30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL ANNUAL MEETING
NOVEMBER 16 - 19, 2022

As of November 10, 2022, and Subject to Change

The Sheraton New Orleans Hotel
New Orleans, Louisiana

NCOIL ANNUAL MEETING
New Orleans, Louisiana
November 16 - 19, 2022
TENTATIVE SCHEDULE

WEDNESDAY, NOVEMBER 16TH

First Annual NCOIL Open Golf Outing to Benefit the Insurance Legislators Foundation (ILF) Scholarship Fund	12:00 p.m.		
Welcome Reception	6:00 p.m.	-	7:30 p.m.

THURSDAY, NOVEMBER 17TH

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.
Health Insurance & Long Term Care Issues Committee	10:00 a.m.	-	11:30 a.m.
NCOIL Innovation Series Have Data Privacy Laws and Regulations Kept Up with 21st Century Technology?	11:30 a.m.	-	1:00 p.m.

The Institutes Griffith Foundation Legislator Luncheon Pandemic-Related Business Interruption Coverage: Past, Present and Future ***Open to Public Policymakers and Staff Only***	1:00 p.m.	-	2:00 p.m.
Workers' Compensation Insurance Committee	2:00 p.m.	-	3:15 p.m.
Networking Break	3:15 p.m.	-	3:30 p.m.
Life Insurance & Financial Planning Committee	3:30 p.m.	-	5:00 p.m.
Articles of Organization & Bylaws Revision Committee	5:00 p.m.	-	5:20 p.m.
Adjournment	5:20 p.m.		
Nominating Committee (Members Only)	5:20 p.m.		
CIP Member & Sponsor Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, NOVEMBER 18TH

Registration *Exhibits Open: 8:00 a.m. – 4:00 p.m.*	8:00 a.m.	-	4:00 p.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:30 a.m.
Networking Break	10:30 a.m.	-	10:45 a.m.
NCOIL – NAIC Dialogue	10:45 a.m.	-	12:00 p.m.
Luncheon with Keynote Address	12:00 p.m.	-	1:30 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.

General Session Examining the Impact of Wildfire Risk on the Insurance Market	1:30 p.m.	-	2:45 p.m.
Networking Break	2:45 p.m.	-	3:00 p.m.

Property & Casualty Insurance Committee	3:00 p.m.	-	4:30 p.m.
Budget Committee	4:30 p.m.	-	4:50 p.m.
Adjournment	4:50 p.m.		
IEC Board Meeting	4:30 p.m.	-	5:15 p.m.

SATURDAY, NOVEMBER 19TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	12:00 p.m.
The Institutes Griffith Foundation Legislator Breakfast "Health Insurance": Exploring the Structure of the U.S. System - A Primer for Public Policymakers ***Open to Public Policymakers and Staff Only***	7:45 a.m.	-	8:45 a.m.
General Session What's it Going to Cost Me? – A Discussion on Hospital Price Transparency	8:45 a.m.	-	10:15 a.m.
Networking Breakfast	10:15 a.m.	-	10:30 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	10:30 a.m.	-	12:00 p.m.
Executive Committee	12:00 p.m.	-	12:30 p.m.

******Please note all speakers listed are scheduled to speak as of November 10, 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.******

Wednesday, November 16th, 2022

First Annual NCOIL Golf Outing to Benefit the Insurance Legislators Foundation (ILF) Scholarship Fund
Wednesday, November 16, 2022
12:00 p.m.

Welcome Reception
Wednesday, November 16, 2022
6:00 p.m. – 7:30 p.m.

Thursday, November 17th, 2022

Welcome Breakfast
Thursday, November 17, 2022
8:15 a.m. – 9:45 a.m.

1.) Welcome to New Orleans
The Hon. Billy Nungesser - 54th Lieutenant Governor of Louisiana
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.) Any Other Business
6.) Adjournment

Networking Break
Thursday, November 17, 2022
9:45 a.m. – 10:00 a.m.

Health Insurance & Long Term Care Issues Committee
Thursday, November 17, 2022
10:00 a.m. – 11:30 a.m.

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

1.) Call to Order/Roll Call/Approval of July 14, 2022 Committee Meeting Minutes
2.) Introduction and Discussion on NCOIL Biomarker Testing Insurance Coverage Model Act
    Asw. Pam Hunter (NY) – Sponsor
    Dr. Marc Matrana - Director, Precision Cancer Therapies (Phase I) Research Program, Endowed Professor of Experimental Therapeutics and Associate Director of Clinical Cancer Research - Ochsner Cancer Institute
    Tammie Middletown, Volunteer – GO2 Foundation for Lung Cancer
    James Gelfand, President – ERISA Industry Committee (ERIC)
3.) Discussion on Policies that Enable Value-Based Payment Arrangements (VBPs) for Gene Therapies
    JP Wieske – Campaign for Transformative Therapies
    Bert Bruce, U.S. President, Rare Disease – Pfizer
    Jesse Lemberger, Senior Director, Strategic Pricing – Pfizer
4.) Discussion on Gold Card Laws and Prior Authorization Reform Efforts
    Jeff Drozda, CEO – Louisiana Association of Health Plans
    Maria Bowen, VP, Governmental Affairs – Louisiana State Medical Society
    Miranda Motter, Senior VP, State Affairs & Policy – America's Health Insurance Plans (AHIP)
5.) Any Other Business
6.) Adjournment

NCOIL Innovation Series
Have Data Privacy Laws and Regulations Kept Up with 21st Century Technology?
Thursday, November 17, 2022
11:30 a.m. – 1:00 p.m.

Moderator: Rep. Edmond Jordan (LA)

Andrew Barnhill
Head of Public Policy
IQVIA

Brett Meeks
Vice President
Health Innovation Alliance

JP Wieske
Vice President of State Affairs
Horizon Government Affairs

The Institutes Griffith Foundation Legislator Luncheon
Pandemic-Related Business Interruption Coverage: Past, Present and Future
Thursday, November 17, 2022
1:00 p.m. – 2:00 p.m.
***** This non-partisan and non-advocative session, presented by The Institutes Griffith Foundation, is open to public policymakers and staff only.*****

Paul E. Traynor, JD, LLM
Assistant Professor of Law
University of North Dakota School of Law

Workers' Compensation Insurance Committee
Thursday, November 17, 2022
2:00 p.m. – 3:15 p.m.

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

1.) Call to Order/Roll Call/Approval of July 15, 2022 Committee Meeting Minutes
2.) Presentation on Fentanyl and Its Impact on the Workers' Compensation Marketplace
Phil Walls, RPh, Chief Clinical Officer – myMatrixx
3.) Discussion on Louisiana Workers' Compensation System
Kristin Wall, President & CEO – Louisiana Workers' Compensation Corporation (LWCC)
Angela McGhee, SVP, Underwriting & Chief Actuary -LWCC
4.) Discussion on Workers' Compensation Legislative & Regulatory Trends
Tim Tucker, Washington Affairs Executive, External and Government Affairs - National Council on Compensation Insurance (NCCI)
5.) Any Other Business
6.) Adjournment

Networking Break
Thursday, November 17, 2022
3:15 p.m. – 3:30 p.m.

Life Insurance & Financial Planning Committee
Thursday, November 17, 2022
3:30 p.m. – 5:00 p.m.

Acting Chair: Rep. Carl Anderson (SC)
Vice Chair: Sen. Walter Michel (MS)

1.) Call to Order/Roll Call/Approval of July 15, 2022 Committee Meeting Minutes
2.) Discussion and Consideration of NCOIL Paid Family Leave (PFL) Insurance Model Act
   Sen. Paul Utke (MN) – Sponsor; Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary – Co-sponsor
   Karen Melchert, Regional VP, State Relations – American Council of Life Insurers (ACLI)
3.) Discussion on Uniform Regulation of Insurer Investing
   The Hon. Jim Hodges - Former Governor of South Carolina; Executive Director - National Alliance of Life Companies (NALC)
   Jennifer Webb, AVP, Assistant General Counsel & Head of State Government Affairs – Pacific Life
   Michael Porcelli, FSA, Senior Director - AM Best Rating Services
4.) Presentation on Life Insurer Investments in Social Infrastructure and Community Development Initiatives
   Kelly Edmiston, Ph.D., Policy Research Manager – NAIC Center for Insurance Policy and Research
   Pat Reeder, Vice President & Deputy General Counsel - ACLI
5.) Any Other Business
6.) Adjournment

Articles of Organization & Bylaws Revision Committee
Thursday, November 17, 2022
5:00 p.m. – 5:20 p.m.

Acting Chair: Sen. Walter Michel (MS)
Vice Chair: Rep. Carl Anderson (SC)

1.) Call to Order/Roll Call/Approval of November 19, 2021 Committee Meeting Minutes
2.) Discussion and Consideration of Proposed Amendments to NCOIL Articles of Organization & Bylaws
3.) Any Other Business
4.) Adjournment

Nominating Committee (Members Only)
Thursday, November 17, 2022
5:20 p.m.

CIP Member & Sponsor Reception
Thursday, November 17, 2022
6:00 p.m. – 7:00 p.m.

Friday, November 18th, 2022

Financial Services & Multi-Lines Issues Committee
Friday, November 18, 2022
9:00 a.m. – 10:30 a.m.

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

1.) Call to Order/Roll Call/Approval of July 14, 2022 Committee Meeting Minutes
2.) Discussion and Consideration of NCOIL Insurance Regulatory Sandbox Model Act
    Rep. Bart Rowland (KY) – Sponsor; Rep. Wendi Thomas (PA); Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer – Co-Sponsors
3.) Discussion on the Development and Use of Environmental, Social and Governance (ESG) Scores
    Peter Giacone, Sr. Managing Director – Kroll Bond Rating Agency (KBRA)
    Dave Carlson, Managing Director, US Manufacturing and Automotive Industry Practice - Marsh
4.) Presentation on Retention and Recruitment of Insurance Talent
    Noelle Codispoti, CPCU, ARM, National Alliance for Insurance Education and Research
5.) Presentation on Insurance Developments in the Federal Home Loan Bank System
    Eric Haar, Director of Government and Industry Relations - Federal Home Loan Bank of Dallas
6.) Discussion and Consideration of Re-adoption of Model Laws
    a.) Model Act to Support State Regulation of Insurance by Requiring Competition Among Rating Agencies — Adopted 11/19/17 ***(*Proposed amendments sponsored by Sen. Bob Hackett (OH))***
    b.) Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes — Adopted 11/19/17
    c.) Credit Report Protection for Minors Model Act — Originally Adopted 11/20/16; Amended Version Adopted 11/19/17
    d.) Credit Default Insurance Model Legislation – Originally Adopted 7/11/10; Readopted 11/19/17
7.) Any Other Business
8.) Adjournment

Networking Break
Friday, November 18, 2022
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, November 18, 2022
10:45 a.m. – 12:00 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 July 15, 2022 Committee Meeting Minutes
2.) Discussion on Federal Insurance Office (FIO) Activities
3.) Update on Work of NAIC Innovation Cybersecurity and Technology (H) Committee
4.) Discussion on the Impact of Wildfire Risk on the Insurance Market
5.) Discussion on Development of New NAIC Data Privacy Model Law
6.) Discussion on Proposed Amendments to NAIC Life Insurance Illustration Model Regulation
7.) Discussion on Adoption of NAIC Pet Insurance Model Law
8.) Any Other Business
9.) Adjournment

Luncheon with Keynote Address
Friday, November 18 2022
12:00 p.m. – 1:30 p.m.

John Ashford
Chairman and CEO
The Hawthorn Group, L.C.

General Session
Examining the Impact of Wildfire Risk on the Insurance Market
Friday, November 18, 2022
1:30 p.m. – 2:45 p.m.

Moderator: Rep. Jim Dunnigan (UT)

The Honorable Jon Pike	*Roy Wright*
Commissioner	*President & CEO*
Utah Dep't of Insurance	*Insurance Institute for Business & Home Safety (IIBHS)*
Amy Bach	*Karen Collins*
Executive Director	*Assistant Vice President of Personal Lines*
United Policyholders	*American Property Casualty Insurance Ass'n (APCIA)*

Networking Break
Friday, November 18, 2022
2:45 p.m. – 3:00 p.m.

Property & Casualty Insurance Committee
Friday, November 18, 2022
3:00 p.m. – 4:30 p.m.

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

1.) Call to Order/Roll Call/Approval of July 16, 2022 and September 29, 2022 Committee Meeting Minutes
2.) Discussion on Idaho's Efforts to Lower the Uninsured Motorist Population
Rep. Rod Furniss (ID)
3.) Presentation on Developments in the Surplus and Excess Line Insurance Marketplace
John Meetz, Sr. State Relations Manager – Wholesale and Specialty Insurance Association (WSIA)
Daniel Maher, Executive Director – Excess Lines Association of New York (ELANY)
4.) Discussion and Consideration of Model Laws
a.) NCOIL Delivery Network Company (DNC) Insurance Model Act
Rep. Bart Rowland (KY) – Sponsor; Del. Steve Westfall (WV) –Co-sponsor
Frank O'Brien, VP, State Gov't Relations, American Property Casualty Insurance Association (APCIA)
Jon Schnautz, Assistant VP, State Affairs – National Association of Mutual Insurance Companies (NAMIC)
b.) NCOIL Dog Breed Insurance Underwriting Protection Model Act
Asm. Kevin Cahill (NY), NCOIL Vice President – Sponsor; Rep. Tammy Nuccio (CT) – Co-sponsor
Ledy Vankavage, Sr. Legislative Attorney – Best Friends Animal Society
Frank O'Brien - APCIA
Jon Schnautz - NAMIC
c.) NCOIL Insurance Underwriting Transparency Model Act
Rep. Matt Lehman (IN), NCOIL Immediate Past President – Sponsor
Frank O'Brien - APCIA
Jon Schnautz - NAMIC
Wes Bissett, Senior Counsel – Independent Insurance Agents and Brokers of America (IIABA)
5.) Any Other Business
6.) Adjournment

Budget Committee
Friday, November 18, 2022
4:30 p.m. – 4:50 p.m.

Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Treasurer
Vice Chair: Sen. Neil Breslin (NY)

1.) Call to Order/Roll Call/Approval of July 13, 2022 Committee Meeting Minutes
2.) Consideration of 2023 Budget
3.) Any Other Business
4.) Adjournment

IEC Board Meeting
Friday, November 18, 2022
4:30 p.m. – 5:15 p.m.

Saturday, November 19, 2022

The Institutes Griffith Foundation Legislator Breakfast
"Health Insurance": Exploring the Structure of the U.S. System - A Primer for Public Policymakers
Saturday, November 19, 2022
7:45 a.m. – 8:45 a.m.

***** This non-partisan and non-advocative session, presented by The Institutes Griffith Foundation, is open to public policymakers and staff only.*****

Tice Sirmans, Ph.D.
Assistant Professor of Risk Management and Insurance
Illinois State University College of Business

Amanda Cook, Ph.D.
Associate Professor in Economics
Bowling Green State University Schmidthorst College of Business

General Session
What's it Going to Cost Me? – A Discussion on Hospital Price Transparency
Saturday, November 19, 2022
8:45 a.m. – 10:15 a.m.

Moderator: Rep. Tammy Nuccio (CT)

Terrance Cunningham, JD
Director, Administrative Simplification Policy
American Hospital Association (AHA)

David Balat
Director, Right on Healthcare
Texas Public Policy Foundation

Maureen Hensley-Quinn
Senior Program Director of Coverage, Cost & Value
National Academy for State Health Policy (NASHP)

Cynthia A. Fisher
Founder & Chairman
PatientRightsAdvocate.org

Networking Break
Saturday, November 19, 2022
10:15 a.m. – 10:30 a.m.

Joint State-Federal Relations & International Insurance Issues Committee
Saturday, November 19, 2022
10:30 a.m. – 12:00 p.m.

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

1.) Call to Order/Roll Call/Approval of July 14, 2022 Committee Meeting Minutes
2.) Presentation on National 988 Suicide & Crisis Prevention Lifeline
    Stephanie Pasternak, Director, State Affairs, Gov't Relations, Policy & Advocacy – National Alliance on Mental Illness (NAMI)
    The Hon. Charles Curie, Consultant – Elevance Health; former Administrator of Substance Abuse and Mental Health Services Administration (SAMHSA)
3.) Presentation on Implementation of the Federal Clinical Treatment Act
    Megan Lydon, MPH Policy Fellow – Bristol Myers Squibb
4.) Understanding the Healthcare Provisions in the Federal Inflation Reduction Act
    Alexander Dworkowitz, Partner - Manatt, Phelps & Phillips, LLP
5.) Discussion and Consideration of Re-adoption of Model Laws
    a.) Exhaustion of Administrative Remedies Model Legislation - Originally Adopted 11/22/02; Readopted 3/4/05, 11/21/10, 11/19/17
    b.) Producer Compensation Disclosure Model Amendment to the Producer Licensing Model Act (In conjunction with the NCOIL Executive Committee) - Originally Adopted 3/5/05; Readopted 11/21/10, 11/17/17
6.) Any Other Business
7.) Adjournment

Executive Committee
Saturday, November 19, 2022
12:00 p.m. – 12:30 p.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 July 16, 2022 Committee Meeting Minutes
2.) Future Meeting Locations
3.) Administration
    a.) Meeting Report
    b.) Receipt of Financials
4.) Consent Calendar – Committee Reports Including Resolutions and Model Laws Adopted/Re-adopted Therein
5.) Other Sessions
    a.) The Institutes Griffith Foundation Legislator Luncheon & Breakfast
    b.) General Sessions
    c.) Featured Speakers
6.) Nominating Committee Report/Election of Officers
7.) Any Other Business
    -Consideration of Auditor
8.) Adjournment

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 14, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Hyatt Regency in Jersey City, New Jersey on Thursday, July 14, 2022 at 2:00 p.m.

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

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Asm. Tim Grayson (CA)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Rep. Derek Lewis (KY)
Rep. Rachel Roberts (KY)
Rep. Edmond Jordan (LA)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Wendi Thomas (PA)
Rep. Carl Anderson (SC)
Rep. Lacey Hull (TX)
Rep. Tom Oliverson, M.D. (TX)
Rep. Dennis Paul (TX)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Asm. Mike Gipson (CA)
Rep. Roy Takumi (HI)
Sen. Katy Duhigg (NM)
Sen. Siah Correa Hemphill (NM)
Asw. Elaine Marzola (NV)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Carl Anderson (SC), and seconded by Rep. Derek Lewis (KY) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection to adopt the minutes of the Committee's March 6, 2022 meeting in Las Vegas, NV.

PRESENTATION OF LEGISLATIVE TOOLKIT ON DEVELOPMENTS IN MEDICAL COVERAGE FOR OBESITY

Randy Pate, Founder of Randolph Pate Advisors, LLC and former Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight (CCIIO) at the Center for Medicare & Medicaid Services (CMS), thanked the Committee for the opportunity to speak and stated that as some of you may recall, last year I had the opportunity to testify on this same issue before this Committee. So, I'm really excited to be back but based on some of the conversations that I had with some of you and others I've put together a tool kit of options for state policymakers who really want to dig into some of the barriers for obesity coverage in particular in their states. The toolkit I've put together, which Will Melofchik, NCOIL General Counsel, I believe is going to post it following this meeting, is about 30 pages long and it focuses on a number of practical solutions that I think can really help to address some of these barriers in financing and coverage. I think there's some innovative proposals in here that I want to talk about but, I think they are achievable and I think the recommendations will really balance both affordability and access to care.

So, this slide shows that today over 42% of Americans have obesity and that's defined as having a body mass index (BMI) of 30 or higher and experts predict that by the end of this decade fully half of Americans will have a BMI of 30 or higher which is really shocking and as you can see from this slide obesity prevalence is higher in the South and the Midwest but it is a nationwide problem. Back in 2000, which doesn't seem like that long ago, no state in the union had an obesity prevalence of over 25%. Right now, all but three states now have crossed that threshold. 2020 Centers for Disease Control and Prevention (CDC) data showed that right now there are 16 states with an obesity prevalence of 35% or higher which was an increase of four states in just one year. The available data are clear that racial and ethnic disparities play a role in the nation's obesity crisis. African Americans have a 51% higher obesity prevalence and Hispanics have a 21% higher obesity prevalence than whites.

This slide illustrates the path that we're currently on. Using current trends, it projects what the most common BMI will be in each state by the year 2030. You can see the projection for African Americans on the far left wherein the majority of states the most common BMI for African Americans will be 35 or higher which is considered severe or morbid obesity. Looking at all these groups none of them are on a good pathway when it comes to obesity but using the current trends the predictions are particularly dire for African Americans and Hispanic American populations. This slide shows the most common BMI prevalence in each state again projected to 2030 but this time by income group. For nearly all of the states severe obesity will be the most common BMI for Americans making less than $20,000 a year by the end of this decade. The map does get slightly better as you go up the income scale but clearly, we can see that obesity is a disease associated with socioeconomic status and for all of us in this country the cost of obesity is high and growing. While we spend roughly $480 billion a year on direct medical costs of obesity, including over $60 billion through Medicare and Medicaid alone, the cost to individuals and to the economy is even greater.

A recent study found that health care costs for people with obesity are around $3,500 a year higher than those with normal weight and when the indirect costs are included such as negative labor market outcomes like absenteeism and lower earning potential, the total economic costs of obesity are truly staggering, estimated at nearly $1.4 trillion

dollars per year. Or roughly $4,300 for every man, woman, and child in the U.S. In the past we viewed obesity primarily as resulting from lack of character or lack of willpower. This view has really perpetuated a lot of the stigma and shame for people both inside and outside of the healthcare system and unfortunately today it continues to deter millions of people from seeking medical help that they need. Instead of seeking advice and care rooted in sound medicine, Americans with obesity have often resorted to unsustainable fab diets, dangerous supplements and other potentially harmful approaches based on risky or false assumptions. But to effectively address the obesity crisis in this country we have to change our attitudes especially when it comes to our healthcare system and public policy. There's a recent Wall Street Journal editorial by University of Chicago Economist and former member of the President's Council of Economic Advisors, Tomas Philipson in which he cites two major economic shifts as the primary root causes of the obesity crisis.

First, technological advancement which has caused American's work to become more sedentary. And second, increased agricultural output that greatly reduced the cost of food. Supporting his thesis is the fact that obesity as an epidemic is not merely an American problem anymore but one observed in many other developed countries where these same shifts have occurred. In his piece, Philipson proposes that programs like Medicare and Medicaid as well private insurers should increase coverage on new anti-obesity medications (AOMs) as a means to reverse obesity and lower overall healthcare costs. Thankfully, a number of key developments have really helped to reshape attitudes towards obesity and seeking medical treatment. For example, in 2013, the American Medical Association officially recognized obesity as a chronic disease and while there's still a lot to be done to continue to shift attitudes in the healthcare system, this change represents a shift in the view toward obesity away from purely a matter of personal choice or character towards a treatable disease the healthcare system and those of us who oversee it should work to address. Like other chronic diseases obesity treatment requires a continuum of care including primary care, AOMs, and surgical interventions. In particular, some of the new and more effective AOMs coming on the market promise to bridge the gap in obesity treatment options between behavioral interventions and more invasive options like bariatric surgery.

