model State Uniform Building Code
- Trucking and Messenger Courier Industries Workers' Compensation Model Act
- Employer-Sponsored Group Disability Income Protection Model Act
- Resolution Regarding Health Benefit Exchange Navigator Programs
- Resolution in Support of H.R. 1206, The Access to Professional Health Insurance Advisors Act
- Resolution in Support of H.R. 506, The Health Partnership Through Creative Federalism Act
- Resolution Urging Congress to Extend the Effective Date for Non-admitted Insurance Provisions of the Dodd-Frank Act
- Resolution in Support of Expanding Annuity Suitability Requirements
- Resolution in Opposition to Amending or Repealing the McCarran-Ferguson Act
- Resolution Opposing Certain Executive Sessions of Public Policy Officials
- Resolution in Support of State Insurance Commissioner Authority Over Fixed Indexed Annuity Products
- Resolution in Support of "No Pay, No Play" Laws to Address the Problem of Uninsured Motorists Knowingly Driving Uninsured
- Resolution Supporting State Regulation of the Use of Credit Information in Personal Insurance
- Resolution Regarding State Land-Use Policies
- Resolution Regarding Efforts to Make Insurer Receivership Model Act ("IRMA") Provisions Part of the NAIC Accreditation Standards
- Resolution Regarding Motor Vehicle Crash Parts
- Resolution in Support of the Confidentiality of Risk-Based Capital Information
- Resolution Regarding Medical Malpractice Reform

WHEREAS, George was an active legislator outside of NCOIL and was consistently recognized for his expertise in insurance as he was the first state legislator ever to be appointed to serve on the Federal Advisory Committee on Insurance; and

WHEREAS, throughout his legislative career, George was a passionate supporter of the state-based system of insurance regulation, and always voted based upon what he believed was in the best interests of the citizens of North Dakota; and

WHEREAS, upon being diagnosed with ALS (Amyotrophic Lateral Sclerosis) in the Spring of 2019, George fought the illness with courage, good humor and grace just as he lived his life; and

WHEREAS, NCOIL lawmakers and participants remember warmly the times they worked with, laughed with, and grew to know him as a great legislator and both a great and good man; and

NOW, THEREFORE, BE IT RESOLVED that NCOIL lawmakers Recognize and Honor Representative George Keiser for his significant personal and professional

contributions he made to NCOIL over the years and acknowledges him as a dedicated, extremely effective legislator, and

BE IT FINALLY RESOLVED that NCOIL, with great appreciation, will send this resolution to George's family in honor of his special place in NCOIL history.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUSINESS PLANNING COMMITTEE AND EXECUTIVE COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 20, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Business Planning Committee and Executive Committee met at The Westin Kierland Hotel in Scottsdale, Arizona on Saturday, November 20, 2021 at 12:00 p.m.

Indiana Representative Matt Lehman, NCOIL President and Chair of the Committees, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson (AR)
Asm. Kevin Cahill (NY)

Asm. Ken Cooley (CA)
Asw. Pam Hunter (NY)
Sen. Travis Holdman (IN)
Sen. Bob Hackett (OH)
Rep. Joe Fischer (KY)
Rep. Tom Oliverson, M.D. (TX)
Sen. Paul Utke (MN)

Other legislators present were:

Sen. Keith Ingram (AR)
Sen. Walter Michel (MS)
Rep. Craig Snow (IN)
Rep. Hank Zuber (MS)
Sen. Michael McClendon (MS)
Rep. Carl Anderson (SC)

Also in attendance were:

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

QUORUM

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

MINUTES

Upon a Motion made by Sen. Paul Utke (MN), and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's July 17, 2021 meeting in Boston, MA.

FUTURE MEETING LOCATIONS

Rep. Matt Lehman (IN), NCOIL President, stated that the first item on the agenda for discussion is an update on future meetings. Our 2022 Spring meeting is in Las Vegas. Our other meetings next year are set for Jersey City in July, which you may recall is

where we were supposed to meet in July of 2020 but due to COVID we moved that 2022, and our Annual Meeting will be in New Orleans.