While these new interventions can be highly effective, numerous barriers remain in the way of patients receiving them. Insurance coverage for obesity treatment which is the focus of my toolkit is often limited. This has resulted in a patchwork of coverage for the continuum of obesity care treatments across the states. For example, while every state's essential health benefits benchmark plan which governs Affordable Care Act (ACA) compliant plans in the individual and small group health insurance markets covers basic obesity screening and counseling to some degree, only 38 states' benchmark plans include coverage for nutritional counseling and only 23 states cover bariatric surgery and only two currently cover AOMs. But increasingly policymakers at both the State and Federal levels are looking at these barriers and taking action to address them. Just to cite a couple of recent examples, New Mexico amended its essential health benefits benchmark plan to extend coverage for AOMs and anti-obesity programs with those changes going into effect for plan year 2020. And earlier this year, the Federal Office of Personnel Management required insurers participating in the Federal Employee Benefits Program to provide adequate coverage of FDA approved AOMs on formulary.

State policymakers wishing to address insurance barriers to effective obesity treatment do have the ability to do so. The toolkit sets forth some options including a number of

innovative approaches that state policymakers can use to expand coverage for obesity treatment in a cost effective and fiscally responsible way. But rather than simply listing out options, the toolkit discusses best practices amongst states when available and it makes specific recommendations for implementing each option. It also offers guidance on practical considerations including timelines and who can act within each state and it also includes a glossary of terms on the first page to make it easier for state policymakers to use the toolkit. And because every state is different, each recommendation is adaptable for the state's needs including the discussion of potential variations and sub-options. And perhaps most importantly this toolkit does not shy away from taking on costs and utilization concerns recognizing that in order for any state anti-obesity program to be successful it must be both affordable and sustainable. It does not recommend simply legislatively mandating new coverage for obesity treatment. Rather it is cognizant of the trade-offs inherent in expanding benefits and uncovering new drugs and therapies and discusses the payer perspective on these issues as well.

For each option, the toolkit provides a simple explanation of the background and the problem focusing in on options that are feasible, achievable, and realistic. Several of the options included in this toolkit are bold and innovative, but each recognizes tradeoffs and the need for states to manage costs. In the interest of time, and to leave time for questions, I just want to briefly highlight a couple of the options in the toolkit. First of all, states can broaden coverage for obesity as I mentioned through state and employee benefit plans. States do have great latitude in this area in how they choose to finance and operate their public employee health plans. For example, most states self-fund their employee plans and contract with a third party to process their claims. This basically means that states can largely decide what services they want to cover and to which employees they want to offer coverage. Using this flexibility state policymakers have the opportunity to pursue innovative strategies for controlling costs while maintaining or increasing health plan quality. Not only that, but because state governments are often the largest employers in the state, these state employee plans provide an excellent opportunity to test the effectiveness of innovative policy reforms.

And next as I mentioned, states can also amend their essential health benefits (EHB) benchmark plans to broaden coverage. New Mexico took that option a couple years ago. But if you go back most states initially choose their benchmark plans based on the most popular small group plan available in 2013 and while many of them have updated their benchmarks over the years most of these benchmark plans were selected before obesity was designated as a chronic condition or before the availability of some of these new more effective AOMs on the market. Therefore, many of the benchmark plans entirely exclude or greatly limit coverage for obesity treatments. Starting in 2020 the Federal government provided new options for states to make adjustments to their existing EHB benchmark plans. So far as I mentioned, two states have changed their benchmark plans specifically to cover obesity treatment and those are New Mexico and North Carolina.

In order to receive approval under federal regulations for this change, the state’s benchmark plan amendment must meet a generosity test meaning that the cost of any new benefit to be included in the benchmark plan cannot have a material impact on premium rates. This means that any premium impact must be less than a 1% increase. In submitting a successful application, New Mexico relied on an independent actuarial study finding that expanding weight loss drug coverage to patients with obesity rather than those with just morbid or severe obesity alone would not materially impact

premiums. And finally, states can leverage ACA Section 1332 waivers to reduce pricing uncertainty and incentivize private insurers to cover obesity treatments. The states may apply for these states innovation waivers otherwise known as Section 1332 waivers to modify many of the ACA central coverage provisions. These provisions may be waived as part of a state's plan under the waiver to implement innovative programs that best fit the state's unique healthcare needs. If a Section 1332 waiver results in a reduction of Federal spending on premium tax credits, small business, health insurance tax credits, or cost sharing reductions, states can receive the difference in passthrough funding to support the state's waiver plan.

In 2022 the Federal government awarded states over $1.87 billion in passthrough payments to carry out their Section 1332 waivers. Since 2017, the Federal government has approved 18 Section 1332 waivers. Sixteen of these are for state reinsurance programs aimed at improving affordability of coverage. In addition to placing downward pressure on insurance premiums, reinsurance programs can make insurers and plan actuaries more comfortable about incorporating new therapies into coverage by reducing some of the risk involved. Analysis of CMS data has shown that not only do reinsurance programs result in lower premiums, but they're also associated with increase insurer competition in those markets. The more competition in the market the more likely insurers will be willing to adopt new therapies or broaden coverage. States wishing to go further to provide coverage for obesity treatments can explore even more innovative approaches through Section 1332 waivers. For instance, states could directly combine a reinsurance waiver with increased coverage for comprehensive obesity care, or specific treatment such as AOMs. Under such a hybrid reinsurance EHB waiver approach the state would first waive the definition of EHB to require insurers to incorporate obesity coverage into the benchmark.

Now, on its own, waiving the benchmark to broaden coverage of health care services or add new benefits would potentially violate the law's deficit neutrality guardrail because it would likely lead to some level of increase premiums and federal outlays. But the next step would be to combine the EHB waiver with a state reinsurance program that lowers premiums across the board in the market. This reduces federal outlays resulting in passthrough funding for the state to carry out its waiver. In the third step, the state could then use a small portion of the passthrough funds to offset any higher costs of covering obesity treatments such as AOMs. This high-rate approach and others like it offer a low risk high reward pathway for states to expand coverage for obesity treatment while lowering overall premiums in the individual market. Today state policymakers around the country, you're all grappling with runaway healthcare costs and the resulting pressure on state budgets. But in doing so, we should all not lose sight of the end goal to help our citizens lead healthier and more productive lives. The cost of inaction on obesity grows every day and can no longer be ignored. In fact, there's mounting evidence that greater coverage for effective obesity treatments can actually help to lower healthcare costs and increase economic efficiency over time. If undertaken carefully and appropriately these options and others not only promise to help state residents lead healthier and more productive lives, but can also save money in the long run.

Asw. Hunter asked if the toolkit includes any considerations or factors like emergency health issues like COVID. People have the COVID weight. I think a lot of times we're not taking into consideration other factors that contribute other than poverty relative to weight gain. I also wanted to know if there's anything in the toolkit relative to inflation where people have less disposable income where they may not make as good healthy

food choices with less resources. Mr. Pate stated I do talk about those issues in the toolkit. People with COVID were more likely to be hospitalized, and more likely to die from the disease as a result of being obese. And certainly coming out of the epidemic and of the pandemic all of us have experienced the weight gain or the COVID weight as you said. I see it as part of an overall trend in the data when you look back 20 years ago we still are on the same trend of half of the country being obese by the end of this decade. And so the toolkit is really looking at a number of different options. Through Section 1332 waivers, for example to get to your other question, I think there are probably opportunities to look at things like social determinants of health and other sorts of broader efforts to try and get at some of these issues with food security and things like that as well.

Rep. Stephen Meskers (CT) stated that obesity as an addiction and a social policy issue, it's one we need to address and deal with. I can see that in a constituent base in service to the community but when I'm listening to your presentation, we're not talking about incremental or supplemental costs to resolve the issue. So, I think we have to be frank about that. So, it's a social and an addiction issue that we're thinking of dealing with. The subsidies and workarounds because at least in the current environment the insurance companies don't see ultimately the treatment versus the cost of obesity as being equally measurable and that can be externalities that insurance companies don't bear and that surprises me given the cost of insulin, given the cost of hospitalization, given knee replacements, hip replacements, everything associated with aging and obesity. So, I'm surprised - is there any kind of measurement, without taking externalities, of the cost differential between the demands and claims on the insurance industry - and the medical costs versus the obesity and the treatment? Do you have a rough estimate of what that cost looks like?

Mr. Pate stated that a study came out looking at Medicare and Medicaid coverage of the full range of obesity treatments and found that for those programs over I think it was a 10 year window that it would actually save those programs money when you talk about not having as high rates of heart disease, and diabetes and these other attendant conditions. So, I look at it sort of like drugs for hypertension, for example. Hypertension on its own it gets bad but it's called the silent killer because it shows up in other health problems like stroke and heart disease. I think it's the same thing with obesity. And I agree that there is an issue and I talk about it in the toolkit of any time an insurance company's looking at covering a new therapy, the actuaries are trying to see what the utilizations going to be and predict what it's going to be and it's really difficult when you don't have that solid data although we're starting to get it we don't have necessarily the solid data and experience on that. But I think the 1332 waiver idea I'm proposing and some of the other ideas are designed to sort of provide a little cushion for the pricing actuaries, for the insurance companies to cover it and then see what the experience is over time. And hopefully, the value proposition will be there. I think it will be, as that Wall Street Journal editorial was talking about as well. I think the value proposition will be there. But these are ways to test it out and get it into coverage.

Sen. Mary Felzkowski (WI) stated that one of my largest concerns is as a policymaker, if we say that, okay now take a pill and we're going to help you with your obesity. And you're saying that within the ten years that we can actually show that we're going to reduce costs because we're going to save it on the heart disease and everything else. But at what point then do people stop trying to curb it on their own and we're just exacerbating it and 90% of the U.S. is taking a pill for obesity instead of getting at the

root cause: cheap food, processed food, lack of exercise and education. It's a slippery slope and that concerns me as a legislator.

Mr. Pate stated that first of all there's no magic pill to solve the problem and my suggestion is not that it just be covered and that be the end of the discussion at all. The way the continuum of care really is supposed to work is you start with diet and exercise, you start with nutrition counseling, you start with these less invasive interventions. Now, I do believe the healthcare system needs to do a better job of when you go to the doctor, screening you and explaining your options and getting you plugged into these things. I think we can do a much better job of that. But really, the AOMs, the medications, are really just designed to be there when those things have failed and I talk about in the toolkit ways to make sure that that's the way the prescription works and that's the way the utilization management works. But I absolutely agree with you that all of these other factors have to be addressed as well. This is just part of how the healthcare system can hopefully step up on this epidemic.

Sen. Felzkowski stated that I understand and there are some people where it's a genetic issue no matter what they do but I think for the majority of people, and you can see it in the trending obesity - go back 50 years and this was not the issue that it is today. So, it's very much lifestyle, calories and calories without exercise. But when you use a term "supposed to work," that's a huge red flag for me because we as a society have gotten very lazy. We go to the doctor and we want a pill to take care of everything without putting in the work to do it and the pressure will be for that pill not doing the work. Nr. Pate stated that I don't think we're lazy. When I think about the economic factors, it used to be that most people in this country, part of your job involved some sort of strenuous physical activity for eight hours minimum a day probably five or six days a week. And we just don't live like that anymore. I don't think that we have less character, less willpower that we've had in the past. I think we've got different problems and complex problems that technology can hope to address. I mean technologies are part of the reason we got into this mess and hopefully it should be part of the answer to get us out of it. But overall I think all of these things should be part of the discussion. They should all be options. The toolkit's focus is really on how can we better engage the healthcare system and bring some of these technologies to bear on the problem.

Rep. Tammy Nuccio (CT) stated that we've looked at legislation similar to this in our state. We're a small state of 3.6 million people if we had mandated something like this, first of all it's only going to affect, which we all know in this room, 15% of the populous – about 220,000 people in the state of Connecticut. And the cost is well over $4 million a year to do something like this. So, that's a problem for me especially when I hear doctors who say, like the bariatric surgery, it's a 60% success rate, and 50% of those people will gain the weight back. So, it's like a cycle and the problem that I have with the drugs is I'm not sure whether or not there's enough research there to show whether it's going to have long term sustaining effects. But, I'm also under the impression that a majority of insurance companies pay for bariatric surgery. It's actually part of a benefit structure that is included in it. So, is this just the AOM drugs and what is the cost of those drugs?

Mr. Pate stated that it depends on the market you're looking at. The EHB benchmark applies to the individual health insurance market and the small group market and then you've got the large group self insured and fully insured markets. So, it's kind of a patchwork and I can get the data on that. I don't have it in front of me. But, the idea is

that when I say it's a patchwork that means some states may cover bariatric surgery but they may not cover the nutrition counseling. Some states maybe cover the nutrition counseling but they don't cover the AOMs. So, the point I'm trying to make is when you look at, and I'm not a clinician and I don't have all the data but from what I've read, you really have to have the continuum there. You have to have all of those options there available to people to really get the long term results so you don't have people gaining the weight back and it it's sustainable over time which is really what I'm arguing in this toolkit.

Rep. Dennis Paul (TX) stated that I've enjoyed the discussion and it's good to hear about how this works and I'm interested in going back to your data of you calculated of how we got to this point now and why are we here and I think a lot of it was like you said the work. Maybe nowadays there's working families where both the man and woman are working so there's less good prepared meals. But, the slide where you're showing the income levels that was dramatically worse with income, and also for different races, what is the majority factor in that? Is the fact that these races might be lower income and that's why they're higher? Or is it a race has a higher reason over the income? Which one is controlling there? Mr. Pate stated that I've read literature. I haven't done my own studies on this. I will say exactly to your point, it's very, very complicated. It seems to be related to lack of education, lack of income, and lower access to recreational facilities. There are all sorts of factors that go into it. But again, it's very complex and there are a lot of us who have plenty of access to all those things and we still struggle so I would say it's a very complex problem. I don't think we're fully there in terms of how do we fix it and really understand it but I do think some of these things and ideas I'm talking about ought to be first steps that we should look at in order to try to get a handle on this.

PRESENTATION ON USING HEALTH INSURANCE RATE REVIEW AUTHORITY TO CONSTRAIN HEALTH CARE COSTS

The Hon. Chris Koller, President of the Milbank Memorial Fund (Fund) and former Rhode Island Health Insurance Commissioner thanked the Committee for the opportunity to speak and stated that I'm going to speak from the experience of both the Fund and then my own experience as Health Insurance Commissioner in Rhode Island from 2005 to 2013. I have four main points to make. I think health insurance is fundamentally different from other kinds of insurance so we ought to have a policy that reflects that. We've got a real problem with commercial health insurance affordability. You can use health insurance rate review as a tool to get at that and that's in points three and four. So, this is what the Fund is about. We are an independent operating foundation. We're just across the river here in Manhattan. We work on health policy leadership. We work on specific state issues like state health policy issues like affordability and primary care and then we publish communications. Our mission is to improve population health and health equity by collaborating with folks like yourselves and connecting you with sound evidence and experience.

So, my first point - health insurance is fundamentally different. We don't mandate insurance coverage for oil changes but we mandate insurance coverage for preventive services. We don't require body shops to treat anyone who comes in but we require it of emergency room doctors. And we don't treat roofers in a special way to make sure that they get paid adequately. All those are things that we do for healthcare in our public policy. It says that we look at health insurance in a fundamentally different way and I

think that was the genesis that inspired Rhode Island legislatures to actually break out health insurance regulation from the rest of insurance regulation - give it a different set of charges and that leads to how you look at rate review. So, what's the problem we're trying to solve? We have an issue with affordability. It has permeated these conversations. We talked about it in terms of obesity. We talked about it the Spring with 340B. You've all seen data such as this and I like this one because it indexes everything to general price inflation and you can see the employees are bearing the cost of that. So, as healthcare costs go up, employees are bearing a bigger portion of it. The causes are systemic and they're getting worse. This is my version of the obesity map. This is just showing how we've got an affordability issue that's getting worse over time. This is data from the Commonwealth Fund of the average employee share of premium plus deductible. So, it's all the cost sharing as a percentage of median income. Dark is worse and we're getting more and more dark.

So, this is an increasing problem. I'm here to say that the problem is mostly in commercial health insurance as opposed to Medicaid and Medicare and analysis would say that the two major drivers of this are health systems and pharmaceuticals. This is a lot of data by state each of these vertical lines is a state. The red triangle is the average hospital payments inpatient, and outpatient indexed to Medicare. So, the average overall commercial payment is 235% roughly of what Medicare pays and there's enormous variation by state and there are a lot of reasons for this kind of variation. The main story though is it was Medicaid and Medicare constraining prices. Health systems are consolidating and extracting prices from commercial health insurance and employers and employees are paying the cost. Actually, employers pay the cost for it. They pass it to employees and they pass it to customers in terms of what we pay for our prices. The other culprit is pharmacy. I know we have Representatives here from Connecticut. This is data from Connecticut that looks at different cost drivers. The horizontal axis is cost per member per year. And the axis is the trend over time. The orange dot is pharmacy and the blue is hospital outpatient.

So, you can see that it is where our money is going when we talk about affordability issues. Don Berwick, who has served a number of different positions in Federal government and thought leadership positions stated that healthcare is confiscatory. This is data that he got from Massachusetts that shows it has a stayed budget. You can see that all the things that we want to spend money on we're skimping on. This is pre-COVID so this is older data. Because the money's going into healthcare. It's worth noting that all those things on the right, human services, public health, mental health, and education are all things that actually improve health over time but we've been busy pumping it into the healthcare system. So, we can think about in general, when we think about affordability, historically there've been three strategies around affordability. We play whack-a-mole and we go after specific areas. We toss the hot potato to somebody else whether it's an employee, an employer, and we get someone else to pick up the cost. Medicaid's very good at that - get someone else to do it. Or we have magical thinking and we put forth non-evidence-based policies and hope that it makes a difference.

Our position is that systemic problems require systemic solutions. You must start with good data to get a common view of reality. You must get alignment of policies across payers - Medicare, Medicaid, and commercial. And there is still room for competition but it's with some referee and rules. Commercial health insurance rate review can be part of that. It can get commercial health insurance into the game to start getting at the

systemic affordability issues and that's why we talk about rate review as a tool to improve affordability. The system needs a sheriff, particularly on the commercial side because what you have is kind of the wild west out there and you need some folks making sure everybody is playing by the rules and we're moving in a direction towards affordability. I'm going to put forth some language and items to consider as you think about rate review and the job of health insurance. I want to make the case that the traditional charge of how insurance regulators work with the standards you've given them doesn't work for healthcare. They traditionally have these first two. Their job is to guard the solvency of insurers and to protect the public interest and the interest of consumers by making sure contracts are honored.

I think for healthcare you need some other things. We care about the treatment of providers and we care about the system as a whole and we want to direct health plans and the players and the systems towards affordability. Those are statutory standards that ensure regulators can't assume, they have to be given them by you as the legislators. And when you do that then you can have expectations of what happens in your rate review process. Then when you think about rate review, you have to understand the scope of it. Our federal colleagues can talk about what's required under Federal law to demonstrate that you have adequate rate review for the individual market but think about your other markets, your small group, your large group - what type of rate review do they have? Is it file and use and does it vary by market authority? Think about the scope. In Rhode Island we work with individual, small group, and large, and that gives us a consistent way of directing the insurers and working with the providers. And think about consumer protection authority and do you have specific requirements for affordability. I won't get into the detail but this is from our colleagues at the National Academy of State Health Policy (NASHP). This is sample language of what you could put in to increase those standards and to have broader standards for health insurance than what you have for other lines of insurance.

So, what's been the experience of states as they've done this rate review, whether it's in Rhode Island where we have rate review for individual, small group, and large group. Colorado does not have it for large group. Colorado uses rate review to balance transparency and proprietary information. So, they're the referee. And I think what they're doing is promoting more transparency than previously existed so the folks can understand what actually is driving the cost increases and understand price and utilization trend by a hospital and by provider so that you can understand and get that kind of data that we had earlier to understand what's really driving premiums.

Comprehensive rate review is part of affordability strategy. Here are some specific things that you can either require in statute or direct your regulators towards and they consider this notion of prior approval. Do the rates have to be approved before they can be implemented? A public analysis of submissions, trends, and driver analysis. In my experience this is really important. Folks have to understand what's driving healthcare costs and get away from simple solutions like well let's just eliminate the CEO's salary from Blue Cross and that'll make healthcare affordable. No, it won't, and we need to understand that it is provider rates, it's pharmacy utilization. And then if you're particularly ambitious you can develop affordability standards that you or your regulators want the entire system working towards. What are things that will get at the underlying drivers of affordability? These are things that have been tried in different states. Delaware and Rhode Island is in the middle and actually Oregon is actually telling the insurers to spend more on primary care as a portion of their total budget to transfer

money from other places to put more in primary care. In Rhode Island and Delaware, we've actually limited the rate of growth at which hospital prices can grow. It's been in place in Rhode Island for ten years. You can use the legislation to advance provider payment reforms to get providers off of fee for service. You can use the rate review to encourage participation in your state-based exchange and there's been a lot of topics about public option products now on the exchange.

We work at the Fund particularly closely with the eight states that are listed at the bottom around understanding underlying cost drivers and getting a common view of reality so you can focus policy on the areas that will get at systemic costs. I'm happy to talk more about that. So, what have been some of the results. This is the history in Delaware. They actually started out with a separate office of health based, healthcare affordability or healthcare delivery. They developed affordability standards. Then the legislature actually gave the department of insurance (DOI) the ability to enforce those standards put in place the way it exists for other lines of insurance. And enforcement is due to begin. In Colorado, this points to the savings that they have versus what was submitted versus what it was decided in their small and large group rates amounting to half a billion dollars over the nine years and affecting three million Colorado citizens. And then in Rhode Island, this is trending overall all in per capita costs compared to a control group that's the same population, same age and sex demographics. You can see that in 2011 when we implemented hospital rate caps, our trend flattened and we went below our control group. That is real dollars that's delivered to employers and to employees. We can document less cost sharing that's going on to employees and delivery system improvements.

Let's be careful, health insurance rate review isn't going to save everything. We get resistance from health insurers in some places when we try to put this in. There's concern about consistent enforcement as well as larger providers who have frankly had a pretty good time working in the system the way that it is now and it's not going to solve for monopoly providers. It raises the risk or regulatory capture. It doesn't solve for self-insured employers who are over half of the market although they sometimes benefit. In Rhode Island, the self-insured folks have benefited from these rate caps. And everything else that your voters don't like about healthcare. Because you get complaints all the time about stuff and rate review is only a partial solution. So, while I close, this really is an important policy issue. I'm happy and very privileged to be able to speak with you folks about it. We fundamentally have to decide is healthcare a tool for economic growth? In which case, we have to live with increasing disparities and affordability issues. Or, is it something that everyone is entitled to and that we want to have reasonable access to so that we can use money for employees that they can take home and spend with their families and we can spend on social services because that's not what we have right now with our healthcare economy.

Sen. Felzkowski stated that one of the things you said is alignment of policies between Medicare, Medicaid, and commercial. Can you expand on what you mean by that? Cmsr. Koller stated that let's say you and your legislators say to your regulators, "Look, get the insurers in line, get them doing the same thing." What that gives the regulator the authority to do is to get the insurers in the same room and adopt consistent policies that treat providers in the same way. If you talk to providers, they will say what really drives them crazy is different policies from different insurers. We get different things from different Medicaid managed care sections. Different prior authorization requirements, different administrative requirements, different goals around payment

reform. Different formulated drug lists. The providers are saying stop the madness. Get some force to get them together, and this gives your regulator the authority to get folks in a room and say, "Okay, let's all get on the same page." In Rhode Island, there are 12 quality measures that all insurers have to report on. Nothing more, and the providers love it because they get an aligned set of measures that they're held accountable for and one way of paying for primary care, that's the kind of alignment that we're talking about. And if you're getting a blueprint from Medicare, let's just align with Medicare and try to further get some synergies. It's this cost of confusion that we're trying to get rid of.

Rep. Derek Lewis (KY) stated that on the presentation you had listed a provider growth cap. What is that and how does that work? Cmsr. Koller stated that as a result of the data that we are collecting in rate review, we can document that insurers were expecting an 8% to 9% price increase in their hospital contracts. And I could use that to go to employers and say, "Okay, 40% of your insurance premium is going to go up by 8% or 9%." That's 3% on your base right there before any money goes to any place else. What are we going to do about that? And so that created frankly the political will for me to turn to the insurers and say, "You know what, from here on out, only give the providers consumer price index plus one. If it's good enough for Medicare, it's good enough for you." And so, the insurers implemented that and that's what resulted in that flatten of the curve. So, this was our attempt to address some of the price discussions that we're now we're finding throughout the country on these hospital prices. And Delaware is following suit and some other people are talking about it.

Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, stated that you mentioned in here under your obstacles, I think it was your last slide you were talking limitations and self-insured employers - obviously you were referencing the Employee Retirement Income Security Act (ERISA). So, I know in my state we're down to less than 20% of our marketplace is actually fully insured. So, what's the net effect of this type of regulation in terms of shifting the balance for or against self-insured plans? Because I think that would be one of my concerns is just that going to force more employers out and into this self-insured market. Cmsr. Koller stated that I'll only speak for Rhode Island because that's the place that I'm most familiar with. I would argue that the steps that we've taken in Rhode Island have benefited self-insurers because the insurers are the administrators and they impose those same price caps on their self-insured contracts as on their fully insured contracts. So, the self-insured are getting a free ride, basically. Rhode Island has the same issue of an erosion of that fully insured market. I don't think these regulations have led to it. I think it's frankly a favorable selection. Rep. Oliverson asked if it has reversed the trend. Cmsr. Koller replied no, it hasn't reversed the trend because if you've got an insurance pool half of those people are going to be below cost and those employers are going to get cherry picked. They're going to get approached by a broker who's going to say, "You know, I can get you a better deal if you self-insure." And that's a bigger issue than frankly what you can solve with your insurance commissioner.

DISCUSSION ON PREPARATIONS FOR/IMPLICATIONS OF END OF PUBLIC HEALTH EMERGENCY

Miranda Motter, Senior VP of State Affairs and Policy at America's Health Insurance Plans (AHIP) thanked the Committee for the opportunity to speak and stated that I'm very grateful for the opportunity to speak and have a conversation about what Asw. Hunter said is really sitting in front of every single state in terms of the work that needs to be done once the public health emergency ends. I did want to just take a couple of

quick moments to run through just really as a reminder for everybody to sort of remember what I'm going to call emergency waivers and flexibilities that were put in place once the COVID pandemic hit. Because I do think that it's really important to remember the series of things that happened. And then obviously very close attention and focus on the public health emergency (PHE) is warranted and how that will impact Medicaid specifically on the redeterminations that will need to take place all across the country. Here are two or three slides to walk through all of the authorities that were at play or are at play as a result of the COVID pandemic. Obviously, the public health emergency, which is the one we will come back to, provided certain things and triggered certain issues. The National Emergencies Act. was declared in March of 2020. There was a renewal date and then an additional renewal for March 1st with no specific end date.

And again, it activated specific things under the federal statute particularly allowing temporary waivers, or modifications of certain requirements of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) program. The Stafford Act was declared in March 13, 2020 which enabled the Federal Emergency Management Agency (FEMA) to help deliver virus response funds to state and local governments. The Public Readiness and Emergency Preparedness (PREP) Act was invoked in March as well. It provided ten additional amendments. That will end October 1st of 2024 and it essentially authorizes Health and Human Services (HHS) to limit certain legal liabilities. And then Emergency Use Authorization (EUA) which were incredibly important as it related to vaccines was declared on March 27, 2020 and allowed the FDA to authorize when certain conditions were met the emergency use of certain medical products or on unapproved uses of approved medical products to diagnose, treat and prevent serious life threatening diseases and conditions. The other thing that it's really important to remember is there were also a couple of major Federal legislative actions that tied into the public health emergencies - the Families First Coronavirus Response Act, or the Coronavirus Aid Relief and Economic Security Act referred to as CARES and the American Rescue Plan Act. There were also a series of changes that waived or modified things at the administrative level under Medicare, Medicaid, CHIP, and The Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Those administrative changes provided some additional flexibility particularly in the commercial insurance markets. And then I also think it's really important to remember that in each one of your states there were a variety of mechanisms that the Governors or the legislatures put forward to make sure that there were certain authorities available during COVID. So, as it relates to the state emergency declarations, I do think it's really important as you think about your own state situation to really go back to those original authorities and understand what triggered them and what was the basis of them to really help you understand once we unwind some of these things. Some of the state emergency declarations reference the Federal PHE. Some of them referenced a specific state PHE. Some of them referenced both actions by the State and the Federal Government. Some of them were just general COVID-19 public health challenges. And then some of those were silent. A full review of individual state actions and the authority cited is necessary to fully understand how a termination and/or non-renewal of the PHE or national emergency issued in connection with the COVID19 pandemic will impact the various state emergency orders, bulletins, guidance, mandates, and other actions

Going back to some of those changes that I referenced by the federal legislation I wanted to just quickly mention with most emphasis on the fourth bullet, key federal

legislative provisions that were tied to that Federal PHE. So, coverage for COVID testing and testing related services without cost sharing in the commercial market and for Medicare. Coverage without cost sharing for nearly all Medicaid populations for the COVID vaccine and the administration costs that were associated with that. Coverage for testing and treatment for Medicaid populations. And this last bullet is where we're going to focus on - an increase of 6.2 percentage points in the states Federal Medical Assistance Percentage (FMAP) provided that states maintain what you'll hear referred to as a maintenance of effort requirement. So, in other words, making sure that everybody who is on Medicaid stays on Medicaid and does not get bumped off of Medicaid during the PHE crisis. So, those things have to be met through the end of the month in which the PHE ends. So, that's the trigger in terms of time and the additional federal resources that were available but they were contingent upon state's making sure that individuals that had access to Medicaid coverage continued to have access to that coverage.

I also wanted to run through a couple of important dates both for now and then certainly as we think about the future. The end date of the PHE was most recently extended to July 15th which is actually tomorrow. Once the PHE ends, most of the flexibilities and requirements will end automatically. Relative to that increase of that 6.2 percentage points that I talked about, if the PHE is not once again extended, I just wanted to provide some dates to give you some context in terms of what the triggers will start to look like. So, the continuous enrollment requirement will end on August 1st. The enhanced FMAP will conclude at the end of the quarter – September 30 of 2022. I will reiterate and many of you are probably aware of this - the administration has indicated that they would give states a 60 day notice to help plan and prepare before the PHE actually expires. The states were not notified on May 16th, so I say here we are assuming that the PHE will be extended at least once again. And then in terms of future dates that you should also be attuned to, if it is extended for another 90 days, that 90 day period will end on October 13th. And that 60 day notice out to states would be given on August 14. So, again just a couple of dates to keep in mind as we move forward.

Medicaid redeterminations - just a quick overview of what it is and why it has to be done. So, before the PHE, states were required to annually verify that the individuals that had Medicaid coverage were eligible for that coverage. What has changed? I talked about what had changed as a condition of receiving additional funds, the states had to maintain those individuals and make sure that they continued to receive coverage through Medicaid. Post PHE when it ends, the states will resume the processes. So, why is that significant? First of all, the volume in terms of the number of individuals that will need to be redetermined is significant and we'll talk about that here in just a moment. The second thing is that states will have 12 months to initiate and then 14 months to complete. So, 12 months to initiate and then an additional two on top of that to complete the full renewal of individuals that are currently enrolled in Medicaid, CHIP, and the basic health plan. So, now we have a time frame by which it has to be done and then States, counties, and beneficiaries have not had to do this or have not done this in two years. And so, as you think about staffing within Medicaid agencies, as you think about staffing at the county level if the counties are the ones that are actually performing the Medicaid redeterminations. And then similarly, those individuals that are receiving coverage through Medicaid, they have not had to go through this verifying process in order to maintain their coverage in two years.

So, let's talk a little bit about the numbers. So, how many individuals are we talking about in terms of that volume? Slightly more than one in four Americans rely on

Medicaid for their coverage and care today making it an essential safety net for 87 million individuals. We I think firsthand now understand how important health care coverage is coming out of a pandemic and understand how important it is to have access to healthcare which is made possible through health insurance. You'll see here that I've cited some numbers from the Kaiser Family Foundation. So, the total Medicaid and CHIP enrollment has grown approximately 87.4 million. So, that's an increase of 16.1 million from enrollment from February 2022. That increase may be attributed to a couple of different things - economic conditions, policy changes, postpartum coverage. In many states I know right now either legislatures or through waiver plans, states are allowing 12 months of postpartum coverage. Or as I talked about this temporary continuous enrollment requirement. So, all of those things are contributing to this increase. Between 5.3 million and 4.2 million Medicaid enrollees could be disenrolled in the months following the end of the end of the PHE. I know that this is a big delta but you'll see there again, those numbers are from analysis that Kaiser Family Foundation put forward and they actually did a survey of state officials from January 2022 and then February 2022 and it's those two numbers that provide the range of which we think individuals potentially could lose coverage.

The other thing that may be interesting for you to look at is there is a 50 state survey that provides a lot of good information if you want to look at your own individual state in terms of what those numbers look like. The redetermination process at very high level, there are Federal and State requirements as it relates to what needs to be done for Medicaid redeterminations. Those processes do vary depending upon eligibility based on income, waiver or disability status. And your Medicaid agency may be using information or they can use information through other sources to decide whether or not somebody may be eligible for Medicaid or CHIP. If more information is needed the state will reach out to that individual and ask for that additional information so that they can verify that that individual is still eligible for Medicaid. Again, I put a link here to very basic enrollment information and there is also a link here on what each different state requires for that too if you're interested. The stakes are high. I talked about how the volume is significant. I talked about how this hasn't been done in two years and the number of individuals that are at risk. The stakes are high because you'll have individual patients that might be deemed ineligible because their verification was unsuccessful.

So, in other words, you might have an individual who is now not eligible for Medicaid coverage just because they weren't able to verify their eligibility. They may still be eligible for Medicaid coverage. You're going to have ineligible patients who will become uninsured and may not be able to find another source of healthcare. The other thing that will be very important to remember and understand is there will be providers on the ground in the states who have been treating individuals who had a reimbursement source for their healthcare coverage and now may not. The other thing is obviously those individuals that lose their healthcare coverage, it will increase states uninsured rates. And then we talked a little bit earlier about how affordability and uninsured rates are obviously and ultimately going to impact other kinds of health insurance coverage because of the cost shifting that happens and takes place. I just wanted to spend a couple of my last minutes on 10 fundamental actions that states can take as they are preparing to unwind. This is information that CMS has made available to states. There are a number of different state toolkits that are out there.

So, first is creating a comprehensive state unwinding operational plan. That seems to be a no brainer. But really, states need to sit down and understand how they are going

to accomplish that and how they're going to make sure that there's continuity of coverage and actually facilitate the transitions of coverage that individuals are going to need to have. Second is to coordinate with partners including the state, tribal, and government partners - working with state sister agencies and leveraging other government agencies and coordinating with your exchange marketplace whether that's a federally facilitated marketplace or state based marketplace. Consulting with tribes to help support what that strategic planning looks like is really going to be very important. Third is implementing and strengthening automated processes. So, this includes ex-parte renewals, you might hear this term which is essentially doing as much of this as possible without having to touch the person, whether it's online, whether it's via phone so that process is as automated as possible for the beneficiary. Fourth is work early and closely with eligibility system vendors to identify the changes and the starts and the planning and really performing that robust testing that needs to be done end to end. Fifth is establishing a renewal redistribution program. So, understand how a state's going to account for and mitigate churn and account for any workforce challenges or system challenges that they may have due to capacity.

Sixth is engaging with community partners, health plans and providers in the community. And many of your states are doing this in a terrific way working with the community partners, working with hospitals, working with providers, working with health plans. So, making sure that they're working with the Medicaid managed care plans, making sure that they're working with the health plans that might be providing products or coverage through the exchange marketplace on the qualified health plans (QHPs) and really leveraging those constituencies to serve as workforce arms of the states to help them do this. Seven is obtaining updated contact information which will probably be the most challenging issue. So, really implementing and utilizing multiple strategies to make sure that there's mitigation of coverage losses and using those strategies to make sure that you can have the most recent contact information and are trying to contact that eligible beneficiary in multiple different ways. Eight is launching an effective communication strategy. You've probably seen this in many of your states already where there are multiple strategies and messaging communications on the ground to make sure that there is, first and foremost, an awareness that this is coming, and then what needs to be done. Nine is assess eligibility enrollment and fair hearing work capacity. This is just making sure that there are sufficient workforces in place and ensuring that there's adequate staffing and sufficient training to complete this work. Finally, develop a robust monitoring strategy so that there is an approach and a framework in place to make sure that the reporting that will need to be done to CMS is ready. I am really hopeful that this is the start of a couple of conversations as this gets closer to sort of understand how this is going and certainly the work that is being done on the ground.

Asw. Hunter stated that it's almost inconceivable at least in my state that they would be prepared to re-enroll millions of people within that short time frame even when engaging community partners and our counties that are responsible for enrollments. So, this is very urgent that we're having this conversation. Is there money from the Federal government given to states to help implement or to cover gaps that are going to be put in place? Ms. Motter stated that I think the answer in terms of direct dollars is no. That additional FMAP money will go away but there may be other dollars that states can use in terms of infrastructure preparedness and those sorts of things that they can use to get ready and help systems and those sorts of things and I do believe some states are actually utilizing some of those dollars.

Rep. Oliverson stated that you gave a lot of reasons why this is going to create a lot of issues for a lot of people and I guess the thing that just kept popping in my head was given the administration and the current thought process and the folks that are kind of in power - what's the rush? You have all these people that are continuously eligible right now for going on two years, including states that have stubbornly refused to expand Medicaid, like my home state and now you have people that can't roll off the roll. Have you heard anything and has there been any discussion about whether the administration will keep kicking the can down the road because maybe it's politically good to do that?

Jeff Wu, Deputy Director for Policy at CCIIO stated that I think the rush is caused by the way the statute is structured. This FMAP goes away and this continuous meetings of effort requirements goes away. And then in fact, the normal Medicaid standards which require redeterminations kick in at which point we'll have this big issue. Now, normally this is an incremental thing that happens every month but now, we're going to have a situation where because the law has called for states not to do this we will have a two year backlog and a giant tidal wave of folks to handle and that's going to be a big challenge. Rep. Oliverson stated that you're saying that statutorily at the Federal level that there's nothing that can be done from an agency standpoint - this is going to happen? I got the impression from your presentation, Ms. Motter, that it's just kind of in this cycle of well we're just going to keep renewing it and renewing it. Mr. Wu asked Rep. Oliverson if he was talking about the renewal of the PHE. Rep. Oliverson replied yes and stated that my question is, not that I'm necessarily in favor of it as a Texan, but I'm just thinking based on kind of where things are at the national level, what's the hurry? Mr. Wu stated that I can't speak with a lot of details of this but I do think a lot of factors go into this determination of whether or not to extend the PHE. This obviously is one of them. This is a big deal but as Ms. Motter noted, there's a lot of flexibilities out there that are in place and I do think that the PHE is not intended to go on forever and at some point we'll have to turn off and at which point, this whole cascade of work is going to have to happen and that's why agencies in all of your states and the federal government and so many private sector entities have been furiously working together to try to get ready knowing that there's a deadline coming at an uncertain point.

Sen. Bob Hackett (OH) stated that a lot of this is because of competition. We pay much better wages and people are making more money. But one thing I don't see you talking about is Medicaid is really good health coverage and people are going to get forced off to higher deductible plans and coverage. Why don't we talk about the cliff effect that actually we're going to have a number of people who take home less money even though they're making more money. Is the protection already in there that we don't have the cliff effect problem? Ms. Motter stated that as I talked about the transitions to other coverage, if we're talking about somebody who is deemed ineligible, the goal would be that they would go to one or two markets. One would be the marketplaces where it will be really important for the American Rescue Plan Act (ARPA) subsidies to get extended as well because those subsidies have really helped the exchange marketplace become more affordable. But to your point, the other option for some of those may be access to employer coverage. If they've gotten a job, if they're economic situation has changed, it may be that they have access to that employer coverage. And to your question about what to be done in terms of high deductibles or the high-cost sharing, I do think that goes back to a lot of the conversation that we've been having today. Those issues are a direct reflection of the affordability of the underlying cost of care. I always say cost sharing and deductibles plus premiums equals your health insurance costs, it's the

underlying cost of healthcare until we sort of get at that, but individuals who are going to lose that hopefully will have options under those two marketplaces.

Sen. Hackett stated that Medicaid is great coverage. Medicaid doesn't cost them anything. Now, they get worse coverage that they have to pay out of their pocket even though they're making more money and not eligible for Medicaid so the net result to the worker is the income went up but less take home dollars. How are they going to get through that? Ms. Motter stated that I would reiterate certainly with the ARPA subsidies and that help for so many it made that coverage much more affordable and for many of them it is very minimal f not zero. So, that has helped many individuals that have to move over to that exchange marketplace but it's a challenge. Sen. Hackett asked if there are cases where the subsidy pays the entire thing? Ms. Motter replied yes and we've got some information about that in terms of how it's impacted different states and I'm happy to share that with you as well.

Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, stated that the thing I haven't heard you discuss, and maybe Arkansas is an outlier, but you talked about ramifications for patients. But Arkansas is a small state and we're making about $75 million a quarter because of the 6.2% enhanced reimbursement. Is that typical of other states? It's going to be a huge financial loss for us to lose the enhanced reimbursement. Ms. Motter stated that I don't know the specific answer in terms of where the different states are relative to that number. I'm sure we can get that for you in terms of where different states fall as it relates to that increased FMAP amount. I would just like to leave you with again, hopefully we can have this as a continued conversation, but the other thing I would encourage you as legislators to do is if you are getting calls once this starts, if you start to get questions, I do think there's a real opportunity to work with your Medicaid agencies or your sister agencies to make sure that either you or your staff have some really good talking points for some answers as your going to be getting some of these calls because I really do think that will help arm and really help understand the constituencies that you're going to hear from understand what's happening.

HEALTHCARE MARKETPLACE PRIORITIES: VIEWS FROM CCIIO

Mr. Wu thanked the Committee for the opportunity to speak and stated that in the interest of time, I will hit on a couple of highlights really focusing on the big priorities we have this year and The No Surprises Act (NSA). I'll touch a little bit further on the Medicaid unwinding process, which really is a major priority of ours. I'll talk a little bit about Section 1332 waivers and then I'll talk just a few sentences about our regulatory priorities going forward as well. And in each of these areas I think there are opportunities for coordination, and cooperation between the federal levels and the state levels. So, let me start with the NSA. It's been a very busy year. A year and a half ago Congress in a bipartisan manner passed the NSA and we have been implementing furiously this very complex statute ever since. At the beginning of this year the consumer protections of that law went into place and some number of months after that we put in place the arbitration process. But there are many other transparency and consumer protection aspects of this law that are to come and we're going to be very busy working on those. Of course, this is not a new issue. Many of your states have laws in place, and had laws in place for a number of years providing consumers protections against surprise billing. Those laws have worked very well and we have looked very closely at many of those laws and their operations in helping us understand how to implement our law. But now that there's a federal structure in place, the

landscape becomes much more complicated because states that have their own provisions, those provisions apply, and then otherwise the federal provisions apply. And in many states it's sort of a patchwork. It kind of depends on which providers and which types of plans and other circumstances and so there's an extensive process of cooperation and coordination happening right now between regulatory agencies and authorities in your states and CMS.

And defining those lines and making sure that handoffs and enforcement occurs and the consumers get the protections of this law is very important. So, there is lots more to come in this area. It is a really remarkable change to the way commercial health insurance works in this country and it is going to have big effects. To the extent that any of you are interested in working on measures or legislation in this area to make these regimes align better together, I will say we are very happy to work with you. We're happy to provide our thoughts and our advice on the way these regimes can work together better and there will be many years of work on this structure to make sure that it works well for consumers.

Secondly, regarding the unwinding effort, Ms. Motter through the issue that is happening. I can assure you that at CMS and across the entire federal government we're taking a whole of government approach to this issue. We think it is extremely important. It is nearly inevitable that some people will fall through the cracks as we look at the millions of people that will be going through a mandatory re-enrollment process and so we're working very hard with our partner exchanges in the states as well as all of the state Medicaid agencies. We're working on things like making sure that the quality of the data transfer between those entities is consistent and clear. That's sort of the foundation of this issue. We want the exchanges, we want the Medicaid agencies to sort of know which people are being re-determined. What is happening to those people? And we're building out a process to track all of those folks so that we can continue to conduct outreach on those folks and have as few of those people fall through the cracks as possible but it's a real challenge and in some sense for the exchanges that we run, it's an opportunity to really make sure that all those folks are picked up and continue to have high quality coverage. As Ms. Motter was noting, if the ARPA subsides are extended, in fact the cliff effect that we were talking about a little bit earlier really is mitigated and it can be a very smooth transition to high quality very affordable coverage.

Let me say a couple of sentences about state innovation waivers. We continue to be very busy as we have been for many years now working with states on Section 1332 waivers. So, these are opportunities for states to craft their own programs and wave certain provisions of the Affordable Care Act (ACA) and receive pass through funding to the extent it saves the federal government any money on premium tax credit subsidies. The process here can be complicated and it involves a lot of discussions with states especially when implementing ambitious, thoughtful waivers. Now, many of our waivers are fairly cookie cutter. We have now 16 and counting reinsurance programs across states that are fairly straightforward to implement at this point and have had very positive impacts on premiums and affordability for consumers. But I will also note that we're very interested in partnering with states to put in place other sorts of waivers. I'll note that we have recently approved a waiver in Colorado to implement what they call the Colorado option. It has the effect of lowering premiums and healthcare costs within that state - putting in place a standard set of benefits available to all consumers across the state and it mandates the lowering of healthcare premiums over a course of three years. And so, we'll be working very closely with that state and the implementation of this waiver.

Any of these Section 1332 innovation waivers requires legislative work. They require the passage of a law to point the state, and start the state down this process and often we can be helpful in helping make sure that all the required triggers in that law are there giving the state maximum flexibility to do what they want.

Regarding our regulatory agenda going forward, every year CCIIO puts out a Notice of Benefit and Payment Parameters which is the main rule that governs payment parameters across the individual market in particular but the commercial market generally as last year's rule put in place or re-instituted standardized plan options on healthcare.gov as well as reinstituted network adequacy provisions. Those are very significant provisions. We're going to be continuing to look very hard at the implementation of those provisions and any tweaking that is required there. I'll also note that our regulatory agenda as listed has pointed out the fact that we plan to regulate on short term limited duration plans and mental health parity in the coming months so you can expect that as well. Finally, I'll say just a sentence about individual coverage health reimbursement arrangements, ICHRA's, which continues to be a new form of coverage available to small businesses and any businesses as it allows them to have their employees select the coverage that's right for them in the individual market and have funds flow to those accounts. We're very interested in continuing to promote and monitor this market and we have put in place a number of data collection mechanisms to allow us to track this more closely but we continue to be very interested in this and are also interested in partnering with states and private institutions on this front as well.