Will Melofchik, NCOIL General Counsel, then provided an update on meeting locations beyond 2022. Mr. Melofchik stated that there has been progress made getting Illinois to return as a Contributing State. That is important because there are openings right now in the NCOIL meeting calendar for the Summer of both 2024 and 2025, which would be a great time to go to Chicago. However, the National Association of Insurance Commissioners (NAIC) currently has its 2024 Summer Meeting scheduled to be in Chicago. So, if Chicago was chosen as an NCOIL Summer meeting location, the idea has been preliminarily discussed of possibly returning to the joint meeting format NCOIL had with the NAIC in Austin, Texas a couple of years ago.

Hearing no questions or comments from any legislators or interested persons, Rep. Lehman stated that he takes silence as everyone is ok with that idea. Rep. Lehman stated that this decision is not being made necessarily right now but there was some discussion a couple of years ago from the travel standpoint of some people didn't like it because it made for a longer week for those who were attending both conferences. At the same time, some said they liked it and while they may be away from home longer, they didn't have to travel twice. Rep. Lehman requested that legislators and interested persons continue to think about the idea.

Commissioner Tom Considine, NCOIL CEO, stated that following the joint meeting in Austin a couple of years ago, there was enormous feedback of "never again in December" since it's too close to the holidays. However, there was some underlying feedback on how if it were a summer meeting, people might bring their families and maybe that would be worth exploring. We thought people might have some comments today about that, but it is indeed the end of a very long meeting here, so we really would invite comments back as you think about that going forward as it is a few years away. And of course, Illinois would really need to pay their NCOIL dues.

Sen. Michael McLendon (MS) stated that there's a number of us that are in session in the early parts of the year and in Mississippi, we go through March, and we're normally done in April. Has moving the Spring Meeting from March to April been considered? Mr. Melofchik stated that for next year and 2023, our contracts with the hotels are already signed for dates in March, but this past year we ended up delaying the Spring meeting from the middle of March to the middle of April and it worked out very well. Accordingly, it was decided that going forward the Spring Meeting will be in either early or middle of April.

Rep. Lehman stated that he thinks that the April meeting was well received, and we're in a similar position in Indiana regarding conflicts in March with session dates. Having the Spring Meeting in April is a good thing to keep considering.

Cmsr. Considine stated that he believes there's actually one contract that's signed already for April and the folks who negotiate the contracts on our behalf know that Spring Meetings are now in April and conflicts with Passover and Easter should be avoided. Mr. Melofchik stated that in 2024, the Spring Meeting will be April 11th to 14th in Nashville, TN.

ADMINISTRATION

Mr. Melofchik stated that there were 357 total attendees here in Scottsdale which included 70 legislators from 25 states. That included 22 first time legislators, and we had seven Insurance Commissioners participating. Overall, there were 12 insurance departments represented.

Mr. Melofchik gave the 2021 unaudited financials through October 31st of this year, showing revenue of $1,390,659.30 and expenses of $1,007,364.46 for an excess of $383,294.84 heading into this meeting.

Rep. Lehman stated that he thinks those numbers illustrate that we're reaping the benefits of the decisions to change our dues structure, and he appreciates everybody who was supportive of that and who stepped up in their respective states to help us get through that.

CONSENT CALENDAR

Rep. Lehman noted that the consent calendar includes committee reports including resolutions and model laws adopted and re-adopted therein, as well as ratification of decisions made and actions taken by the NCOIL Officers in the time between Executive Committee meetings.

The consent calendar included:

- The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Telemedicine Authorization and Reimbursement Model Act, the NCOIL Accumulator Adjustment Program Model Act, and the NCOIL Model Act Regarding Air Ambulance Patient Protections

- The Financial Services & Multi-Lines Issues Committee adopted the NCOIL Remote Notarization Model Act, the NCOIL Uniform Captive Insurer Model Act, and re-adopted the NCOIL Identify Theft Protection Model Act.

- The Workers' Compensation Insurance Committee adopted a Resolution Opposing Federal Monitoring of the State-Based Workers' Compensation System, and re-adopted the NCOIL Model State Structured Settlement Protection Act until the Spring Meeting.

- The Articles of Organization & Bylaws Revision Committee adopted amendments to the NCOIL Articles of Organization & Bylaws

- The Joint State-Federal Relations & International Insurance Issues Committee adopted the NCOIL Resilient Revolving Loan Fund Model Act, technical corrections to the NCOIL Insurance Business Transfer Model Act, and re-adopted the NCOIL Company Licensing Modernization Model Act.