Sen. Beverly Gossage (KS) stated that I just want to say in our state I serve on the Bob Bethell Committee which is a committee that looks at these issues and our Medicaid program has already been all along looking to see who didn't qualify. This is not going to be a two year all of a sudden we're doing it. They know who they are, they already have the list. They have been keeping track of this all along anyway and I don't know if other states have been doing that, but I think that's a really good idea. We have a 12 month period to where they're going to look at the ones who probably have the highest income to take them off first, and take them off in a regimented way. So, I appreciate the discussion on that. And I just want to say as far as ICHRA's go, unfortunately there are so many regulations on that and with the subsidization of the ARPA funds that have gone to the marketplace you have very few people who would qualify for those. And then the last thing I'll say is in the marketplace, because we too have not expanded Medicaid, we find it easier for people who meet certain poverty level guidelines that they basically get a free private health insurance plan with $250 total out of pocket - free doctor's visits, $4 prescriptions and generics are free as well, and $5 for specialist visits. So, they already have really low cost plan that they can buy. Mr. Wu replied yes and it's good coverage.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Hackett and seconded by Rep. Oliverson, the Committee adjourned at 3:30 p.m.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Biomarker Testing Insurance Coverage Model Act

Sponsored by Asw. Pam Hunter (NY)

Draft as of October 18, 2022. To be discussed during the Health Insurance & Long Term Care Issues Committee Meeting on November 17, 2022.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Biomarker Testing Insurance Coverage Act."

Section 2. Definitions

(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" is 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” as used here are statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. These 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” as used here are 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.

Section 3. Health Insurer Requirements

(a) Health insurers, nonprofit health service plans, and health maintenance organizations issuing, amending, delivering or renewing a health insurance contract on or after [DATE] shall include 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:

1. labeled indications for a test approved or cleared by the Food and Drug Administration (FDA) of the United States government or indicated tests for an FDA approved drug;

2. Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

3. 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 Section. Such process shall be made readily accessible on the health insurer’s, nonprofit health service plan’s, or health maintenance organization’s website.

Section 4. Medicaid Coverage Requirements

(a) The State Medical Assistance Program (Medicaid Program) shall cover biomarker testing for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of a recipients 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 (FDA) of the United States government or indicated tests for an FDA approved drug;

2. Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

3. Nationally recognized clinical practice guidelines and consensus statements.

(c) 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.

(d) The recipient and participating provider shall have access to a clear, readily accessible, and convenient processes 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.

Section 5. Rules

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

Section 6. Effective Date

This Act shall take effect [xxxxx] and shall apply to al policies and contracts issued, renewed, modified, altered or amended on or after such date.

Material for "Discussion on Gold Card Laws and Prior Authorization Reform Efforts"

CLICK HERE TO VIEW LOUISIANA SB 112 AS INTRODUCED IN MARCH, 2022

CLICK HERE TO VIEW LOUISIANA SB 112 AS ENROLLED AND SIGNED INTO LAW IN JUNE, 2022

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 15, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Hyatt Regency in Jersey City, New Jersey on Friday, July 15, 2022 at 9:00 a.m.

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

Other members of the Committee present were:

Sen. Jason Rapert (AR)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Rachel Roberts (KY)
Rep. Bart Rowland (KY)
Rep. Edmond Jordan (LA)
Rep. Hank Zuber (MS)
Sen. Jerry Klein (ND)
Rep. Wendi Thomas (PA)
Rep. Lacey Hull (TX)
Rep. Tom Oliverson, M.D. (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Asm. Mike Gipson (CA)
Asm. Tim Grayson (CA)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Kerry Wood (CT)
Rep. Rod Furniss (ID)
Rep. Michael Sarge Pollack (KY)
Rep. Brenda Carter (MI)
Rep. Kevin Ford (MS)
Sen. Mike McLendon (MS)
Sen. Nellie Pou (NJ)
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Hank Zuber (MS), Vice Chair of the Committee, and seconded by Rep. Wendi Thomas (PA) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Bart Rowland (KY), and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes from the Committee's March 4, 2022 meeting in Las Vegas, NV.

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

Jeff Eddinger, Executive Director, Regualtory Business Management at the National Council on Compensation Insurance (NCCI) thanked the Committee for the opportunity to speak and stated that we're going to do a quick review of workers' compensation results and guess I want to leave it with one word, and that is the results of workers' compensation are strong. Another year of good results. So, we'll start out looking at the combined ratio which is just basically how much was paid out versus how much collected in premium and for two years in a row the combined ratio for calendar year has been 87%. It's a very good result and I just want to highlight that basically that's eight years in a row of underwriting gains in Workers' Compensation. Basically, when you look at the components, it's fairly stable over time. There is a slight uptick in the expense ratio but improvement in the loss ratio. So, now we're looking at loss ratios in Workers' Comp under 50% snd then the investment gains for the line, another strong year showing 12%. So, the long term average there is about 12% and when you combine the underwriting results, underwriting profit it's 13% and then investment gain of 12% we're looking at a very strong 25% pre-tax operating gain in the latest year.

So, there's a little bit of movement in Workers' Compensation premium basically caused indirectly by COVID and the impact to the economy and then some inflationary pressures as well on premium. So, we're looking at in the latest year payroll is up almost 11% and a lot of that is made up of wage increases of 7% and then employment is also up. But we're going to see how that translates to actual changes in the premium. So, the premium is up slightly for 2021. Again, $43 billion for private carriers and state funds. Just to get the full picture, look at the premium in the residual markets. So, this is the market of last resort for anybody that can't find coverage in the voluntary market. It continues to be a very manageable and stable market size. So, we're looking at about $700 million in premium in the residual market and that translates to about 6% of the market. So, as you can see, for the last almost ten years, it's been very small, very stable. So, the overall change in written premium is actually only a 2% increase. So, we'll get into the reasons why we're seeing 10% increases in payroll and 2% increases in premium. It does vary a little bit by state. You see there some negative changes in blue and some very large changes in orange.

So, one of the reasons for a smaller increase in premium is the changes in the bureau loss cost levels. So, this is a picture of what was filed in every NCCI state over the last 12 months and basically, anything in blue is a decrease and you see a lot of double digit decreases there for the states. So, that translates for 2022 about a 7% overall decrease in the loss cost. So, right away you're taking a big bite out of that 10% increase in payroll looking at 7% decrease in the actual loss costs. This is just showing the written premium for private carriers and state fund, how it's been relatively stable but I think you also see that what we saw happen to the premium during the great recession took many years for that premium to recover to its level prior to that. But when you see the drop in premium from 2019 to 2020, it pretty much is starting to bounce back already in 2021. So, this is just a breakdown by component. So, payroll for 2016 to 2021 you just see the movement there for those last six years. The payroll during that period of time increased by 28% but the loss costs and some mix changes actually put downward pressure of 33% on the premium. So, that's why even though you see growth in payroll growth and employment, overall premiums are staying relatively stable.

This is just showing the loss cost departures that we see by company pricing - fairly stable. Very small dividends. Schedule rating. And then just a slight uptick in the loss cost departures that will be filed by company. So, when we look at the loss drivers, we'll just briefly mention COVID. Not a very big impact on overall loss experience for Workers' Compensation. However, in NCCI states there were about 60,000 claims paid accounting for a $500 million in losses. That's for both accident years 2020 and 2021. And as a result of the huge shake up in the labor markets we saw claim frequency there for 2021 up 7%. So, that's not a number we're used to seeing either positive or that large. However, there is some distortion there for just the changes in employment and the changes in premium that happened during that one year. So, really when you look at combined two years it's a 1% decrease which is really like the overall long term trend that we're used to seeing in claim frequency. And then we have indemnity claim severity. So, this is how much is paid for wage replacement. For the latest year it's flat and for the latest several years indemnity claim severity has been muted compared to changes in wage inflation. So, you see the gold line there is the changes in wage inflation. You would expect indemnity claim payments to move in line or pretty much in line with wage inflation which it did for a period there between 2016 and 2020 but it still is below that line and 2021 is well below that line.

It's a similar story for medical. Again, we're seeing flat and no change in the medical claims severity for the latest year and when you compare the medical claim severity to the healthcare index there in gold, there were times where the medical severity did move pretty much in line with that but now it's below that line. So, for both indemnity and medical payments we're seeing very small changes. We're not seeing the inflationary pressures that we're all experiencing in the general economy. We're not seeing it in the Workers' Compensation medical payments and there's a lot of reasons for that like medical fee schedules and things like that but I think it's just important to keep in mind that claim frequency does look to be continuing to be stable or even decreasing. And the average claim size is staying relatively controlled as well. So, the combined ratio was 87% The reported accident year combined ratio was a 102%. However, we expect that to develop downwards so I would expect even in an accident year basis to be below 100 and about $500 million in COVID losses since 2020 have been paid out.

Sen. Hackett stated that you don't talk too much about the drop in the market and the pressure on premiums. I totally agree with payroll and everything but those of us that are in the investment business, we know how bad the market's been so we're going to see really low returns and with low interest rates even our bond portfolios are not going to be really good. So, I'm surprised that the companies don't have the pressure on premium increases to offset market losses. Or is it always a delay? Mr. Eddinger stated that I would also say that I'm surprised in the sense that we all know what kind of returns we can get at the bank, or certificate of deposits (CD's), or whatever so it is difficult to know every company's portfolio and how they might have old things that they're cashing in now. But yes I would agree that I would think that, and I think we've been saying this for years that the low interest rate environment would put downward pressure on the returns that companies would get.

Sen. Hackett stated that in Ohio we're a state run system but we really worked hard to increase our portfolio return and they do a really good job under that scenario. So, we have professional money managers and they do an excellent job. So, there is still a decent amount in equites that are going to get slammed this year. And so, I agree with

you on the bond portfolios and insurance companies pretty well hold them to maturity so that they don't have a lot of time and don't worry as much about the bond but equities are getting slammed.

EVALUATING THE EFFECTS OF COVID-19 PRESUMPTIONS ON THE WORKERS' COMPENSATION INSURANCE SYSTEM

Michael Dworsky, Ph.D., Senior Economist at Rand and Faculty at Pardee Rand Graduation School thanked the Committee for the opportunity to speak and stated that I've been at Rand almost 10 years and have done a lot of work for the State of California but we don't always get to share findings with folks from other states. This is an exciting opportunity. What I'd like to discuss today is just most of the work that we've done on COVID has focused on the impact of presumptions that were adopted in California. So, we did a state mandated study on Senate Bill 1159, which was California's presumption legislation and we're going to see what COVID claims have been like in California and what some of the findings were from the report that we published in May. And then I'd like to sort of tee up hopefully some discussion from this Committee about what we still don't know about COVID in Workers' Comp and whether any of the lessons we've learned from this pandemic should have bearing on how we respond either to the future of COVID or a future pandemic which seem likely at this point.

This is pleasure to speak to an audience that probably knows a lot more about Workers' Comp and about the status of current legislation than I do but in total, according to NCCI since the start of the pandemic 20 states at one point or another adopted either a COVID presumption or a more general infectious disease presumption. Many of those have expired. So, according to NCCI we're back down to about seven states that have presumptions currently in force. I just want to note to set the stage that presumption is not a new policy lever in Workers' Comp. It's been widely used for public safety workers in situations where similar to COVID you have an occupational disease where it's really difficult to evaluate causation on an individual basis. So, we've seen these extensively adopted for cancer, post traumatic stress disorder (PTSD), and other health conditions but primarily in firefighters, police, and the public safety workforce. COVID presumptions are different in a few key ways. First of all, COVID obviously is an infectious disease that has very high levels of community transmission. And second of all, compared to other presumptions, the COVID presumptions that were adopted in California and in a number of other states actually touch the private sector workforce in a way that we haven't seen with other public safety worker presumptions. We've been doing some work trying to understand the amount of liability associated with long COVID and how that might be spread across different parties. So, we've been coding up some of these presumptions. What we're finding is that every state for the most part really has taken a slightly different approach either in terms of who is covered by a presumption or by what conditions need to be met for the presumption to kick in. So, I think it is worth bearing that in mind that I'm going to be talking about California for the next ten minutes or so, and California probably took a slightly different approach from what happened in your state.

So, this figure is meant to illustrate that California adopted not just one but actually three presumptions over the course of the pandemic dealing with COVID. So, this is just sort of a timeline of when different presumptions were in effect. In the early days of the pandemic roughly March through June of 2020 there was a presumption that broadly covered workers who were outside the home that was adopted by executive order and

then what we're going to focus on mostly are the two presumptions that were adopted legislatively under Senate Bill 1159. We call one of them the frontline worker presumption and this generally is a presumption that was rebuttable and it covered workers in public safety and in healthcare facilities as well as home health agencies and basically this presumption kicks in as long as you have a positive Polymerase chain reaction (PCR) test result and you have one of those jobs. However, California also adopted a broader presumption that covers the rest of the workforce under certain conditions. We call this the outbreak presumption because the requirements were for there to be a positive PCR test and what the statute called an outbreak period at your jobsite when your case is diagnosed. I'm not certain that other states adopted this kind of an outbreak requirement. And now the advantage of this from a broad coverage point of view is that it kept the state out of the business of picking which occupations and industries were high risk or would be eligible for that broad presumption. It may have created other challenges which is that the claims administrators now had to track whether there was an outbreak in effect basically in real time to decide if a claim would be eligible for the presumption or not. So those two presumptions covered all the workers in California potentially. They're scheduled to expire at the end of this calendar year. There is pending legislation I think in the Assembly that would extend that for two more years.

So, I want to just highlight a few high-level findings about the claim volumes and some of the other policies that impacted COVID in Workers' Comp. So, I think looking at the total claim volumes this may be similar to what you've seen in your states but really it's the dynamics of the virus that have been driving the volume of claims that come into the Workers' Comp system. So, this chart is showing the number of COVID cases in the state and then the number of COVID claims filed and pretty much when there's a case surge in the state, we also see a surge of Workers' Comp cases. So, in the period that we studied which ends in mid-2021, COVID was about 15% of the Workers' Comp cases over the preceding year and a half but that kind of understates the impact on the administration of the Workers' Comp system because you look at this surge in the Winter of 2020 when there were about 45,000 Workers' Comp COVID claims in a month. That was actually a majority of claims in the system and that was, as far as we know, the all-time record for the number of Workers' Comp claims that were filed at one time. We did hear that this placed some burden on claims administrators trying to process all of that at once and after our study period ended we had the Omicron surge which led to an even higher claim volume. So, it's not just an average volume of COVID claims that impacted the system but really the volatility month to month.

Looking at which workers filed Workers' Comp claims, we did something that sometimes was difficult with Workers' Comp data, which is that we used an algorithm that the National Institute for Occupational Safety & Health (NIOSH) developed to impute an occupation code so that we could sort of break out the claims into frontline workers. So, the firefighters, police officers, and healthcare workers covered by this frontline presumption, and then what we called the outbreak workers which is the other 95% of the workforce. So again, these frontline workers are approximately 5% maybe a little bit more of the California State workforce. The outbreak workers about the other 95% and in terms of who is filing claims, we found that 42% of the COVID claims came from those frontline presumptions even though they're only about 5% of the workforce. Now, typically these are high risk jobs for Workers' Comp apart from COVID so they would typically account for about 15% of the Workers' Comp claims but looking at COVID it was more like 40%.

Looking at which industries were driving COVID claims not surprisingly it's the industries that contain those frontline workers, the state and local government and healthcare social assistance had claims rates over a one year period per 10,000 workers that were about four times, or about double the statewide average of 70 claims per 10,000 workers. I would note however that transportation and warehousing and retail trade also had above average claim rates. Manufacturing as a whole was a little bit below the average although some manufacturing industries had high claim rates. Looking at which occupations within these presumptions had a lot of claims, I think it's interesting for a few reasons. One, it sort of tells us about where the liability might be in the longer term as long COVID emerges and second of all, it also may speak to some of the social equity concerns you would have. We know the impact of the pandemic was disproportionately born by some disadvantaged groups so it's worth understanding whether those groups actually had access to the Workers' Comp system. What we found is among the frontline workers the public safety occupations, the firefighters and police officers, had substantially higher claim rates than most of the healthcare workers although the healthcare workers, of course, also had elevated claim rates. Something that we thought was interesting is within industries in healthcare, it was really the healthcare support occupations rather than sort of the more credentialed practitioner and technical occupations that tended to have high claim rates. We saw that across these industries.

That's consistent with speculation there may have been differences in the availability of personal protective equipment (PPE) but we certainly couldn't investigate that within the scope of our study. What I thought was really striking that we didn't expect to find is that within healthcare it wasn't the providers but actually the maids and the housekeeping cleaners who had by far the highest claim rate out of anybody that we looked at and they were covered under the frontline presumption because the way it was written in California but I know that looks different in some other states. In terms of other industries covered by this outbreak presumption, there were some very high claims rates in some of these industries as well. I mentioned transportation and warehousing. A lot of that was driven by couriers and messengers which is sort of industry coding jargon for shipping and local delivery companies. What I thought was interesting is the truck drivers had high claim rates, but actually the laborers, the material moving occupations really had I think the highest claim rate that we saw among the large occupational groups under this outbreak presumption. We also saw some high rates in some of these retail industries so essentially hardware stores, auto dealerships were multiple times higher than the statewide average. Assisted living facilities weren't covered by the frontline presumption but obviously they had a lot of outbreaks. They had actually very high rates, a little bit lower than the skilled nursing but comparable to hospitals.

Then finally, I mentioned that manufacturing had a below average rate as a whole but slaughterhouses and animal processing had very high rates particularly among machine operators. So, in some ways this corresponds to some of the people who we knew were working a lot and had high COVID exposures outside the home. What I think is worth noting in contrast to some of the stats that Mr. Eddinger just mentioned, these stats reflect claims filed without sub setting the claims that were accepted or paid. In many of these groups especially the couriers and messengers and the slaughterhouse operators had very high denial rates generally in the range of close to 90% of the COVID claims being denied. For the frontline workers that was more like 20% and I'm happy to say more about denial rates in the Q&A if that's of interest. So, I want to say a little bit about other policies, some of which as state policymakers you should be thinking about as we

continue the COVID pandemic or gear up for the next pandemic and our study had a large qualitative component. My co-project lead did a ton of interviews really fast in the summer of 2021 and what we were trying to understand is thinking about the objectives of Workers' Comp which include providing paid leave to workers, reducing contagion by allowing workers to stay out while they're still contagious, and providing access to medical care. There were a lot of other state and federal policies that also served these functions that may have taken some spending and some claims pressure out of the Workers' Comp system.

So, in particular, there were federal sick leave mandates. California also had its own sick leave mandates that kind of wrapped around and filled some of the holes in the federal mandate. We heard from public health officials that they think that was much more important for reducing contagion than Workers' Comp was simply because there's a lot less hassle for the worker to use sick leave than there is to file a claim and potentially worry about whether it's going to be accepted or not. The other thing we heard is that expanded payment for hospital care for COVID by private health insurers as well as some federal programs that target the uninsured really contributed substantially to the low proportion of COVID claims that had paid medical bills. So, I'm sure you've all heard that COVID claims were very unusual and that many of them had no paid medical or no medical bills submitted to Workers' Comp. We heard qualitatively that a lot of that is because it was basically easier for people and potentially easier for providers to send those bills to health insurers and get them paid out. What I think is worth bearing in mind is that a lot of these programs have either expired or only existed in California so if you look at our study, we're going to say that Workers' Comp was less valuable than anticipated to a lot of workers or less important for accessing medical care but that may not be the case moving forward.

So, why don't I just wrap up by highlighting a few questions that I think we weren't able to address in the context of California and then also raise some discussion questions that I think you folks should all be thinking about both in the context of COVID and future pandemics. One is that we didn't really have data available given the timeframe of the study on settlements or permanent disability. We would expect to see more settlements given the high level of uncertainty on the costs associated with COVID but those simply weren't happening when we looked at the data and I think permanent disability rating is going to be interesting and potentially contentious and we also pulled the data too soon to look at that. We also can't really say whether disputes or frictional costs would have been higher in the absence of the presumption. There's reasons to think they might have been but we didn't study a world without the presumption in California. Also, this outbreak provision that, as far as I know, was unique to California, probably limited costs and may have led to greater accuracy in terms of the application of the presumption but it was a real headache for the claims administrators. It's worth thinking about whether there could be better information sharing with public health departments to track outbreaks.

I think some other big questions of course include what role experience rating's going to have. The rating bureau in California recommended that COVID claims be included in experience rating but the last I heard the insurance commissioner had disagreed with that. I think it's worth thinking about the equity aspects especially given those high denial rates in the private sector that we saw and we heard anecdotally about retaliation, other barriers to claim filing from some of those vulnerable populations. I think it's worth thinking more holistically, if you're going to adopt a presumption for Workers' Comp or

other pandemics, know whether sick leave will do the job better for some of your policy objectives. There's a lot of unknown questions about long COVID given that long COVID wasn't priced into 2020 premiums, so where are folks going to come up with that money and how are those costs allocated between governments, employers, insurers, and reinsurers? And also whether having Workers' Comp involved in the long COVID care is going to lead to issues with healthcare fragmentation that might affect quality adversely. And the last thing I'd like to add is there's a lot of potential reasons why you might think about a Workers' Comp presumption. Workers' Comp serves a lot of functions for different stakeholders. I think having clarity on which of these you're pursuing can help you think about whether Workers' Comp presumptions are actually the best policy instrument because what we heard is that for some of these, it was actually questionable whether Workers' Comp was optimal compared to sick leave or other types of healthcare payment.

Rep. Stephen Meskers (CT) stated that when I look at Workers' Comp and I look at the issue of COVID, it takes me back to the initial Severe acute respiratory syndrome (SARS) issue in terms of viruses and the pandemics and the exception on a lot of general insurance policies. If you're talking about future pandemics and we're talking about Workers' Comp, what's a tipping point in general ratios where you begin to look at a pandemic and it's an impact on long term and short term worker impact and on claims on the system? How does a system sustain itself? Where's the break point on a pandemic in terms of the ratio? It would be good financially if in the future we saw some data on what the survivability of the payout ratios and the sustainability of Workers' Comp is on the basis of a modeling of a pandemic because at some point it becomes a federal issue bailout versus a question of can we self-finance the Workers' Comp, right? Dr. Dworsky stated that's a great question and probably the actuaries are in a better position to answer some of that about at what point it becomes financially unsustainable and burns through reserves. I think the one thing I would note is that probably the status quo in Workers' Comp is for pandemic related diseases not to be covered due to ordinary disease of life exclusions and so on. So, certainly one policy option is to leave that in place and not adopt presumptions but of course that raises sorts of fairness and contagion issues which motivate a lot of states to adopt presumptions. I think what we saw with COVID is the claim volume overall in the Workers' Comp is, at least through the end of our study period, was still lower than what it was before the pandemic just because the drop in non-COVID claims more than offset the volume of COVID claims so generally we're about 6% lower at least through mid-2021 in terms of the monthly claim volume when you include the non-COVID claims.