- The 2021 budget as adopted by the Budget Committee on 11/17/21.

- Ratification of Decisions Made & Actions Taken by the NCOIL Officers in time between Executive Committee Meetings.

Rep. Lehman asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a Motion made by Asm. Ken Cooley (CA), NCOIL Vice President, and seconded by Rep. Deborah Ferguson (AR), the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Rep. Lehman stated that it was great to see Congressman Andrew Garbarino (NY) back at NCOIL in his new role, and he delivered great remarks as the Keynote speaker during the luncheon.

The Griffith Institutes Foundation held another great luncheon with their presentation on the Direct-to-Consumer Insurance.

We had three great general sessions:

- "Insurance Score Transparency"
- "Prior Authorization in Healthcare – Are Goldcards the Answer?"
- "Man's Best Friend But Not Insurable?"

Asm. Cooley stated that he would like to point out how well the organization's budget is doing, and that during Congressman Garbarino's remarks at the luncheon, when talking about the role of NCOIL and his career, he said, "Everything I learned about insurance I learned at NCOIL." For those of us who come to NCOIL, we know that insurance is such a complicated subject, and if you're a busy lawmaker you can't actually gain a comprehensive understanding and feel of insurance at any point in your career. Insurance is kind of like the old story of two guys getting chased by a bear and one of them stops and takes off his shoes. And the other one says, "Why are you doing that, you have to outrun the bear." To which he says, "No, I actually only have to outrun you."

He continued that he believes "insurance is that way. We go back to our state capitals and colleagues are going to look to figure out who in the room seems to have an orientation on the subject matter. It doesn't even need to be comprehensive knowledge, you just have to know what you're talking about, what the general subject is, have a baseline understanding, and be able to ask intelligent questions that illuminate the issue. And that is what NCOIL can do for lawmakers who are in this space in all the 50 states. The organization is doing great, both financially and structurally, and those who come to NCOIL - we're the ones that can lead the conversations on insurance and the organization is a great asset. That's part of what makes us distinctive and very important in this space."

NOMINATING COMMITTEE REPORT

Sen. Travis Holdman (IN), NCOIL Immediate Past President and Co-Chair of the Nominating Committee, stated that the Nominating Committee met on Thursday and voted to recommend the slate of officers for next year which includes two new officers. The Committee had five outstanding candidates and we labored long over the selection. The Committee's recommendation is that Arkansas Representative Deborah Ferguson be slated for the position of NCOIL Secretary, and Texas Representative Tom Oliverson be slated for the position of NCOIL Treasurer.

The Treasurer position will be open next year because current NCOIL Secretary Kentucky Representative Joe Fischer has decided not to proceed through the Chairs as he's not fully certain that he will seek another term in the legislature[2]. Rep. Fischer decided that it would be best for the new officer to be selected now so they can gain experience as opposed to a new officer being selected immediately before becoming NCOIL President which is the situation that we got ourselves into a few years ago when Vermont Representative Bill Botzow stepped down from the legislature just one year prior to becoming President of NCOIL.

Additionally, the Committee naturally continued and approved the progression of New York Assemblyman Kevin Cahill and Asm. Cooley to advance through the Chairs to the positions of Vice President and President, respectively. Sen. Holdman stated that, accordingly, the officer group would now be those four individuals plus Immediate Past Presidents Rep. Lehman and Arkansas Senator Jason Rapert. Sen. Holdman then presented a Motion to adopt that slate of officers. Sen. Bob Hackett (OH) seconded the Motion.

Rep. Lehman asked if any of the officers would like to say a few words.

Rep. Ferguson thanked the Committee for its consideration and stated that she has really enjoyed NCOIL over the years as it's really one of the best groups she belongs to in terms of really advancing sound policy and model legislation. Rep. Ferguson stated that she looks forward to working with everyone to continue the good path that NCOIL's been on.

Rep. Oliverson stated that he would like to echo Rep. Ferguson's comments, as well as Congressman Garbarino's – "Everything I learned about insurance I learned here." Rep. Oliverson stated that this organization is deeply, deeply important to him and he wants to see it continue to flourish.