Rep. Meskers stated that that's my only question is really basically when we move forward on coverage on different issues of policy basis, I want to know what the breakpoint is for the fundability of our claims system. I'm not against the policy issues, I just worry about the funding. Mr. Eddinger stated that early on NCCI developed a tool which produced a wide range of scenarios based on different assumptions. So, before anybody really knew what the impact on Workers' Comp was going to be and looking at some of these presumption laws that were happening at the time, there were some scenarios based on well, it's presumed that if you caught COVID it was at work or we probably had some assumptions about more higher medical. It turned out to be an indemnity only of pay the wages while the person is out sick but there were scenarios where the annual payout was three times what it is for the entire Workers' Comp market. So, there is a possible I guess you would say tipping point but luckily we did not see that but I guess there's always the potential for something catastrophic like that.

Dr. Dworsky stated that I'd actually like to amplify that. There was similar modeling done by the rating bureau in California that predicted a conclusive presumption that couldn't be rebutted that basically showed 100% of COVID cases from working people go into the Comp system would have more than doubled the paid benefits and the losses. That could have been really destabilizing but we were nowhere near that as it turned out. It is hard to say how much of that is because hospitals found it easier, or potentially in California more remunerative to bill health insurance payers rather than Workers' Comp. California has a fee schedule that pays statewide maybe half of what the average commercial insurer pays so it's a 120% of Medicare versus around 260% statewide in California. I'll jump to this slide which we cut out in the interest of time that kind of compared the number of COVID fatalities from working age people by occupation that were estimated by the State Department of Public Health. So, the blue bars here show the number of COVID claims filed in the following year that actually have the death of the worker reported and I don't think the benchmark should be that every working age person who died of COVID necessarily would determine it to be work related and file a comp claim but if you're worried about this kind of financial Armageddon scenario where every COVID cost goes into the system, we're nowhere near that in California, even with fairly expansive presumption laws. But what does that look like in the next pandemic I have no idea.

Rep. Wendi Thomas (PA) asked if you are continuing to study the long term COVID? And are the presumption laws permanent in California? So, in three years if we have another outbreak of COVID are they going to still exist or do they sunset? Dr. Dworsky stated that to the second question the presumptions that we studied under current law are going to expire at the end of this calendar year. There is pending legislation that would extend them basically unchanged for two years and we're getting close to the end of the session so they're still alive but there's two more months and anything goes. I think in terms of what we're doing at Rand, this was a state mandated study that was bid competitively that we did as a contractor. We're not currently analyzing on the long COVID or really anything about COVID from the California system. Rand also has other funding streams and we're doing a small sort of preliminary study with some basically donor based funding about long COVID liability. That's why I mentioned we're looking beyond California to kind of code up some of the other presumption laws and trying to get again back of the envelope calculations that I think would complement what NCCI and other folks are doing by looking at the liability for governments and self-insured and people who aren't in the insured system. But no, we're not currently studying long COVID quantitatively beyond that.

Rep. Forrest Bennett (OK) stated that we discussed earlier the kind of intersection of paid family medical and Workers' Comp and we're having these conversations back in our states especially when it comes to pandemic response. Do you have data on, especially for the employer side, the overhead and cost benefit analysis of stronger Workers' Comp versus paid family medical? And which tool is a better one for responding to that? And also if you think that the solution is some combination of both or a paid family medical that conditionally allows an employee to sort of proactively take themself out of the workplace if they're afraid of being infectious?

Dr. Dworsky stated that's a great question and that's I think one of the takeaways from our study. I should be clear, California had some unusual provisions that were part of the presumption legislation in that California required workers to exhaust any COVID

specific sick leave before temporary disability benefits would start. So, that probably limited some of the indemnity payouts that you would have seen if it hadn't had that provision to coordinate those two types of benefits. But what we heard, and I've kind of been harping on sick leave here even though this a Workers' Comp Committee, is that the public health officials we spoke with felt very strongly that Workers' Comp was not really a good mechanism for reducing contagion. It's probably better than having no paid leave or having no Workers' Comp access but basically their sense was that by the time you're diagnosed and you think about filing a Workers' Comp claim and you're worried about the uncertainty of whether you'll actually receive indemnity benefits or not the cat's kind of out of the bag. I think we heard from a lot of the stakeholders we spoke with that the after the fact aspect of Workers' Comp limits its value as a preventive or a public health measure in terms of reducing workplace transmission. Now, Workers' Comp could work through other mechanisms. I wrote something on the Rand blog in 2020 about how in an ideal world Workers' Comp would create incentives for the insurers to get engaged with loss prevention. Similar to what the Bureau of Workers' Comp in Ohio does, I know for a while it was preemptively mailing masks out to people and they have a safety grant program for other industrial hazards. You could have imagined something like that happening for COVID once you moved those liabilities into the Workers' Comp system but it's not clear to us that that's actually happened on the large scale through other Workers' Comp payers. I think in terms of sick leave, we haven't analyzed from the employer's point of view whether sick leave is more or less cost effective but I think that's a super important question to examine moving forward if you wanted to set the policy for the next pandemic.

PRESENTATION ON OHIO WORKERS' COMPENSATION SYSTEM

Sen. Hackett stated that Rep. Brian Lampton (OH) and I are from Ohio and Ohio has a state run work comp system. John Logue, Chief of Strategic Direction at the Ohio Bureau of Workers' Compensation, who will speak in a second will tell you when I first ran over ten years ago our system was really struggling and I think most people that ran, ran on the principle to privatize the system but our Workers' Comp system has had a tremendous turn around and a lot of dividends have gone back to the employer.

Mr. Logue thanked the Committee for the opportunity to speak and stated that I'm going to talk a little bit about the Ohio Bureau of Workers' Compensation (Bureau). Sen. Hackett's correct - when I began my career in the Ohio system about almost 30 years ago, the famous line in Ohio from then Governor Boynavich was that the Bureau was the silent killer of jobs in the State of Ohio and I would say he was very justified in that comment, certainly at the time. As we heard earlier, we are one of four exclusive compulsory state run systems in addition to Washington, Wyoming, and North Dakota. We currently have about 1,600 employees across the State of Ohio. Again, when I began my career that number was over 4,000 so we have come down quite a bit over the last couple of decades and we are funded entirely by premiums and assessments paid by Ohio private and public employers. So, a little bit about Ohio and our workforce. We are number ten on the competitive labor market, third manufacturing workforce in the United States, first in plastics and rubber manufacturing, and we are number four in the number of active apprenticeships in the United States. Our injury rate is 2.4 injuries per 100 workers in calendar 2020, which does put us below the national average of 2.9 injuries per per 100. We currently cover approximately 250,000 private and public employer policies. That represents about 55% of Ohio's workforce. The remaining 45% of the workforce is employed by about 1,200 employers who are self-insured for their

Workers' Compensation coverage. Currently, we have just over 200,000 claims that we are managing. We have claims that go back to the late 1940's that are still open, active ongoing claims up until likely a claim that happened at some point this morning. That number is down from well over 600,000 probably ten years ago.

So I'll hit a couple points on the actions we took during COVID. The agency issued three dividends to Ohio's employers totaling nearly $8 billion. All three of those were done in calendar 2020 with the last one that we paid in December of 2020 of $5 billion. At Gov. Mike Dewine's request since 2019 our Board of Directors has authorized over $9 billion in dividends to Ohio employers. Regarding COVID claims, we did not have a presumption law in Ohio. I know there were a few introduced but we did not actually have one. We handled them through our occupational disease guidelines and put together a team that has remained through today so we had a consistent internal team made up from our medical, legal, policy and claims divisions looking at every single one of those claims so that we were handling them in a consistent matter across the State of Ohio. To date we have allowed as just under 1,400 claims, which seems low compared to the 3,600 filings. What we saw during the first few months of the pandemic as businesses were closing, we had probably 1,500 claims that were filed with us under Workers' Comp that were actually individuals intending to file under our employment system. So, we had a large number of claims that were then subsequently dismissed by the employee because they weren't actually alleging a workplace injury. Of those 1,400 claims on the state fund side we have paid out just under $9 million in medical and indemnity benefits. The self-insured employers that we regulate have had just over 1,100 claims since the onset of the pandemic that they have accepted. During the state of emergency in Ohio which Gov. Dewine lifted in June of 2021, any COVID claims that were allowed we did not charge to the employers experience. Since the end of the state of emergency the frequency has declined significantly. However, anything since that time are being charged to the employer's experience. We also during the pandemic expanded availability of telemedicine to injured workers and we extended and forgave many of our deadlines and penalties for late payment, lapses in coverage, etc.

So, a few comments from some of our customers and interest groups during the pandemic. First one is from Roger Geiger, the Executive Director of the Ohio Chapter of the National Federation of Independent Business. I won't read it for you word for word but basically, this is thanks on behalf of his members to the administration for everything we were able to do to help employers keep afloat." And again, from Jack Tran at Jergens Inc., the pandemic placed enormous pressure on businesses and individuals across Ohio and across the Country. The dividends we were able to provide and support during that period we did receive a lot of feedback from employers across the state that it was able to help them get through and maintain their employees and their payroll and fortunately the agency was in a position to do so. You heard a little bit from the prior presenter here talk a little bit about some of the programs we have. So, I'm glad those have gotten notice outside of our state lines. The Bureau does have a division of safety and hygiene roughly a 150 individuals that are paid through employer premiums that we support those businesses with loss preventions, consultative services, training. We'll do a walk through, air sampling, anything we can to help them reduce the risk of injury and illness and keep their workforce safe and healthy.

We annually offer $35 million in a variety of grant programs to help employers invest in equipment to reduce the risk of injury and illness. We have specific programs targeted for firefighters for equipment to reduce some of the environmental exposures they have.

Police body armor, organizations that work with adults with developmental disabilities and then as well as just broad based grants that employers can apply for, we will review them as there's some filing that they have to make with us and we'll offer up to $40,000 per employer during their eligibility cycle. A new initiative we just launched in our recent bi-annual budget, we were granted the authority for $15 million each year. During the pandemic there was certainly a focus on PPE within Ohio and across the country and what we wanted to do was take a shot at providing research funding. This is funding that goes to Ohio's University or not-for-profit research organizations of what else can we do out there to help keep Ohio's workforce safe? What we made clear testifying before the legislature is we weren't interested in a paper research study, we wanted to see things get into the workforce to be tested, to be tried out. Gov. Dewine has repeatedly encouraged us to, in his words, throw some long passes knowing that not every single one of them might be caught but we need to take some shots and see what we can do.

So, we've recently just issued our first three awards under this program. They are just off the ground but one is looking at, and it's outside my realm of expertise, but nanotube technology to assist firefighters with their turnout gear to make that better fitting and more comfortable for them. Others have a sensor type of technology that will be worn with individuals in metal grinding and stone grinding that will actually measure the particulates in the air with the respirator they're wearing and alert them and the management if we're at a dangerous level. So, we're going to see where this goes. Again, we just issued our first round of funding on July 1st. As far as Ohio and our Workers' Comp system, our aim is to increase our capabilities of our agency to provide the best service for our customers that are in Ohio and those that may choose to come to Ohio. I wanted to leave some time in here for questions. There was a discussion earlier about investments and I believe roughly our portfolio has dropped the value of about $3 billion since the beginning of the year. We currently are running our total assets which you might imagine will vary by the day, and are somewhere in the $20 billion to $22 billion range. Our long-term liabilities are currently about $15 billion.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that he has a quick question as a border state to Ohio. It can be problematic at times with a monopolistic state of Ohio and Indiana's not but one question I have is there's the issue my employers in my state can work in Ohio not more than so many days etc., but if they have to buy an Ohio policy one question I'm asked a lot of times is how much more will that cost me? Where do Ohio's rates fall in that scale of the high states, low states? Mr. Logue stated that the best measure we have on that is the Oregon study of Workers' Compensation that is done every two years. Obviously, it varies and we use the NCCI's system for our class codes. The Oregon study currently has us as 13th highest, or actually lowest rates in the country. At one time we were the 47th lowest, meaning we were the 3rd highest. On the most recent version of the Oregon study the way that's calculated our index, at the way they calculate it, we were lower than all of our border states. Now, I would tell you with a business coming into Ohio, if they're not coming in for an extended period of time, and they have coverage in your example in Indiana we will honor that coverage. We will not require them to take out a policy for Ohio. I think sometimes what we'll find is perhaps a general contractor or someone may require them to have an Ohio policy but for the most part, if they're hiring workers in Ohio strictly to work in Ohio, yes we would like them to have an Ohio policy or require them to have an Ohio policy. I'd be happy to follow up with you afterwards, but generally if they have coverage, we're usually pretty good with it.

CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL MODEL STATE STRUCTURED SETTLEMENT PROTECTION ACT

Rep. Bart Rowland (KY) stated that the prime sponsor of these amendments to the NCOIL Model State Structured Settlement Protection Act (Model), Sen. Paul Utke (MN), unfortunately couldn't be here with us today but as co-sponsor of these proposed amendments I'm happy to offer them for the Committee's consideration today. I know that there's been some communications to Sen. Utke and the members of this Committee requesting that further amendments be made to the Model but Sen. Utke has made his intentions clear to us that he would like to move forward with what has originally been presented and is in your binders on page 119. I'll leave it to the speakers we have here today to make any specific comments on the amendments, but I'll just reiterate Sen. Utke's request that we move the amendments as they have been presented to the Committee. I support that request and look forward to the Committee considering the amendments.

Jack Kelly, on behalf of the National Association of Settlement Purchasers (NASP), thanked the Committee for the opportunity to speak and stated that we've been before this Committee since a year ago this month on this issue. In the meetings in 7/21, 11/21 and 3/22 this issue was deferred over by Sen. Utke who had announced a year ago in July that he had amendments he was working on for the Model that had been adopted from Louisiana, Nevada, and Georgia. Then in October of 2021 news articles appeared in Minnesota concerning some untoward behavior by non-members of our association and Sen. Utke announced at that time that he would like to defer the amendments until he could deal with the legislation in Minnesota. NASP worked nationally since the enactment of the Model. I personally have been involved in this since the creation of structured settlements when I was a member of the Ways and Means staff of the House of Representatives in Congress when we created structured settlements so I'm intimately familiar with this. NASP has worked nationally throughout all the years and today after our work and effort, all 50 states and the District of Columbia today now has a structured settlement protection Act. We have appeared in every one of those states and worked vigilantly on it. In 2019 then Sen. Dan "Blade" Morrish, former NCOIL President, identified a concern in Louisiana where structured settlements when they were entered into, nobody knew who was doing business in their states. The companies weren't registered and you didn't have to report who was doing business there. It was strictly a civil procedure hearing to the federal statute to get a court order and the only way you could find out who was doing business in those states was literally go through court records and search it out. So, Sen. Morrish and Louisiana adopted a registration or licensure procedure and a bond that had be proposed and in following that, Georgia adopted it and then following that last year, Nevada adopted it. It's kind of interesting about that as that's a mix of the variety of legislatures of Republicans and Democrats and it shows the uniformity and these laws develop as a uniformity occurs.

Then Sen. Utke intended to do that and he began the negotiations in Minnesota which we actively participated in. I made six trips to Minnesota and Sen. Utke personally spent ten hours negotiating with the interested parties in this legislation. This is very important to know - the Minnesota structured settlement protection Act that they operated on was before NCOIL or the federal law existed. They were the first state to have a structured settlement protection Act so it wasn't even the NCOIL model and Sen. Utke said we're going to do the NCOIL model and I'm going to work to address some concerns that are

identified here and then if there are local issues we need to identify my intent is to take these changes that I'm updating here to bring them back and pass them at NCOIL. That's where we are today. There were two issues identified in Minnesota that were unique to Minnesota. There were local rule issues. Minnesota does not provide for the appointment of a guardian ad litem in these types of cases. A guardian ad litem is appointed by a Judge traditionally in a court to protect somebody who she thinks interests need protected.

In Minnesota they only appoint them in juvenile cases and in family law cases. Judges felt they didn't have the authority to do that. So, they created a provision for Minnesota unique to that state to address that issue of creating an attorney advisor to address that but that was unique to Minnesota. And Sen. Utke said at that time that he would do that there, but that was not his intention nationally - he would stick to the Model. And the one other provision that they put in was that Minnesota had a Court of Appeals decision that set four criteria that they wanted judges to look at in these cases and rather than have a conflict of law where the statute would say one thing and you'd have an Appellate decision that says another, they incorporated those four provisions into the law in Minnesota, unique to Minnesota. They're Minnesota decisions and not in any other states. So, we worked vigilantly with him and I commend Sen. Utke as he spent several hours negotiating with all of the interested parties. We've got a good bill. We need to move this now, and we urge that you do it today.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) stated that it's my pleasure this morning to introduce Ingrid Hopkinson of the National Structured Settlement Trade Association (NSSTA) who worked extensively on the structured settlement issue in Minnesota and has some comments to share with the Committee regarding some specific issues emanating from Minnesota and some of the Minnesota language which is not currently in your model bill.

Ms. Hopkinson thanked the Committee for the opportunity to speak and stated that I'm here on behalf of NSSTA which is an organization of skilled professionals that deal with providing a funding solution for personal injury matters. The members of the organization include consultants who are highly specialized in the field, life insurance producers, and companies that issue the annuities that fund these settlements, as well as property casualty insurers who are settling these personal injury cases. It takes a lot of time to settle a case. It takes a lot of energy. And they're put together to provide these individuals with a long-term financial security. Structured settlements have over time provided that and keep people from being on the social safety net. It's our position that structured settlement protection Acts are primarily a consumer protection statute. They are to protect the individuals who have been injured as a result of an accident. They also do protect the insurers who provide these products for the injured as well as the public policy of keeping individuals off the social system.

The current proposal focuses on providing a registration provision that will register the companies that buy from these individuals the product. The registrations will not serve ultimately the payee who may enter into a transaction with a third party. The provisions as well, while helpful, don't address some of the major issues that were brought out in the various articles in Minnesota but have also been brought out in articles in the Washington Post before Maryland changed its structured settlement protection Act. And Maryland has a very rigorous registration process very unlike the registration process that's been adopted in the various states that Mr. Kelly mentioned. We seek to provide

additional protections for the payees that these structured settlement protection Acts are intended to provide. What we have proposed and what has been adopted in Minnesota is not unique to Minnesota as many states have some of these provisions. The ad litem issue is in several states. The factors that we seek to have added in are also included in numerous structured settlement protection Acts. They're not controversial provisions. There are provisions that will provide the necessary protections for the payees for which these products were written.

Rep. Meskers stated that structured settlements sounds like a very complicated process but it's not. You're buying a cash flow basically. It's like a discount and it's for the general audience. It's the equivalent of taking your lottery payment up front, discounted and the only question is that you're changing the obligor so if you have a settlement from an insurance company, you're selling it to a third party. The third party is giving you a discounted cash flow. So, there's a bunch of words floating around that leave me more confused than I've been when I sold products like this on Wall Street. So, what I want to understand is what's the dispute in terms of either the transfer of the title or the obligation of the payee and I don't understand what the dispute is that I'm hearing here and it confuses me as to where the differences or discrepancies are in the legislation we want to look at.

Mr. Kelly stated that the original issue when this was created and it's interesting as we're here in the shadows of the World Trade Center and 9/11 - the actual law that allows for the transfer of these was in the 9/11 victims law. And what that said was that Congress said when structured settlements were created back in the 70s in Ways and Means we said, you cannot accelerate them, you're not going to decrease them. You can't accelerate the payments, the person had to receive it in a stream of payments for their tax structure. The carriers when this business emerged as a startup business of buying these structures were genuinely and rightfully concerned that the tax free treatment of the inside buildup of the money in the annuity could be subject to federal tax. There was a right point to make. And Ways & Means and the Senate Finance Committee addressed that and they said what we'll allow for is these to be transferred but a court of general jurisdiction is going to determine, and Congress specifically picked it, and a judge must determine if it's in the best interest of the person and that's where we are today and the structured settlement protection Model is what does that and allows for that civil procedure.

And what is at issue here today is a distinction between what Minnesota did in their uniqueness because of certain decisions and what's been adopted nationally by most states. While some might say that they were involved in Minnesota, we were physically there every day negotiating this with everybody and it worked out. It's a good bill in Minnesota and the provisions that people talk about here that were adopted in Minnesota, if a state finds something unique in their state in their civil procedure and they need to address it, they can. I came out of the Family Court in New York where guardians ad litem were thrown around regularly. Everybody had a guardian ad litem and it was a righteous system to protect people in the interest of juveniles and the interest of people like that. Minnesota didn't allow for that, and I was flabbergasted that they just didn't in Minnesota and they said we need this in statute. I worked in Maryland on the bill there and I worked hand and hand with NSSTA and Maryland adopted a registration system which then portions of it or the types of it were migrated to Louisiana, Georgia, and Nevada. Three states adopted those. Three different states. So, I think where we are today is if as time goes on, and that's why NCOIL revisits these every five

years, and we see states start to emerge in multiplicity of wanting these amendments that were talked about today, then that's a right move to make to bring them into a model act. But models are just that, a frame.

Sen. Hackett stated that one thing that I've said consistently is that at NCOIL we really create the framework with our model laws. Ohio and California are different and Indiana and Ohio are very different from California and so each state can come in and take the Model and make it work to a way that fits their state under a situation like that so that's why I think these are good amendments and it creates a framework. If all the states eventually agree and we can get a standard Model act, we can do that but that's more the exception than the norm. We really try to create a framework and then let the policy come in as the states come in and decide what they need.

Rep. Thomas stated that as someone who's a co-sponsor on the NCOIL sandbox model legislation and seen Models come before NCOIL meeting after meeting after meeting, I just want to support what Sen. Hackett said. I think we have a member here who spent a lot of time and effort on this message and it's hard frankly at this point for me to know whether Pennsylvania will want those additional things or not. But I think passing the base legislation and then taking it back to our states and seeing how we have to tweak it is a good move for us. We meet three or four times a year as opposed to when we're in our general assembly and we're fighting it out every day at midnight. I think it's a good idea to pass the Model as it is presented and then take a look back in our own states as to how we have to modify it. As you said, it's just model legislation and if we keep pushing it down the road then we're behind the curve instead of leading the curve as an organization. NCOIL leads. Here's the Model and then each state modifies it as it needs.

Rep. Rowland stated that I appreciate the discussion and questions and stated that if there are no more questions from the Committee, I move that we pass the amendments as presented this morning. Rep. Lehman seconded the Motion. Hearing no questions or comments, the Committee voted without objection by way of a voice vote to adopt the amendments. Then, upon a Motion made by Rep. Rowland and seconded by Rep. Hank Zuber (MS), Vice Chair of the Committee, the Committee voted without objection by way of a voice vote to re-adopt the Model as amended.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Jason Rapert (AR), NCOIL Immediate Past President, and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, the Committee adjourned at 10:15 a.m.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 15, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Hyatt Regency in Jersey City, New Jersey on Friday, July 15, 2022 at 3:45 p.m.

Representative Carl Anderson of South Carolina, Acting Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Ken Cooley (CA)
Rep. Kerry Wood (CT)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Jerry Klein (ND)
Asw. Pam Hunter (NY)
Sen. Bob Hackett (OH)
Rep. Wendi Thomas (PA)
Rep. Lacey Hull (TX)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Asm. Mike Gipson (CA)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Roy Takumi (HI)
Sen. Beverly Gossage (KS)
Sen. Mike McLendon (MS)
Rep. Hank Zuber (MS)
Sen. Vickie Sawyer (NC)
Rep. Brian Lampton (OH)
Rep. Dennis Paul (TX)
Sen. Mary Felzkowski (WI)

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. Jerry Klein (ND) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Sen. Klein, the Committee voted without objection to adopt the minutes from the Committee's March 4, 2022 meeting in Las Vegas, NV.

CONTINUED DISCUSSION ON NCOIL PAID FAMILY MEDICAL LEAVE (PFML) MODEL ACT

Rep. Anderson stated that we'll start today with the continued discussion on the NCOIL paid family medical leave model act (Model). We've been discussing this is for consecutive meetings and since our last meeting in Las Vegas, the model language that was originally introduced by the American Council of Life Insurers (ACLI) is now being sponsored by Sen. Paul Utke (MN) and co-sponsored by Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary. That language appears in your binders on page 220. I know that Sen. Utke couldn't be here with us today but Rep. Ferguson is here and would like to say a few words before we get started. Rep. Ferguson stated that this Model it establishes paid family leave as a class of insurance and would authorize state insurance departments to receive and approve paid family leave policies in your state. It authorizes insurers who are licensed to transact life insurance or disability insurance business in the state to issue policies covering paid family leave and this would empower employers to be able to give paid family leave to their employees.

Karen Melchert, Regional VP of State Relation at ACLI thanked the Committee for the opportunity to speak and stated that I would especially like to thank Rep. Ferguson for sitting in for Sen. Utke and for also being co-sponsor on this important piece of legislation. As Rep. Anderson pointed out, we have discussed this at length at several NCOIL meetings and we have finally brought this to you in a formally introduced NCOIL Model. It is as Rep. Ferguson pointed out, giving authorization to insurance companies to file products that would provide paid family leave to employers. This can be used in states that have mandatory paid family leave requirements for their employers and it can be used in states that don't have the paid family leave requirement but that employers want to offer as an enhanced benefit to their employees as we see an ever-increasing competitive employment market. So, I'm happy to answer any questions, but this is an authorization for us to file products in your states. Currently, we cannot do that. So, this would give us that opportunity and it is designed so you can either create it just as an authorization statute and then have as a regulation the standards that would go into that policy or you can put the entirety of it into your statute when you propose it. It has been adopted in Virginia, that was our test case this year. They enacted it earlier this year with the authorization language and they are now working on the promulgation of regulations. It was also passed out of the Senate in Minnesota but failed to advance in the House before the end of this session. So, we appreciate your support and I'm happy to answer any questions and we look forward to this being adopted as an NCOIL model that you can all take back to your states when this issue comes up and there is a private option to address the need.

Rep. Dennis Paul (TX) stated that I guess it's pretty new in Virginia since they just enacted it but do you have an idea what their premiums would be? Ms. Melchert stated that I asked that question earlier, and no we do not but they would be similar to a disability income type of policy. Rep. Paul asked like a short term disability that they might already have? Ms. Melchert stated that a short term and long term but more in line with short term since it is limited to 12 weeks. Rep. Paul asked if most companies are planning to do it where it would be the employee paid the company back or is it just companies are deciding what they're going to do? Ms. Melchert stated that I would say in a state where it's mandated by law that employers provide paid family leave then the employer would pick up the cost of the premium. Rep. Paul stated that and the ones that don't they would pass the cost on. Ms. Melchert stated that it would be up to the individual employer and how much they wanted to split with their employees and whether or not their employees wanted to take it.

Molly Weston Williamson, Senior Fellow at the Center for American Progress thanked the Committee for the opportunity to speak and stated that I come from the Center for American Progress and before that until actually this week I was Director of paid leave and future of work at a Better Balance and I have been working in that capacity on paid leave policy at the state level for nearly a decade and I think because of that I have a slightly different perspective on what might be a way to compliment this approach of pure authorization. So, as I think you know from your past discussions as of 2022, 11 states and the District of Columbia have laws on the books guaranteeing workers the right to paid family leave and with it paid medical leave benefits and of those 12 laws all but two have a meaningful structural role for commercial insurance. So, I think commercial insurance is already part of the solution in most of the states that have moved more aggressively and I think there's an opportunity to build on that legacy. I think here as we think about different approaches that can potentially work together what I call your attention to is that when we look at those states that have established laws, particularly when we date back to their history for many of them, rooted in historical temporary disability insurance laws we've got years and years of experience and in some cases we're talking about decades of experience in this kind of model where you have a guaranteed right for workers and flexibility for employers and how they meet that obligation which typically does include commercial insurance. So given the hour, I'm going to keep my remarks brief but I would just suggest that I think there's an opportunity to consider going further or complimenting a move that's focused on the authorization to think about if there's an opportunity, and I think particularly an opportunity with a focus on what we want the insurance market to look like. To think about whether we can go further and instead of just authorizing the sale of a product, or an addition to that, also providing a right to the product. So, I think in some ways we're thinking sort of flipping to the way we think about something like Workers' Compensation Insurance where we have an insurance marketplace that operates in a context of some guaranteed rates. I think thinking about examples like Virginia, I think we're all looking to see what happens. My understanding is, I think the law went into effect on the first of this month and so really truly it is not a criticism to say we just don't know yet what's going to happen there but I think we have some reason to think about what might occur. I think short term disability is a really good analogy here.

So, when we're thinking about speaking to all of you as lawmakers, how do you meet the needs of constituents, short term disability is an established product in every state in the country but what we know from the Bureau of Labor Statistics, is that only about 40% of the civilian employee workforce currently has access to short term disability insurance. When you look at lower income workers that gets cut in half. So, I think when we think about moving into paid family leave coverage and these benefits that I know you've already been through a lot and all the reasons why they're so important I think thinking about are there ways to compliment the availability of commercial products with some built in rights in states that are interested in moving in that way to ensure that everybody has access to these benefits that I know you already know all the reasons are so important. Again, thank you so much for this timely and valuable conversation and I'm really looking forward to being helpful in any way I can moving forward.

Sen. Mary Felzkowski (WI) stated that you're looking at this it would be an employer purchasing it where he pays for it as going to be optional, almost like an Aflac type coverage. I can do the general short-term disability, I can take paid family leave, I can take other maybe coverages, maybe there's a term policy at two time my wages. Would

this just be a compliment to those other type coverages or it could stand alone? Ms. Melchert stated that it's intended to stand alone and it could be mixed in with all those but it is intended to address specifically the paid family leave. The other accepted benefits or the supplements that you referred to not every employer offers that and most employers don't offer that when they pay for it but this could be something that an employer may choose to pay for themselves because they want to add that benefit to attract more employees and then as I said earlier in the states where it's mandated the employer would have to offer it and they would have to pay for it but it's really designed so that it can be used by employers in whichever way they need to use it, either as a selected benefit or as a mandated benefit.

Rep. Ferguson closed by stating I'm not a fan of mandates and the Model doesn't mandate that you have paid family leave. It's just a private public partnership avenue to do that. Rep. Anderson thanked everyone and stated that hopefully we'll be able to work on this Model and get it to the point where it can be adopted at our November meeting.

CONSIDERATION OF RESOLUTION IDENTIFYING CERTAIN ENHANCED CASH SURRENDER VALUE ENDORSEMENTS AS VIOLATING THE STANDARD NONFORFEITURE LAW

Rep. Anderson stated that our next topic is the consideration of the Resolution Identifying Certain Enhanced Cash Surrender Value Endorsements as Violating the Standard Nonforfeiture Law. The prime sponsor of the Resolution, Sen. Travis Holdman (IN), former NCOIL President, unfortunately couldn't be here with us today but the Resolution's co-sponsor, Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, is here and will say a few words before we begin.

Rep. Oliverson stated that this was an issue that Sen. Holdman brought to my attention and after listening to the conversation around it I became very interested and decided to sign on and I'm going to let former Illinois Insurance Director Nat Shapo, on behalf of the Life Insurance Settlements Association (LISA), talk specifically about this and kind of give you the nuts and bolts but I would just say that it centers around the idea that these enhanced cash surrender value issues are a violation of statutory law as well as a deviation from what I think all of our states have adopted as the standard nonforfeiture law. So, I'll let him sort of speak in great detail about that. I know that we had a productive interim meeting last month during which the issue that you're going to hear about today was discussed, and an issue was raised which is reflected on the second page of the resolution. That provision of the resolution notes that there are two similar types of products but only one of which is the target of this resolution. The wholly different product never asserted to be in violation of the insurance code and thus not objectionable to NCOIL has the same enhanced cash surrender value name and is a common rider offered at policy issuance but doesn't consist of this limited time spike to offer to terminate the policy. Instead, it's a product designed to support the persistence rather than the termination of corporate owned policies due to tax benefits of treating this surrender of value as an asset. Accordingly, that's why the title of the resolution includes words such as "certain types", and we're not calling for a blanket prohibition with this resolution

Dir. Shapo thanked the Committee for the opportunity to speak and stated that when I was trying to figure out what to say today, I thought I'd try to channel Sen. Holdman in my remarks since he couldn't be here today and in trying to look at the issue through the

Sen. Holdman prism a phrase popped into my head, and it's statutory regulation. When I was a regulator and when I started 23 years ago, I used to hear that phrase a lot - statutory regulation performed by statutory regulators which means that under the rule of law, the federal and state constitution invest policy making power in their legislative branches to be enforced by the executive branch. An executive branch agency like an insurance department is a creature of statute, it exists because it's authorized by the legislature and the insurance code for the specific purpose of enforcing the insurance code requirements written by lawmakers. Thus, it's sometimes referred to as a code agency. Thus, these traditional terms of statutory regulation, statutory regulator. The issue today is about these short-term limited time spiked cash surrender value offers where the cash surrender value is double, tripled, often even more for a short offer period of a couple months. The law on that is that in the 80s each legislature passed an amendment to the standard nonforfeiture law at the National Association of Insurance Commissioners (NAIC) request adding a new standard in addition to standard nonforfeiture minimum values, generally known as a smoothness requirement. So, the standard nonforfeiture law has certain minimum values that have to be met and it has the smoothness requirement.

The drafters described it as requiring, "a reasonably, orderly sequence of increases in cash surrender value. and prohibiting, "sharp jumps" in cash surrender value. Actuarial groups at the time further explained that it prohibits, "benefits discontinuance in nature" or benefits available only, "during certain windows of time." There isn't any dispute that the products that you've been studying since last year violate those descriptions and in fact, it would be hard to design a product more non-compliant. The only argument offered instead is that the rule doesn't apply, that some of this requirement doesn't apply to universal life but as I discussed at length in my testimony last month, statutory regulation says that isn't so. The section of any standard nonforfeiture law that contains a smoothness requirement applies on its face to "all policies" and enumerated exemptions in the "exceptions" section in the law do not include universal life. Furthermore, the same amendments to the standard nonforfeiture law that created the smoothness requirement did authorize rulemaking for universal life pertaining to standard nonforfeiture law minimum requirements but did not authorize tinkering with standard nonforfeiture law standards for the smoothness requirement and the universal life model regulation consistent with that limited statutory authorization only tinkered with standard nonforfeiture law standards for minimum cash surrender values.

I'll spare you a recitation of case law regarding statutory construction, since I think that any legislator instinctively understands the common law rule which is that absent a specific statutory exemption a statutory requirement is inviolate. That smoothness applies to universal life was understood when the universal life model was adopted. The American Academy of Actuaries explained with respect to universal life and smoothness, "what we believe to be obvious universal life should comply with section 8 of the standard nonforfeiture law regarding smooth cash values. It should not be necessary to add this requirement to the model regulation. The requirement already exists." So, that's the law quickly on consumer protection since the purpose of the law is consumer protection. To give an example, if you have identical risks they buy the same policy on the same day, they pay the same premiums for years, one surrenders on Monday for the policy stated cash surrender value of $50,000 and the other identical risk doesn't and then on Tuesday morning gets an offer in the mail for $250,000 on the enhanced offer and takes it, you've got the second consumer has gotten five times the benefit for the

same price on the same policy, unfairly to the detriment of the first consumer who got one fifth of the benefits for the same price.

And perhaps even worse, the first consumer who surrendered for $50,000 did so based on an illustration of future benefits that didn't include the $250,000. That's an amount that the carrier in most of the way these are structured would have known for probably as much as a year was going to be offered to risks like her shortly after the illustration was issued. So, the consumer gets an illustration trying to decide what they're going to do. They see the cash surrender value at a number that they're not liking for the next year. They say, I'll just take the $50,000 and terminate the policy not knowing what the insurer knows and what the insurer didn't tell them that they were going to get an enhanced offer. That's quite misleading, it's quite harmful and you can't put that toothpaste back in the tube as long as these products are allowed. That's why we think the statutory regulation through enforcement of the standard nonforfeiture law requirement is appropriate and necessary. We believe your draft resolution captures that nicely. We thank Sen. Holdman for his thoughtful consideration and persistence just as we thank Rep. Oliverson for engaging on this issue and presenting it here.

Hearing no questions or comments, upon a Motion made by Sen. Bob Hackett (OH) and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to adopt the Resolution.

CONSIDERATION OF RESOLUTION IN SUPPORT OF POSITION STATEMENT RECOGNIZING CONGRESSIONAL CONSENT TO THE INTERSTATE INSURANCE PRODUCT REGULATION COMPACT (IIPRC)

Rep. Anderson stated that if you would turn to page 226 in your binder you will see the Resolution in Support of Position Statement Recognizing Congressional Consent to the IIPRC, and the position statement it references follows the resolution on page 229. The Resolution is sponsored by the Rep. Matt Lehman (IN), NCOIL Immediate Past President, and Rep. Ferguson.

Rep. Lehman stated that I'm proud to serve as the Chair of the IIPRC legislative committee and thank you Rep. Ferguson for sponsoring this Resolution with me. So, for those who may not know, the compact was created to allow transparency or to create uniform standards across state lines for life products, disability products, long term care products, and annuities. The benefit of that has been that a company can take into market a product, have it approved by the compact and begin utilizing that in all their states. It's actually been beneficial to the states as there's a fee charged to that so there's money that comes back to the state when they do that. NCOIL has been an early supporter of the compact when it started. We want to continue that. And I'll let others talk in more detail about the compact, but I just want to point out that as a strong supporter of the compact we need to make sure we move forward with this and the speakers today can go into the details as to what happened and why we're here based on the Colorado Supreme Court decision but as Rep. Anderson noted, the compact's position statement as to why they feel the compact is constitutional and the Colorado decision is misguided is on page 229.

The Hon. Kathleen Birrane, Maryland Insurance Commissioner thanked the Committee for the opportunity to be here and stated that I have the honor of serving as the chair of the compact this year. I think Rep. Lehman has done a great job of setting up the issues

so I'm not going to elaborate on that. I'm going to ask Karen Schutter, IIPRC Executive Director to really give a little bit more detail about what the circumstances are that led to this resolution and the need for it.

Ms. Schutter thanked the Committee for the opportunity to speak and thanked Cmsr. Birrane for being here as that demonstrates the importance of this resolution and the compact on both a regulatory and a legislative platform or how important it is to both bodies in our states. Cmsr. Birrane does chair the compact and I just want to thank her and the legislators around this table that did attend the compact round table here in New York City the day before the NCOIL meeting. I think we saw the importance of the compact not only to our states but also to the industry that you regulate. I have been coming to your meetings briefing you on this ruling that came down just as the pandemic was starting and it came out of the Colorado Supreme Court. They actually looked at it on a certification. So, they looked at it in a way that it wasn't them ruling on the actual case itself just on an issue about this compact and what they found is they looked at it and they looked at it under the prism of federalism and said without congressional consent its general assembly could not delegate the power to prove an insurance policy that was sold in Colorado under a standard that may differ from a Colorado law.

And so that really than called us into looking at that. The commission under the leadership of Cmsr. Birrane and others did an independent governance review and hired the law firm of Squire Patten Boggs to look at this and do a litigation analysis and what they found is that really court or legislators you can agree, you can come together and you can agree really upon anything. You are legislators and while they looked at that and thought well, again they put aside whether the Colorado Supreme Court was right in their reasoning, what they looked at and they said is, you actually have a form of congressional consent. Congress actually looked at this and gave a thumbs up to this compact in 2006 before it was operational and they did that by way of their role with the District of Columbia. If you're familiar with how that works, they actually are the ones that approved the legislation for D.C. and they did issue a federal law signed by President Bush that said that D.C. can join this compact and all the powers in the compact delegated to D.C. And so, that is actually a form of congressional consent. It's called implied congressional consent and what that does is it elevates the standards so that they apply as your state's laws for compact approved products which is the very essence and purpose of the compact legislation that you all have put in place.

So, this position statement was something that has taken two years to develop through the deliberations of our governance committee. Our members working with our legislators. When we took this to them they said, "this is great that you're doing this but we'd like to also see an outside counsel opinion with regards to this opinion." And so we got that back in March and it's in your materials as well. Our outside firm said this position statement is well reasoned, well documented, and we encourage the compact, the body of compacting states to adopt it and put it on record. So, if there's another case that comes along, the courts will have the benefit of seeing the position of the compacting states with regards to the compact that yes you understood. You want to come in and agree with your states that you can use this tool to come together and collaborate in a uniform and standard way that streamlines product approval and helps these life insurance products compete with federally regulated securities and banking products. So, this is all good. I can give you a lot of statistics but I won't bore you with that. You'll hear from the industry on how impactful it is and the compact has become

an integrated part of the product approval process across our states and as legislators you have the final touch points with enacting the compact and many other safeguards.

Ms. Melchert stated that we as the life insurance industry worked hard to get this compact established and adopted across most of the states and the Colorado decision put a chink in that armor and we need to strengthen that and it's a very important tool for us to be able to bring products to the market more efficiently and quickly and that is to the benefit of consumers. It goes through a regulatory review process so we're not cutting any corners. We're just making it more streamlined and we truly appreciate the support of this organization for the compact and appreciate Cmsr. Birrane's leadership and appreciate the continued support with the adoption of this resolution.

Rep. Ferguson stated that I agree with all of Rep. Lehman's remarks and not only does this streamline everything but if you have it one of the most valuable things I got as a member of the compact's legislative committee is they have a sheet that tells you how much it's saving your state and I thought that was very informative. For Arkansas, I think just the administrative savings for us was about $1.3 million so, it saves the state money but it also is a valuable tool to streamline things for insurance companies.

Hearing no further questions or comments, upon a Motion made by Sen. Jerry Klein (ND) and seconded by Rep. Wendi Thomas (PA), the Committee voted without objection by way of a voice vote to adopt the Resolution.

CONSIDERATION OF RESOLUTION REGARDING RECRUITMENT, RETENTION, AND DIVERSITY WITHIN THE LIFE INSURANCE AGENT PROFESSION

Rep. Anderson stated that the next topic is the consideration of a Resolution Regarding Recruitment, Retention, and Diversity within the Life Insurance Agent Profession. That resolution appears in your binders on page 245. I'll turn things over to the sponsor of the resolution, Asw. Pam Hunter (NY)

Asw. Hunter stated that I'm very proud to sponsor this resolution as it deals with a very important and timely topic. Last November at our meeting in Scottsdale we heard a presentation on regulatory obstacles to the recruitment and retention of insurance producers and it really did generate a lot of interest and discussion among committee members and interested persons alike. This resolution is important because the recruitment and retention numbers for life insurance and financial planning agents are really startling. As the resolution notes, only 14 of every 100 new recruits remain with their hiring company after their first four years of employment. That's not a sustainable number. I know in my area alone it's been very difficult and four years is actually very high, it's much less. Furthermore, the life insurance and financial planning industry is experiencing a growing need for professionals who serve our Black, Indigenous, and people of color (BIPOC) communities and who come from those communities as well as the need for greater gender diversity in all communities. I certainly think having NCOIL on record as working to rectify those problems is something worth doing which is why I am proud to sponsor this resolution. Things such as mentorship programs, expanding the life insurance and financial planning market in unserved communities, continued education requirements, and online licensure examination are things NCOIL should be examining in order to make sure there aren't any statutory impediments to licensure and inhibit the ability to recruit and retain a diverse and qualified group of financial professions. So lastly, it's important that the NAIC also work on these issues from the

regulatory perspective. If NCOIL and NAIC can work together on this with NCOIL handling statutory issues and NAIC handling regulatory issues this will definitely be a win, win.

Melissa Bova, VP of State Affairs at Finseca thanked the Committee for the opportunity to speak and stated that I have a very brief presentation and wanted to provide a little bit of background on these issues. I want to thank Asw. Hunter for sponsoring this resolution for us today. As background, quickly we just wanted to go through who Finseca is because we are relatively new compared to many of the other trades that are in the room with us today. Finseca was formed in September of 2020 and was formally kind of a formation of The Association for Advanced Life Underwriting (AALU) and the General Agents and Managers Association (GAMA). So, they came together in 2020. Since then, we've been really pleased to bring Forum 400 under the umbrella of Finseca and just recently the National Association of Independent Life Brokerage Agencies (NAILBA) voted to join Finseca as well. So, Finseca stands for financial security for all and we're really looking to working to reunify the profession and also work with great partners who are up here with me today like the National Association of Insurance and Financial Advisors (NAIFA) and ACLI on furthering some of the initiatives that we're going to be discussing in a few minutes.

So with that just so you know this is what financial security for all stands for. Finseca and AALU never did state advocacy before. I am our first VP of state affairs so I'm learning so much from everybody in the room because I've been doing this job for just eight months but really am excited to be here today and further this initiative. I'm going to give you way too many stats, so hopefully the presentation will be sent out afterwards but this is really the financial problem we're facing. A $12 trillion life insurance coverage gap. 40% of Americans are either uninsured or underinsured. And during COVID, there was a 5% increase in life insurance sales compared to a loss of 3% before COVID so COVID really exacerbated the need for financial security for all Americans. But what we're here to address today is the people problem and there's three buckets that we really think are part of this. Profession that is getting older, lack of diversity, and a need to refocus on the recruitment and retention within the profession. And as Asw. Hunter mentioned, this we believe is a collaboration between a regulatory fix and a legislative fix. So, we think NCOIL's going to be a really big part of the solution. An aging profession, over half the people in our profession while they are great, they're over the age of 55 and they're starting to think about their business transition plans. So, this is an item that we need to start thinking about now to plan for the future. A lack of diversity, I won't go through all of this, but this just really shows I think the need for life insurance and financial planning for the entire population. Finseca does stand for financial security for all and we believe we need to make steps to ensure that everybody can access the products and holistic financial advice that we're able to provide. One of these items that we believe in is creating an advisory council in states that'll focus on diversifying the profession.

Recruitment, these are for any of my commissioner friends that are in the room. Some of these are really easy NAIC fixes. So, take a look at this and as I said, this is a collaboration between Finseca, NAIFA and ACLI, the three of us our working together on this which I think just demonstrates how important these items are. And then of course retention, as Asw. Hunter said, retention's at 14% but there are companies that have retention at above 40% so there is a solution to this and we believe a solution that NCOIL can look at is a mentoring program. Really creating a mentorship program that

will help build advisors and professionals in this industry and give them the support they need to be successful. And to that end, I'd love for you to believe everything I say but I have few quotes up there that you might have trouble reading, so we'll send this out later, that just kind of really show the importance of how firms are starting to look at this. And this just really encourages people to make those investments, bring more people into the profession, grow the profession, and ensure that financial security for everybody.