Asm. Cahill stated that he would like to take a moment to acknowledge the great contributions that Sen. Holdman has made to the organization. Asm. Cahill stated that Sen. Holdman was one of the key figures when Asm. Cahill first got involved at NCOIL. Sen. Holdman presided over a time of great transition, and he shepherded the organization through a difficult time and continued to steady the ship every time it started to wobble a little bit. Asm. Cahill stated that he is very happy to have worked with Sen. Holdman and wishes him great success going forward.

Hearing no further comments and no questions being proposed, the Committee voted without objection by way of a voice vote to adopt the Nominating Committee's report.

Rep. Lehman then stated he would like to say a few words before turning things over to Asm. Cooley as new NCOIL President. Rep. Lehman stated that this is his 34th NCOIL meeting. He first came in Boston in 2010 and he has not missed a meeting since then, not because he's learned everything about insurance at NCOIL but because he's in the insurance business and everything is tied at the hip together. Rep. Lehman stated that

[2] Rep. Fischer has since announced that he will not seek re-election in 2022, and will seek election to the KY Supreme Court.

the insurance industry is heavily regulated, and he's told colleagues that if you're going to make laws you need to know what you're doing.

Rep. Lehman continued that he's not planning on going anywhere but he really appreciates his time as NCOIL President during which he was able to preside over organizational growth. There was a hiccup of course with COVID which at first seemed to not be a big deal, but then suddenly there was the issue of business interruption coverage and for about two and a half weeks he spoke with Cmsr. Considine every day trying to keep Washington D.C. at bay. Rep. Lehman stated that he's glad that the organization is back to meeting fully in-person, and he's excited where the organization's going. He wishes he had been able to travel to more states during his time as NCOIL President but maybe now he'll be freed up and can do that. Rep. Lehman stated that he is looking forward to Asm. Cooley's leadership and noted that if you've gotten to know Asm. Cooley at all, he is a steady hand at the wheel and is someone who's a deep thinker and is going to be a great asset to NCOIL. Rep. Lehman then recognized Asm. Cooley as new NCOIL President.

Asm. Cooley stated that it is an honor to follow Rep. Lehman. The new President noted that his predecessor brings a great passion for the industry, and he brings great knowledge to the industry and he has persevered through two years in this his role as NCOIL President really carrying the organization through during COVID. To persevere in one's work and make things happen during the time of COVID with all the discombobulation that was imposed on people is a real testament to the great work Rep. Lehman has done for the organization, and he has helped really put NCOIL on the national map. Asm. Cooley stated that even during the NCOIL – NAIC Dialogue on Friday morning, there was a change in tone in how we interact with regulators, and how they responded to us, and how they responded when an issue came up concerning the standard nonforfeiture law and maybe some approvals that happened where some regulators were not making the connection between what was the law and what was presented to them. Asm. Cooley stated that it's so important to have legislators who own the policy on behalf of the public as we are the first branch of government because we hold the people's power. Asm. Cooley then presented Rep. Lehman with a replica of the official NCOIL seal in honor of his unique time as a two-year NCOIL President.

Rep. Lehman stated that he would like to thank his fellow officers as they all were a pleasure to work with and really helped him during his time as NCOIL President.

Asm. Cooley stated that it is a great honor to be NCOIL President and his first boss back in the 1970s was an independent insurance agent who went to NCOIL meetings. Asm. Cooley stated that he went to his first NCOIL meeting when he was Chief Counsel for the California Assembly Finance and Insurance Committee in the 1980s. When he was first elected to the CA Assembly back in 2012, the Speaker didn't know him very well so Asm. Cooley had a sit-down get-to-know-you meeting with the Speaker. Part of the ritual in such a meeting is you get to ask for three things. Asm. Cooley stated that at that time, California was not a dues paying member state of NCOIL although California was the nation's largest insurance market. Accordingly, one of the three things Asm. Cooley asked for during the meeting was to get California signed-up as an NCOIL dues-paying Contributing state because it was very important to him.