Maeghan Gale, Policy Director of Gov't Relations at NAIFA thanked the Committee for the opportunity to speak and stated that founded in 1890, NAIFA is one of the oldest and largest agent trade associations representing over 20,000 insurance and financial professionals with 88 chapters across 53 U.S. states and territories. So, I'm here to express our support for the resolution. I'm proud to join forces with my colleagues to eliminate obstacles for financial professionals in their work to serve the insurance industry advisory needs of main street Americans. We strongly believe that NAIFA's work through NCOIL and its partners bolsters our collective ability to bring more diversity into the financial services community and we thank you for your consideration on this very important issue. I would tell you how critical the role of agents are in this industry but I don't think I can express it with the same importance as we heard from NAIC President and Idaho Insurance Director Dean Cameron today during our luncheon. The turnover rate in retention of all advisors regardless of race has long posed a challenge to the industry and it will take our broad collaboration to address it. Many American communities are significantly underrepresented in the financial advisory business, particularly black Americans. The reason for this lack of representation is complex. It mainly results in the factors that have been placed for many years.

But many of the steps that we can take to encourage recruitment and retention will not only serve underrepresented groups but the industry and our communities as a whole. Recruitment, retention, and diversity are threads deeply woven into the fabric of NAIFA's missions. A key component of ours is to serve as an industry expert on diversity and inclusion by attracting and nurturing members from diverse backgrounds and providing the resources to meet the needs of their markets. NAIFA has long held that membership is a powerful component of addressing agent recruitment and retention and promoting diversity, inclusion, and cultural competency. Many of NAIFA's core initiatives drive to this very purpose, including our young advisor program which works with college students and new advisors to educate them on different career paths available within the insurance and financial services industry. The NAIFA talent development center, and diversity, equity, and inclusion council and advanced practice center, all connect advisors at all stages of their careers to share valuable knowledge, training, and provide a pathway to mentorship that may not always be available within their organizations. Encouraging broader, more robust, and more structured mentorship programs that coordinate and compliment existing continuing education requirements will provide a meaningful step forward. During these opening remarks of this very meeting Asm. Ken Cooley (CA), NCOIL President, shared with us about his mentor who is an independent insurance producer, as well as a state legislator and how that impacted his own career trajectory. This really highlights the tremendous value that mentors and mentorships can have on the success of insurance producers and beyond. There is more that can be done by committing to removing barriers to recruitment and enabling tools for retention and promoting diversity and inclusion. We look forward to continuing this work with both our colleagues here, NCOIL, and state regulators. But as legislators and in the spirit of this resolution there are some important things that you can consider within your states today. Currently there are 27 states that still require mandatory pre-licensing education

despite pre-licensing mandates not producing agents better prepared to take the exam. Data from states without the mandate suggest that most candidates for licensing still take a course, buy materials, or otherwise prepare. They do not need to be told to study. But by removing the mandates candidates can study in a way that fits preferred commitments of time, money, methods of study, even geographic location. These are all particularly important when we consider the varying needs of those who may be caregivers, considering insurance is a second career, or may come from non-traditional educational backgrounds.

Another thing to consider is to re-examine look back periods for non-financial and non-violent crimes, particularly class E felonies. A great example of this was in Tennessee House Bill 2225, which lessened the look back for agent applications with class E felonies to ten years. Another thing to look at would be to support personal financial literacy course requirements in schools. There are currently only 14 states that have adopted these requirements. Beyond the obvious benefits of financial literacy, the courses are often the first introduction to financial services and planning. Further providing young consumers with a solid foundation in these topic areas works to encourage greater trust in the industry and to better protect consumers. And finally, support of continuing education credits for association membership. This year Illinois became the 13th state to offer continuing education credit for memberships in agent associations. As associations like NAIFA, the Independent Insurance Agents and Brokers of America (IIABA), Finseca, and others continue to work to encourage recruitment, retention, and diversity in the industry, providing a pathway for these efforts to be eligible for continuing education credit not only provides members with credit for their efforts, but encourages more participation, all while creating more skilled agents to better serve consumers. These are just a few suggestions, and we look forward to continuing this conversation in the future. Again, I would like to thank Asw. Hunter for her sponsorship of this and thank you all for your time, consideration, and I encourage your support for this resolution.

Ms. Melchert stated that I'm here to raise my hand in support of this resolution. Two years ago, the ACLI created its economic empowerment and racial equity initiative and one of the pillars of that initiative is to broaden access and diversity in our supplier, our agent force and this resolution goes further to that point. We've been working with the American College of Financial Services and working on financial literacy to increase the exposure of a career in insurance to a more diverse workforce and I think one of the most important things in this resolution that we'd like to stress and that's important to our membership is the ability to have online testing requirements. And we saw this in the pandemic when people were not able to take their tests in person, they'd taken all their education requirements to sit for the licensing exam but because they were not open due to COVID restrictions those requirements expired and they had to do more and it was really not necessary that they be in a proctored and in-classroom setting. So, we think that online course testing is appropriate and expansive and allows access to more people. In addition, there are limited in-person opportunities and sometimes people had to drive five, six, seven hours to get to the testing location so we would encourage that part of the resolution to be something that you as state legislators can work with your departments of insurance and make the necessary statutory changes. We appreciate Finseca, and NAIFA for bringing forward this resolution and we stand in support and we thank you all for your support as well.

Sen. Mike McLendon (MS) asked if the part could be repeated about wanting to do away with requiring the education before the test or wanting to lower the requirements for the education before the test. Ms. Gale stated that there are currently 27 states that have done away with the pre-licensing education mandate so you still have to pass the exam but it takes away the mandatory 20 or 40 hours of pre-licensing education and it just allows candidates to prepare as best fits their budget, time, and preferred study methods. And the data has shown that there is not a statistically different passage rate and even pre-licensing education providers still report very similar numbers as far as people are still out there purchasing it but it is one less requirement that departments do have to track and we certainly don't need mandates where mandates don't serve a purpose. Sen. McLendon stated that but with online course, you don't think it's helpful if they have a required 20 hours and two years to get a certain amount of hours of continuing education? Ms. Gale stated that we consider continuing education a separate type of education then we would pre-licensing education. Sen. McLendon asked if this would be for all companies? Ms. Gale replied for licensees, yes but not necessarily companies.

Rep. Brian Lampton (OH) stated that I'm a 30 year plus NAIFA member and my question has to do with what are the traditional career carriers saying in terms of the New York Lifes and the Northwestern Mutual's are they just not recruiting like they used to? Ms. Bova stated that I can speak on the profession side for us, I think they are recruiting but I think things have changed and as I think was eloquently said before, nobody thinks I'm going to be a life insurance agent when I grow up. So, I think what we're having right now is people are getting hired but then they're just not getting the support that they need so we're trying to find a way of how can we provide more of that support within the first four years when people are young and learning and just trying to sell product. How can we provide a more holistic support system for them when they might be in an office where they're the only young agent. So, how can you do a broader support for them? I think everybody's changing how they hire. I think if COVID taught us anything, it's changed how everybody's hiring. I think we're trying to think of a creative way to keep people in the profession and give them that support that they need in the first few years so they stay and are successful.

Sen. McLendon asked if you think that COVID had a big role in that because the mentors are at home instead of being at the office? I work for a company in Memphis and for a while there were three people in the office out of a 145 employees so we've had a requirement that producers be in the office for a certain amount of sales meetings in person for that very reason for mentorship. And even in Memphis it's hard to find and we're begging for diversity in our agency and it's tough and we talk to agents all over. Now, we've since been bought by a Fort Worth agency and we've got agencies all over the world now so how much do you think COVID had a role in this? Ms. Bova stated that we have data actually on this and Finseca's current Board Chair did a study of this in 2017 and the retention rates were the same. It was consistently 14%. So, this was an issue and I don't think COVID helped it. I think COVID could cut both ways as you weren't in the office but then you had some people that like the flexibility of remote work. But this has been a problem pre-COVID so it goes back further than that so I don't think it helped but it is a bigger issue than just kind of the COVID remote work problem.

Hearing no further questions or comments, upon a Motion made by Asw. Hunter and seconded by Rep. Ferguson, the Committee voted without objection by way of a voice vote to adopt the Resolution.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Cooley and seconded by Rep. Oliverson, the Committee adjourned at 5:15 p.m.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Paid Family Leave Insurance Model Act

Sponsored by Sen. Paul Utke (MN); Co-sponsored by Rep. Deborah Ferguson, DDS (AR) – NCOIL Secretary

Draft as of June 14th, 2022. To be discussed and considered during the Life Insurance & Financial Planning Committee on November 17, 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.

ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
SCOTTSDALE, ARIZONA
NOVEMBER 19, 2021
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee met at The Westin Kierland Hotel on Friday, November 19, 2021 at 4:15 p.m.

Indiana Representative Matt Lehman, NCOIL President, presided.

Other members of the Committee present were:

Sen. Travis Holdman (IN)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Rep. Deborah Ferguson (AR)
Rep. Jonathan Carroll (IL)
Sen. Beverly Gossage (KS)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)

Also in attendance were:

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

QUORUM

Upon a Motion made by Sen. Travis Holdman (IN), NCOIL Immediate Past President, and seconded by Rep. Tom Oliverson, M.D. (TX), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Holdman and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's October 8, 2021 interim Zoom meeting.

CONTINUED DISCUSSION AND CONSIDERATION OF PROPOSED AMENDMENTS TO NCOIL ARTICLES OF ORGANIZATION & BYLAWS

Rep. Lehman stated that the purpose of this meeting is to consider amendments to the NCOIL Articles of Organization & Bylaws. This Committee held an interim meeting on October 8th to discuss the amendments which are fairly minor and are being proposed to both continue the organization on a path of improvement, and formally recognize current practices within the organization. Rep. Lehman noted that the amendments are

in the binders on page 223 and that he will turn things over to Will Melofchik, NCOIL General Counsel, to briefly go through them.

Mr. Melofchik stated that the first proposed amendment is in Section 3(B) of the Articles of Organization at the end of page 223. The second sentence of that section is proposed to be deleted. The reasoning behind this is to address the situation of a state that hasn't paid dues in let's say five years, but then decides to renew its status as a Contributing State. Under a strict reading of this section, that state would be required to pay all of the previously billed dues in order to be in good standing, as opposed to just paying the one year's worth of dues to re-join as a Contributing State. That makes it virtually impractical to recruit lapsed Contributing States to return and, is not the way the organization currently operates. Hearing no questions or comments, Mr. Melofchik proceeded.

The next proposed amendment is in Section 3(B)(10) of the bylaws on page 228. The language "if she or he has an opponent for the position" is proposed to be added to the end of the last sentence in that section. The reasoning behind this is to ensure that recusals from Nominating Committee deliberations are required only when appropriate. For example, when the Nominating Committee met yesterday, technically the existing officers seeking to advance in their service through the active chairs were candidates for an officer position, in addition to the legislators seeking to start their service as an officer. Under the current language of this section, certain Nominating Committee members would therefore have to decide whether to recuse themselves even though they are only advancing in their officer service with no opponents. Mr. Melofchik noted that in conversations with Rep. Lehman, he and NCOIL staff agreed that adding the proposed language makes sense to avoid any unnecessary recusals while maintaining the spirit and intent of this section. Hearing no questions or comments, Mr. Melofchik proceeded.

The next proposed amendment appears on the same page – Section(3)(B)(11) is proposed to be deleted which sets out the makeup and purpose of a Business Planning Committee. The reasoning behind this is that since Sen. Holdman was NCOIL President in 2016, which also coincided with Commissioner Considine's arrival as NCOIL CEO, all of the functions of the Business Planning Committee as set out in the bylaws have been carried out by the Executive Committee, which has worked well. The Business Planning Committee has actually never met by itself and conducted any business since 2016. The Committee is always just merged with the meeting of the Executive Committee at the conclusion of the national conferences which is really just a matter of following past practices - it's really the Executive Committee that is conducting the official business during those meetings. Hearing no questions or comments, Mr. Melofchik proceeded.

The next proposed amendment also appears on the same page – Section (3)(C) is proposed to be amended by adding the language "however, beginning in 2022, no legislator shall serve as Chair of any one committee for more than three (3) consecutive years." The reasoning behind this is to simply facilitate a wider range of legislators Chairing a committee and to avoid having a legislator feel that they "own" a committee due to their extensive consecutive years of service as Chair. Hearing no questions or comments, Mr. Melofchik turned it back over to Rep. Lehman.

Hearing no questions or comments on any of the proposed amendments, upon a Motion made by Sen. Holdman and seconded by Rep. Oliverson, the Committee voted without objection by way of a voice vote to adopt the amendments.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Holdman and seconded by Rep. Oliverson, the Committee adjourned at 4:45 p.m.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION
AND
BYLAWS

ARTICLES OF ORGANIZATION

PREAMBLE

We, duly elected representatives of the People to the Legislatures of the 50 sovereign States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico, being concerned with the economic and social importance of insurance to our constituents, to the peoples of the States, to all Americans, and to the enterprises and economic resources of our nation and to its strength in world trade and commerce, and seeking a more effective exchange of insurance information among the legislatures of the States, consumers, and other concerned parties; and seeking to provide a forum for legislators to resolve and communicate their positions on insurance and related issues on a State-by-State basis, do hereby proclaim the need for creating and maintaining the resources and capacity of State legislatures to deal with insurance legislation and regulation.

I. NAME

The name of the organization shall be the National Council of Insurance Legislators (hereinafter "NCOIL.")

II. PURPOSE

The general purpose of NCOIL is to advance the knowledge and effectiveness of legislators and legislatures when dealing with matters pertaining to insurance law, participate in the formulation of model legislation addressing insurance and financial services issues, serve as a clearing house for information, reaffirm and advocate for the traditional and proper primacy of the States in the regulation of insurance, prepare special studies on insurance or insurance legislation, disseminate educational materials, communicate positions adopted by NCOIL, and any other activities that will promote the general purposes of NCOIL. These purposes may also extend into these same activities in the other areas of financial services, over which the vast majority of committees of insurance jurisdiction in the legislatures of the 50 states also have oversight.

III. MEMBERSHIP

A. General Membership shall be afforded to all States and territories of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

B. General Members who remit to NCOIL annual dues (which shall not be prorated) in an amount fixed by the Executive Committee shall be considered to be Contributing States.

C. Each General Member and Contributing State shall be represented by its legislators who are permitted to attend NCOIL meetings and seminars.

D. The Executive Committee may, at any regular meeting, confer the title of "Honorary Member" on any individual who has served in the legislature of a General Member but is no longer a member of the legislature, and who the Executive Committee wishes to recognize for outstanding service to NCOIL, and all registration fees shall be waived for a person so titled, unless such person is employed in or providing services to the insurance industry, in which case no such waiver shall be provided.

E. The Executive Committee of NCOIL shall, in accord with the "Purpose" as stated in Section II of the Articles of Organization, offer affiliate non-voting memberships to comparable legislative organizations in non-United States jurisdictions.

IV. MEETINGS/VOTING

A. NCOIL shall meet at times and places designated by the Executive Committee. Special meetings may be called by the President and also shall be called if requested by ten or more members of the Executive Committee.

B. At any meeting of NCOIL, each Committee member shall be entitled to vote on measures before their Committee.

C. A majority vote of those Committee members present and voting shall constitute the requisite vote necessary on measures before their Committee.

D. Voting by proxies shall not be permitted.

V. OFFICERS/EXECUTIVE COMMITTEE

A. The officers of NCOIL shall consist of the following six (6) officers: a President, Vice President, Secretary, Treasurer, and two Immediate Past Presidents. No person shall be elected as an officer of NCOIL who is not a member of the Executive Committee.

B. The Executive Committee shall consist of the six (6) officers, (as stated in Article V, Section A) and at least one (1) and not more than four (4) representatives of each Contributing State of NCOIL. New members of NCOIL Contributing States shall be elected by a majority of the Executive Committee Members. Notwithstanding any other provision of the NCOIL Articles of Organization or Bylaws, the chair of the committee responsible for insurance legislation in each legislative house of each Contributing State shall automatically, by the nature of his or her office, be a voting member of the Executive Committee at his or her first meeting. A state committee chair from a Contributing State must attend the Executive Committee meeting at his or her first NCOIL conference to be recognized as a new Executive Committee member. Past Presidents who are still state legislators shall be voting, ex-officio members of the Executive Committee and shall not constitute a representative of a member State. The President shall not constitute a representative of his state during his term.

C. There may be a Parliamentarian appointed by the President.

D. In addition to the representatives of each Contributing State, the chairs of all NCOIL standing committees, who are not members of the Executive Committee, shall become members of the Executive Committee and shall continue to be members of the Executive Committee as long as they remain as chairs.

E. The Officers of the Executive Committee shall be elected at the annual meeting of NCOIL. Members of the Executive Committee shall be elected at any meeting of the Executive Committee.

F. Persons elected as officers or members of the Executive Committee must be representatives of Contributing States in good standing at the time of their election. The office of an officer or of an Executive Committee member shall be vacant if the member state of which such person is a Legislator ceases to be a Contributing State in good standing, or if the person shall no longer serve in the Legislature.

G. A majority vote of those present and voting at a meeting of the Executive Committee shall constitute the requisite vote necessary to decide any proposition except as otherwise specified in these Articles of Organization.

H. Except as stated in Article V, Section B, A representative of a Contributing State must attend two meetings prior to being considered for membership on the Executive Committee.

I. Each Executive Committee Member must attend ~~in person~~ at least one NCOIL Conference in person, and one Executive Committee meeting annually by whatever means held, or be excused by the President for good cause shown, or his/her executive committee membership will terminate automatically.

VI. DUTIES OF OFFICERS AND THE EXECUTIVE COMMITTEE

A. The President shall be the highest ranking officer in the NCOIL corporate structure. She or he shall direct the general supervision of the business and affairs of NCOIL, see that all orders and resolutions of the Executive Committee are carried into effect, perform all duties incident to the office of President, perform the usual duties of the presiding officer at the meetings of NCOIL, preside over meetings of the Executive Committee, and appoint Chairpersons of all committees and members of committees in accordance with NCOIL Bylaws and perform such other duties as are provided in the Bylaws.

B. The Vice President shall chair committees and meetings chaired by the President in the absence of the President and shall perform such other duties as are assigned him/her by the President and the Bylaws.

C. The Treasurer shall be entrusted with the receipt, care and disbursement of funds of NCOIL, provided however, that if the Executive Committee shall appoint an Executive Director or CEO, the Treasurer shall coordinate and work with the that appointee in those duties.

D. The Secretary shall have charge of all correspondence to and from NCOIL, manage records of meetings including preparation of the minutes, provided, however, that if the Executive Committee shall appoint an Executive Director or CEO, the Secretary shall coordinate and work with that appointee in those duties.

E. The Executive Committee shall have charge of the management of NCOIL and the direction of its activities. The President shall fill vacancies in the offices of Committee Chairs between annual meetings. The Executive Committee may appoint any individual or organization to function, at its discretion, as Chief Executive Officer or Executive Director. Pursuant to these duties, the Officers, in consultation with appropriate Committee Chairs as needed, shall have, between meetings of NCOIL, the ability to make temporary decisions on behalf of NCOIL pending Executive Committee approval.

VII. AMENDMENTS

These Articles of Organization may be amended or repealed at any meeting of the Executive Committee by a favorable vote of two-thirds of the members present and voting, provided however, that notice and text of any proposed amendments shall be given in summary form to the NCOIL Chief Executive Officer or Executive Director at least thirty (30) days prior to the date of that meeting in accordance with the NCOIL 30-day rule for submission of documents to NCOIL for approval or disapproval, as stated in NCOIL Bylaws, Section III. G. Amendments shall become effective immediately upon adoption unless otherwise provided therein.

VIII. REASONABLE DEPARTURE FROM ARTICLES OF ORGANIZATION

In the event of any emergency resulting from a military or terrorist attack, widespread pandemic, or similar disaster resulting in the declaration of a state of emergency (or similar declaration) by Federal or State officials, reasonable departure from these Articles of Organization shall be permitted upon the Officers and Executive Committee declaring that such action is warranted.

BYLAWS

I. QUORUM

A quorum for any meeting of any committee of NCOIL consists of forty percent (40%) of such members of said committee's roster; however, those members of the committee present may reduce the required quorum percentage for good cause as long as they are meeting with twenty four (24) hours notice to all members with said notice setting forth the date, time and place of such meeting

II. VOTING

A. Voting at meetings of the Executive Committee or any other Committee, whether in person, virtual, or telephonic, shall be by voice vote except that a roll call vote shall

be taken at the direction of the Chair or upon the request of a member of that committee in instances where there are dissenting votes.

B. Written Consent in Lieu of Meeting:

1. A decision on any matter previously discussed by the Committee voting, with an opportunity for public comment, and evidenced by the consent in writing (including electronic) of a two-thirds super-majority vote of any Committee shall be as valid as if it had been decided at a duly called and held meeting of that Committee. Each decision consented to in writing may be in counterparts, which together shall be deemed to constitute one decision.

2. Unanimous Consent on any matter previously discussed by the Committee voting, with an opportunity for public comment, as achieved by the lack of objection to a duly valid notice to all Committee members shall also be as valid as if it had been decided at a duly called and held meeting of that Committee.

III. COMMITTEES

A. There shall be an Executive Committee which shall meet at each of the three yearly NCOIL conferences or at the call of the President or upon the written request of ten or more members thereof. Notice shall be given to each member of the Executive Committee setting forth the date, time and place of such meeting.

B. Standing Committees of NCOIL shall be:

1. A Joint State-Federal Relations and International Insurance Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting State-Federal relations and international issues related to insurance and coordinating activities of NCOIL relating to Congressional or Federal agency action affecting insurance and the State regulation thereof.

2. A Workers' Compensation Insurance Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting workers' compensation insurance.

3. A Property-Casualty Insurance Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting property casualty insurance.

4. A Health Insurance and Long-Term Care Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting health insurance and long-term care.

5. A Life Insurance & Financial Planning Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting life insurance and financial planning.

6. A Financial Services & Multi-Lines Issues Committee, consisting of a minimum of seven (7) members with responsibility for representing NCOIL in matters respecting financial services and matters which cross multiple lines of insurance.

7. An Audit Committee, consisting of a minimum of three (3) members appointed by the President and chaired by the Vice President with the responsibility for arranging for and reviewing the audits of NCOIL funds and making recommendations to the Executive Committee with respect to procedures relating thereto. The Treasurer shall be a non-voting, ex-officio member. The Treasurer may vote if the Executive Committee appoints a Chief Executive Officer or Executive Director under Article VI, E of the Articles of Organization.

8. An Articles of Organization and Bylaws Revision Committee, consisting of at least seven (7) members appointed by the President with the responsibility for reviewing the Articles of Organization and Bylaws of NCOIL at each annual meeting.

9. A Budget Committee, consisting of a minimum of seven (7) members, which shall include the Secretary, appointed by the President and chaired by the Treasurer with the responsibility of developing annual budget proposals pursuant to the process enumerated in these Bylaws. The Treasurer may vote if the Executive Committee appoints a Chief Executive Officer or Executive Director under Articles VI, E of the Articles of Organization.

10. A Nominating Committee, consisting of all NCOIL past presidents, the current NCOIL president, and current standing committee chairs with one year or more of service as a standing committee chair that shall interview potential officers for the upcoming year, report nominations for officers to the annual meeting of NCOIL, and reconvene when there becomes a vacancy among the officers in order to nominate a replacement. A Nominating Committee member seekingwishing to be a candidate for an officer shall recuse herself or himself from Nominating Committee participation; if said candidate is a current officer seeking to advance through the chairs, then recusal is warranted only if she or he has an opponent for the position.