Asm. Cooley again stated that it is such a huge honor to now be in a position to step into this role as NCOIL President. Asm. Cooley stated that he is a huge believer in the role

of lawmakers that at the end of the day our very important partners who are the regulators, they're job is to implement the law that we and our predecessors put on the books. The whole regulatory system that is state based that we defend at NCOIL is founded upon a delegation of legislative authority out to the regulators and implicit in that to the NAIC. Everything the NAIC does is sort of surfing on our wave, and it is very important that we assert the dignity of our office which is not egotism but just inherent in our system of government as we are the first branch of government and it's our obligation to represent our constituents and the businesses of our state to make sure there's a fair deal and the system works. Asm. Cooley stated that we must always keep our ear to the ground when an issue comes up which is why NCOIL adopts Model laws because somebody sees an insurance issue that needs some attention and lawmakers need to be in that conversation.

Asm. Cooley stated that it is a great privilege to enter into this role and it's something that he's so thrilled to do. With that being said, he noted that the Committee had a couple of final items of business to address, one of which is the consideration of NCOIL's auditor for next year. Asm. Cooley recognized Cmsr. Considine to address those items of business.

Cmsr. Considine thanked Asm. Cooley and stated that as a brief matter of personal privilege, he can't say enough about Rep. Lehman. He noted that several years ago, during an NCOIL conference a group of legislators and staff were on a day trip after the conference ended early on Saturday and there was some sparring with nicknames. Rep. Lehman's nickname was Santa Claus. Cmsr. Considine stated that during the most recent conference in July, somebody asked him to introduce him to Rep. Lehman and Cmsr. Considine replied: "Well you see the guy way over there in the corner? He looks a little bit like Santa Claus, except when you get over and you speak to him, you'll find the difference is that Matt's nicer." Cmsr. Considine noted it is in fact true.

Cmsr. Considine stated that he annoyed Rep. Lehman and his wife to no end during the last two years with NCOIL matters and they were unbelievably gracious with their time. Cmsr. Considine further stated that it's also not lost on him or Mr. Melofchik that this is what we do for a living, but Rep. Lehman is not a back bench legislator in Indiana - he's the Majority Leader of a caucus. And yet, Rep. Lehman would always make time to talk whenever we needed. Cmsr. Considine stated that it's not too strong a statement to say that he loves the guy, and he can't thank him enough for everything.

ANY OTHER BUSINESS

Cmsr. Considine stated that the current auditor utilized for NCOIL is Collins & Co. out of Pennsylvania. There's a limited number of auditing firms that do this work for organizations like NCOIL. He continued that the firm does some guaranty association work and some insurance trade association work. They have been with us for a number of years and do put new eyes on the account every year. They meet with the Auditing Committee in detail with staff out of the room. Cmsr. Considine stated that it's our recommendation as staff that the organization continue to retain them.

Hearing no questions or comments, upon a Motion made by Asm. Cahill and seconded by Sen. Holdman, the Committee voted without objection by way of a voice vote to retain the services of Collins & Co. for 2021 audits

Asm. Cooley then offered the opportunity for any nominations of legislators to the Executive Committee.

Rep. Ferguson stated that she would like to nominate Rep. Carl Anderson from South Carolina.

Rep. Oliverson stated that he would like to nominate Sen. Walter Michel from Mississippi.

Sen. Holdman stated that he would like to nominate Sen. Keith Ingram from Arkansas.

Sen. Michel stated that he is not sure if he has been formally placed on the Committee yet because there hasn't been a vote, but he would like to nominate Sen. Mike McClendon from Mississippi. Sen. Paul Utke (MN) then nominated Sen. McClendon.

Sen. Hackett stated that his colleague, Sen. George Lang (OH) has tremendous insurance experience and asked if Sen. Lang had to be at a certain number of NCOIL meetings to qualify for Executive Committee membership. Asm. Cooley replied that any legislators seeking nomination to the Executive Committee must be present at the meeting of the Executive Committee in order to be considered.

Hearing no questions or comments, upon a motion made by Sen. Holdman and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to add Rep. Anderson, Sen. Michel, Sen. Ingram, and Sen. McClendon to the Executive Committee.

Asm. Cahill congratulated Asm. Cooley on his new role as NCOIL President and stated that his knowledge of insurance has been terrific from the first day that he heard him speak on the subject and he looks forward to serving together in the NCOIL officer ranks. Asm. Cahill stated that he would also like to take a moment to thank now Immediate Past President Rep. Lehman for his help during COVID and also for his extended tenure as NCOIL President and for everything that he did to make this organization as vital and important as it is. Asm. Cahill further stated that he would like to welcome the two new doctors to the NCOIL Officer group - Drs. Ferguson and Oliverson. NCOIL is very lucky to have them on the team going forward and there is so much great work that the organization can do and that they can contribute to.

Asm. Cahill stated that he would like to address an issue that just came up today at two meetings where speakers included props in their presentation. In one instance it was t-shirts and stuffed animals and baseball hats, and in the other instance it was quite frankly something pretty offensive, and comical. Asm. Cahill stated that he believes that it took away from the decorum and the seriousness of the protocols that NCOIL has and he asked either formally or informally that speakers be advised in the future that this is a serious forum where there are rules and limitations as to what can and cannot be used as part of a presentation and that we would expect them to respect it; or respect the fact that we should not be allowing them to speak.

Sen. Utke stated that he was prepared to raise the same issue and asked if there is any current written policy referring to props being used at NCOIL meetings. Sen. Utke stated that in his legislature and most likely legislatures around the country, there is a type of a decorum where certain things aren't allowed in hearings. Sen. Utke stated that if NCOIL

doesn't have any such guidelines, perhaps it should be addressed whether it's done through the Executive Committee or through staff coming up with a recommendation.

Asm. Cooley stated that he agrees there is a decorum that is associated with most legislative chambers and activities and as a legislative body, NCOIL can work on that.

Cmsr. Considine stated that this was an issue that was beyond regrettable, and it was wrong. Typically, the Chairs have very wide latitude, and we hadn't contemplated it, frankly, because we didn't want to have a "no prop" ban because of situations where if somebody brought a globe or something that was going to have some true value, we didn't want to bar that. He noted that certainly now, staff will be happy to draft something that seeks to thread that needle to say that anything that in any way doesn't meet proper standards of decorum, which is differentiated from things that have scientific or insurance related value, is barred, and that the Chair or moderator can stop comments and end testimony.

Asm. Cooley stated that here in the great state of Arizona he visited its Chambers on Tuesday and there in the gallery of the Senate and Assembly was a message saying that no placards or signs or things that are offensive to decorum are not welcome there. We are certainly in a time when there is an intensity of feeling in the public space that we all encounter in varying degrees. Asm. Cooley stated that he actually sat in his Capitol office recently and had somebody who ended up having to be forcibly restrained trying to open his rear door which is a private door. Fortunately, there was a sergeant nearby.

One of the tremendous strengths of NCOIL is that it's a bipartisan organization focused on trying to further good public outcomes and we believe in free speech, but there's also a need to maintain a sort of civility in the discourse so there should certainly be something that characterizes us what is really the fiber of this organization over its history. Asm. Cooley stated that this can be treated as a facet of the times we are in that people feel empowered to do all manner of things, which might strike us as unexpected, so some boundaries need to be set and enforced, independent of the topic and speech. It's nothing personal, and actual good democratic work.

Cmsr. Considine requested that the recommendation from this Committee be extended. No one wants to get into the censorship business, but if people advertise in the NCOIL conference program that in some way would seek to link their organization to NCOIL or give the impression that the organization is tied to NCOIL by having a website that has NCOIL as part of its address, we should be allowed to restrict that as well. Asm. Cooley agreed.

Rep. Ferguson stated that it would be best to provide the rules and guidelines with the speakers in advance rather than trying to enforce them after the fact. Asm. Cooley agreed and stated that he expects that something will be developed that puts the protocols in writing and becomes a standard part of interaction at NCOIL meetings, and it's probably worth making sure people have annotated it and provided it to us so we know it's read and agreed to.

Asm. Cooley asked if there was a representative from the IEC present who would like to offer suggested topics for discussion at future NCOIL meetings.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA), stated that the IEC has a recommended topic that has to do with insurance industry apprenticeship programs that was put forward by Zurich. The IEC recommends that particular topic for NCOIL's consideration and thanks NCOIL for its continued partnership with the IEC.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Oliverson and seconded by Sen. Utke, the Committee adjourned at 1:00 p.m.