C. The Chair and Vice Chair of any standing or special committee shall be appointed by the President and shall serve at the will of the President. However, beginning in 2022, no legislator shall serve as Chair of any one committee for more than three (3) consecutive years. Only members of Contributing States in good standing are eligible to be Chairs or, Vice Chairs of any standing or special committee. Legislators from Member States may sign up for Committees one (1) through seven (7) listed above.

D. The Chair of any Committee with the approval of the President may appoint a chair and members of task forces and subcommittees to assist in the work of NCOIL. Only members of Contributing States in good standing are eligible for appointment as a chair of a task force or subcommittee. A task force or subcommittee shall continue in existence until it has accomplished the purposes for which it was created or until the next annual meeting of NCOIL, whichever occurs earlier.

E. All Standing Committees, except the Nominating Committee, shall be continuing committees and the members thereof shall serve one-year terms or until their successors are appointed.

1. Standing Committees shall be open to all NCOIL Member Legislators during an Open Registration period. At the Annual Meeting each year, Standing Committee Registration Forms for the upcoming year shall be available in the registration

area, on which NCOIL Member Legislators shall register for the Standing Committees on which they will serve in the upcoming year, whether or not they currently serve on those committees.

2. Standing Committee Open Registration shall remain so until January 15th of the year of committee service. In the period after the Annual Meeting through January 15th NCOIL Member Legislators wishing to serve on Standing Committees but who had not registered during the Annual Meeting shall send an e-mail or letter to the NCOIL Chief Executive Officer or Executive Director stating the Standing Committee(s) on which she or he will serve.

3. From January 16th through the remainder of the year, NCOIL Member Legislators wishing to serve on Standing Committees shall send an e-mail or letter to the NCOIL Chief Executive Officer or Executive Director stating the Standing Committee(s) on which she or he wishes to serve, and the NCOIL Chief Executive Officer or Executive Director will present the request to either the Standing Committee Chair or the NCOIL President for Appointment.

F. Special Committees may be created by NCOIL at the annual meeting of NCOIL, by the Executive Committee at any meeting of the Executive Committee, or by the President between meetings of the Executive Committee and of NCOIL. Any action creating a Special Committee shall specify its size and duties, and may specify the manner of appointment of members thereof. A Special Committee shall continue in existence until it has accomplished the purposes for which it was created or until the next annual meeting of NCOIL, whichever occurs earlier.

G. 1. Any resolution or other document submitted to NCOIL for its approval or disapproval shall be submitted and sponsored by a legislator to NCOIL at least 30 days prior to the next scheduled NCOIL Conference or Annual Meeting. A legislator must attend at least one NCOIL conference prior to sponsoring any resolution or other document submitted to NCOIL for its approval or disapproval. If a document or substantive amendment to a document is not submitted prior to the 30-day deadline, it shall be subject to a two-thirds vote for Committee consideration and a separate two-thirds vote for adoption. This section is intended to provide advance notice of the matters and items on which NCOIL will vote; it is not intended to limit germane amendments that arise during a discussion. Such germane amendments shall not trigger a supermajority vote.

2. Notwithstanding the existence of the requirement that any resolutions or documents be submitted to NCOIL at least 30 days prior to the next scheduled NCOIL Conference or Annual Meeting, such documents may pass through committees to the Executive Committee at a duly called meeting of the Executive Committee. Any resolution or other document properly considered and adopted by an NCOIL Committee shall be referred to the Executive Committee for its consideration and vote. If adopted by the Executive Committee such resolution or other document shall be considered the official NCOIL position on such matter covered.

H. Members of the committee responsible for insurance legislation in each legislative house of each Member state shall be a voting member at his or her first NCOIL conference in meetings of standing committees that he or she has joined.

I. Legislators from Member states who are not members of state committees responsible for insurance legislation shall be eligible to vote on a standing committee of which he or she is a member at her or his second NCOIL conference.

J. NCOIL meetings are open meetings except those involving discussions of the general reputation and character or professional competence of an individual; the legal ramifications of threatened or pending litigation; security issues; price of real estate or professional transactions; and matters involving a trade secret.

IV. FINANCES

The fiscal year of NCOIL shall commence on January 1 of each year and end on December 31 of the same year.

A. The Chief Executive Officer or Executive Director shall submit to the Executive Committee a proposed budget for the ensuing fiscal year 10 days before the annual meeting of NCOIL. The Executive Committee shall have the power to approve, modify or reject, in whole or in part, the budget.

B. The Executive Committee at the annual meeting of NCOIL shall adopt a budget for the ensuing fiscal year.

C. During the fiscal year, the Executive Committee may provide for an increase or decrease of an appropriation. Such increase or decrease shall only be upon the certification by the Committee of the need thereof.

D. The moneys budgeted pursuant to these Bylaws may include money for the retention of staff, the reimbursement of expenses of staff, and the expenses of Legislators for activities on behalf of NCOIL other than expenses of attending regularly scheduled NCOIL meetings.

E. Checks drawn for expenditures of less than one thousand, five hundred ($1,500) dollars shall be signed by the Chief Executive Officer or Executive Director who shall submit a monthly report of all such checks to the President of NCOIL. No more than one such check shall be paid for any one purpose without the prior express written consent of the President. All other checks drawn upon the funds of NCOIL shall be signed by both the Chief Executive Officer or Executive Director and either the President or Vice President. Notwithstanding the foregoing sentence, the NCOIL Officers may approve a system they deem sufficiently secure whereby the NCOIL President approves in writing expenditures other than by the physical signing of the check. Such system shall be endorsed by NCOIL's outside auditor.

F. The Executive Committee shall, at the annual meeting of NCOIL, select an independent auditor who shall review NCOIL's books and accounts for the current fiscal year. The auditor shall submit its report to the Audit Committee by June 30 of the next calendar year. The Audit Committee shall submit its report at the next succeeding meeting of the Executive Committee.

G. In the event that NCOIL shall, for any reason, discontinue its activities and cease to function, any monies remaining in its possession or to its credit after the payment of outstanding debts and obligations shall be distributed in equal shares to the Contributing States of NCOIL in good standing at the time of distribution.

V. RULES OF PROCEDURE

A. Each model act adopted by NCOIL shall be reviewed by the Committee of original reference every five (5) years. The respective Committee shall vote to readopt the model act for an additional five (5) years, readopt the model act for an interim period to allow for additional study or drafting, amend and readopt the model act, or allow the model act to "sunset." Readopted models shall be sent to the Executive Committee for final adoption.

B. The NCOIL committees shall review previously adopted NCOIL model laws in order to provide an appropriate sunset schedule. Such documents shall be reviewed in the following manner: Spring Meeting shall be Life Insurance & Financial Planning Committee and the Health and Long-Term Care Issues Committee. Summer Meeting shall be Workers' Compensation Insurance Committee and Property-Casualty Insurance Committee. The Annual Meeting shall be the Joint State-Federal Relations and International Insurance Issues Committee, Financial Services & Multi-Lines Issues Committee, and Executive Committee. Model laws shall sunset every five (5) years within the Committee. Committees shall have the authority to extend the model laws from meeting to meeting.

C. In any issue not covered by the Articles or Bylaws, Robert's Rules of Order shall be the standard authority.

VI. AMENDMENTS

These Bylaws may be amended or repealed at any meeting of the Executive Committee by a favorable vote of two-thirds of the members present and voting, provided however, that notice and text of any proposed amendments shall be given in summary form to the NCOIL Chief Executive Officer or Executive Director at least thirty (30) days prior to the date of that meeting in accordance with the NCOIL 30-day rule for submission of documents to NCOIL for approval or disapproval, as stated in Section III.G of the Bylaws. Amendments shall become effective immediately upon adoption unless otherwise provided therein.

VII. REASONABLE DEPARTURE FROM BYLAWS

In the event of any emergency resulting from a military or terrorist attack, widespread pandemic, or similar disaster resulting in the declaration of a state of emergency (or similar declaration) by Federal or State officials, reasonable departure from these Bylaws shall be permitted upon the Officers and Executive Committee declaring that such action is warranted.

ARTICLES OF ORGANIZATION/BYLAWS AMENDMENTS

Adopted 4th Annual Meeting, San Francisco, November 28, 1972;
Amended 10th Annual Meeting, Detroit, November 14, 1978;
Amended 11th Annual Meeting, Charleston, November 14, 1979;
Amended 12th Annual Meeting, San Antonio, November 22, 1980;
Amended 16th Annual Meeting, Little Rock, November 17, 1984;
Amended 17th Annual Meeting, Phoenix, November 24, 1985;
Amended 18th Annual Meeting, Nashville, November 16, 1986;

Amended 19th Annual Meeting, Palm Springs, November 18, 1987;
Amended 23rd Annual Meeting, Scottsdale, November 20, 1991;
Amended 24th Annual Meeting, Charleston, November 18, 1992;
Amended 26th Annual Meeting, New York City, November 13, 1994;
Amended 27th Annual Meeting, San Francisco, November 11, 1995;
Amended 28th Annual Meeting, Austin, Texas, November 20, 1996;
Amended 30th Annual Meeting, San Diego, California, November 21, 1998;
Amended 31st Annual Meeting, Orlando, Florida, November 19, 1999;
Amended Spring Meeting, San Francisco, California, February 25, 2000;
Amended 32nd Annual Meeting, New Orleans, Louisiana, November 16, 2000;
Amended Summer Meeting, Williamsburg, Virginia, July 11, 2003;
Amended Summer Meeting, Chicago, Illinois, July 16, 2004;
Amended Annual Meeting, San Diego, California, November 19, 2005;
Amended Summer Meeting, Boston, Massachusetts, July 21, 2006;
Amended Annual Meeting, Napa Valley, California, November 10, 2006;
Amended Summer Meeting, Seattle, Washington, July 21, 2007;
Amended Annual Meeting, Las Vegas, Nevada, November 17, 2007;
Amended Spring Meeting, Washington, DC, March 1, 2008;
Amended Summer Meeting, New York, New York, July 11, 2008;
Amended Annual Meeting, Duck Key, Florida, November 20, 2008;
Amended Spring Meeting, Isle of Palms, South Carolina, March 7, 2010;
Amended Summer Meeting, Newport, Rhode Island, July 17, 2011;
Amended Annual Meeting, Santa Fe, New Mexico, November 20, 2011;
Amended Summer Meeting, Philadelphia, Pennsylvania, July 14, 2013;
Amended Annual Meeting, Nashville, Tennessee, November 24, 2013;
Amended Summer Meeting, Boston, Massachusetts, July 13, 2014;
Amended Annual Meeting, San Francisco, California, November 20, 2014;;
Amended Spring Meeting, Charleston, South Carolina, March 1, 2015;
Amended Summer Meeting, Portland, Oregon, July 14, 2016;
Amended Annual Meeting, Phoenix, Arizona, November 19, 2017;
Amended Annual Meeting, Oklahoma City, Oklahoma, December 8, 2018.
Amended Spring Meeting, Nashville, Tennessee, March 17, 2019
Amended via Conference Call Meeting of Executive Committee, July 1, 2020
Amended Annual Meeting, Scottsdale, Arizona, November 20, 2021

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 14, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Hyatt Regency in Jersey City, New Jersey on Thursday, July 14, 2022 at 3:45 p.m.

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

Other members of the Committee present were:

Rep. Matt Lehman (IN)
Rep. Derek Lewis (KY)
Rep. Bart Rowland (KY)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Rep. Lacey Hull (TX)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Asm. Mike Gipson (CA)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Kerry Wood (CT)
Rep. Roy Takumi (HI)
Rep. Rod Furniss (ID)
Sen. Beverly Gossage (KS)
Rep. Rachel Roberts (KY)
Rep. Michael Sarge Pollack (KY)
Asm. Roy Freiman (NJ)
Rep. Wendi Thomas (PA)
Rep. Dennis Paul (TX)
Sen. Mary Felzkowski (WI)

Also in attendance were:

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

QUORUM

Upon a Motion made by Del. Steve Westfall (WV), and seconded by Rep. Brian Lampton (OH) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Sen. Bob Hackett (OH), and seconded by Rep. Bart Rowland (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 5, 2022 meeting in Las Vegas, NV.

CONTINUED DISCUSSION ON NCOIL INSURANCE REGULATORY SANDBOX MODEL ACT

Rep. Jordan began with turning things over to Rep. Rowland for introductory remarks on the continued discussion of the NCOIL Insurance Regulatory Sandbox Model Act (Model). Rep. Rowland stated that I appreciate the Committee's continued consideration of this Model. At the Committee's last meeting in March it was agreed upon that the Committee would continue the process of developing the Model despite some concerns that had been raised as to whether a Model is necessary because there have not been many applications in the states of these types of sandbox laws. So, I appreciate the Committee for agreeing to do that and thank you to Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, for signing on as a co-sponsor of the Model joining Rep. Wendi Thomas (PA). The current version of the Model appears in your binders on page 90 and it essentially mirrors the Kentucky sandbox law which I sponsored and we passed in Kentucky a few years ago. However, as I've stated from the beginning of this process, I'm certainly open to hearing suggestions as to what should be added or removed from the Model. But the bottom line is that I do believe it would be very beneficial for NCOIL to provide guidance to states that are looking at this issue in the form of a model law.

To that end, what I've decided to do is to introduce an alternative version of the Model which still achieves the main goal of reducing hurdles for companies that want to introduce new concepts and products at the same speed as insurance technology develops, but does so in a much more streamlined and simplified manner. Indeed, the current version of the Model is nearly 15 pages and the alternative version is only half of that. This version, the alternative one, appears in your binders on page 85. Accordingly, what I'd like to do today is hear from the speakers we have scheduled and from my colleagues as to what their thoughts are on the sandboxes in general and specifically on the alternative version of the model that is in your binders. Then after this meeting we can determine which version to choose to move forward with and hopefully we can have it adopted at our Fall meeting in November. One more item I'd like to note is the issue of reciprocity. I've said before that I do think it is beneficial to have reciprocity language in the NCOIL Model, meaning that it would permit companies to obtain a waiver in one state to operate in others without going through the application process from scratch. However, the more that I and others have thought about the concept of reciprocity the more questions have come up of how exactly you would implement that. So, you'll see in your binders on page 84 that there are two options for the reciprocity section and I would like to hear feedback on those options as well and try to figure out how to move forward with reciprocity in the sandbox Model.

Allen Kamrava, Founder & CEO of Eusoh, thanked the Committee for the opportunity to speak and stated that I'm a dual board certified general and colorectal surgeon. I also have a Masters in Business Administration. I'm teaching at a facility in the Department Colon Rectal Surgery and Division of General Surgery at Cedars-Sinai in California and I've been working on a startup and have a startup that's been live that's been trying to bring an alternative concept of how we can achieve coverage using the advents of technology and kind of a preface of why I'm speaking with you today is a sandbox Model would be very beneficial, and what's happened with our own startup and company would help highlight that. So, being a physician I've worked through Kaiser, I matriculated at University of Pennsylvania. I work at a large academic center now. I've seen all sides of the health disparities in terms of cost and access to healthcare and that led me down a rabbit hole of why can't we do this better and led to the startup that I'm here to speak of today. But a simple fact, and I've cited a source at the bottom, 93% of Americans do not trust insurance. Consider that as we go through this that a product that is there to protect people, only 7% of people trust. If that doesn't tell us that we need not just

continue business as usual and look at ways that we can improve this, I don't know what else could.

When we look at innovation in the insurance world, it really falls into two main categories. One is data-AI processing. How do we take the data that's coming in mass and function and utilize that better in an actuarial way to produce better models going forward. Or, how do we build cool apps, so that users will have better interaction with insurance? But at no level are they actually looking at how do we change that model from the ground up and potentially build something that works better for the end user. And that's what we did. I'm only going to go through it in just a single slide here but I could spend well over a few hours discussing the intricacies of what we did with Eusoh for the company that we built. But what we did at its core was using the advents and digital payments technology showed that you can move the surplus that has been coming to define an insurance fund and distribute that across the membership. Now, it goes much deeper than that but if you think about that on a policy standpoint if you have small lines that the surplus can then be freed up because it can be distributed across the membership and utilized for other product lines that have otherwise not had surplus available you start to open up on a policy side, on a regulatory side, different lines of coverage that otherwise were not touchable or fathomable before. We incorporated in 2017. In these five years we've raised $4.5 in funding. Over 20% of that funding was spent on legal due diligence. We spent a full year looking at the regulatory backgrounds and brought on board folks to do actual studying and modeling. They reported a concept report that they published and we looked at all the regulatory rules and precedents both on a state and a federal level before we even started our first line of code.

We knew that what we wanted to do had to be done right and in no way did we fake it till you would make it as is typical of an industry jargon of most startups these days. This is at the end of the day a financial coverage solution and if you're going to do it, it has to be done right. But at the end of the day we were proposing a model that is a zero surplus model and without a surplus you cannot apply for a certificate of authority (COA) - it's impossible. You just can't get one. That's the fundamental principle to get a COA. So, could a startup that is saying we can potentially utilize new technology to introduce a new model that utilizes surplus on a distributed model ever exist not only in the U.S. but I guess 50 different states and all the regulatory bodies with that small amount of funding. You can't. Meanwhile, we went live with a proof of concept as a test of the model in the dog and cat space. So, pets in 2018. This is from our graph reports from one of the top three global reinsurance groups. They audited our data after three years and showed that through our model we had saved users 47% against any like comparable pet conventional insurance plan in the market today. Furthermore, they reported a 37% improvement in average claim size, 24% improvement in claim frequency, and they wrote "Eusoh has successfully provided $15 million in limits to their members with no capital utilization and saw over $2 million in submitted expenses."

Despite this success, we're closing because we can't afford the regulatory burden. We have different states putting inquiries in and the ability of a small startup to pull that burden is not doable. And we have a A+ Better Business Bureau rating. Forbes this year listed us as one of the top one hundred most customer centric companies in America. Insider listed it as the best coverage in America for pets. And we're closing the pet book despite those successes because there was no path for it for us and we were drowning in legal debt. Here are some testimonials from real users and I urge you

to take a look later if you can. This is a member who lost their pet but and said, “in Molly’s honor we’d like to keep our membership active for several months to keep those in our community whole.” These are people who no longer had a pet to serve and were continuing to pay forward essentially paying a monthly equivalent to a premium even though they didn’t have something to cover. A user named Shervin gave their dog up for adoption and writes that they're going to continue to pay forward into the community. Stories like this are abound within our model and the whole point from it from the beginning for us was if we can recreate this from the beginning, from the outset, we can potentially build something where our users have buy-in and when your users have buy-in, then you start to decrease frequency and the severity which is exactly what the global reinsurers showed when they audited our data that we successfully achieved that.

These are some of our awards and recognitions for the last few years as we were listed as the best coverage in America for pets, but we’re closing. The conclusion is that voters are out of a viable solution. Small startups cannot in any shape or form withstand the cost of what it would take on a 50 state sandbox movement or even a 50 state regulatory haul and what it would take to go forward. A sandbox is vitally important if we want to innovate in the world of insurance and really look at what technology can do to start bringing things forward. Incumbent companies are large, slow, and everything works by committee. Innovation is going to come from small startups and we have to open up our world to allow a path forward for them to do that. In working with Rep. Rowland, we had recommended some ideas for the sandbox to help make it possible for small startups to get involved and they’re all listed here. Australia has a model like this of a national essentially ombudsman, a person whose job is dedicated to help new innovative ideas in the world of insurance come through the burdens and say this is what needs to be done and to ensure consumer protection is there and make sure that the path is there for them.

The other is an alternative means for solvency requirements. We live in a complex world. We had a presentation today on private equity, not that I’m saying we use private equity, but the point being that there are so many ways for us to solve for solvency other than what is already known from the past and we should explore all those options and make those, as long as there’s a solvency requirement met even if it’s an alternative, but it meets that requirement and gives the consumer protection. It should be considered and honored if it does that. As Rep. Rowland had said, reciprocity across states is paramount. It’s one thing to do it with one state but to then to do it across 49 other states - the cost by themselves are daunting and basically impossible for a small company. And then if key performance indicators and consumer protections are met, a path to a legislative approval to allow these new models to exist should be present.

JP Wieske, representing the American InsurTech Council (AITC) thanked the Committee for the opportunity to speak and stated that the AITC is a group that formed earlier this year and we are different in part because the only group that we represent is insurtechs. We are not looking at representing folks that are legacy carriers unless they are in the insurtech space. I would note I am also a former regulator and in my role as the Deputy Commissioner of Wisconsin, we had a sandbox law that dated back to the 1970’s and has been widely successful in a number of products. So as much as we’ve had issues with a discussion here about products not coming forward we in fact have had products that started in the sandbox in Wisconsin, moved through that sandbox and are outside. The first point I would want to make is I think what’s important to understand is that the availability of the sandbox in and of itself is important. Those discussions cannot be had

with insurers and with new companies and with new ideas if you do not have a sandbox available. We found in a number of cases that when we had discussions directly with the insurers that in fact the products that they thought needed the sandbox did not in fact need the sandbox and so they were able to file normal products and go through the normal process but they never would have had that conversation with us if we didn't have the sandbox in place.

The other issue is that there are a number of rules and issues inside insurance that cause problems for new carriers in creating new products that take some time. For example, seasoning requirements are often waived. There's a five-year seasoning requirement for a lot of insurers those are often waived but that's a broad issue for a new carrier that is hard to go through. There are filing issues that they have to deal with inside the department that can be extensive and those filing issues also mean that they can't make adjustments to their products on the fly. When you have a new product, you may need to make an adjustment every single month. Under insurance laws that would be considered discriminatory, so you're not allowed to make those changes and so we in some cases use a sandbox to allow adjustments in filing on a regular basis. There are benefit issues that may or may not be legal in the current aspect but may need to be legal and may be available and I'll talk about one of those products in a minute. Capital requirements was also cited, and then notice issues. Wisconsin has an existing insurance law that requires that every single notice be offered on paper in a way that was in the exact same language which did not allow folks who were using a phone to use things like hyperlinks and other pro-consumer things to make it easier from them to be able to understand the policy. Those were not actually allowed under Wisconsin law and we had to make some adjustments there.

In closing I would cite a couple of products that we looked at that needed a sandbox. So, there's a National Association of Insurance Commissioner (NAIC) model around limited duration, long term care. This is long term care that covers a shorter than one year duration. In a number of states before that model that product was considered illegal. It was turned down including in Wisconsin before we got in office, those products were not available in the state despite the value that they provided to consumers. Eventually an NAIC model was adopted and its now a widely available product but again in a number of states without that it was illegal. We also saw some products around coverage for rentals that came through our process that is now available on the market. An insurer is also offering a package for certain consumers that have trouble affording house issues that come up, things like a breakdown in your air conditioning or your furnace which can be devastating so they've got a product that is targeted to those folks to make sure that they have some financial protections in place. So, those products would not exist without the insurance sandbox we went through. There is a lot of value, and again the key value, even if you don't see anything that goes through the sandbox, is the ability to be able to have that conversation with insurers.

Wes Bissett, Senior Counsel at the Independent Insurance Agents and Brokers of America (IIABA) thanked the Committee for the opportunity to speak and stated that the IIABA thanks Rep. Rowland, Rep. Thomas, Rep. Oliverson, and this Committee for the thoughtful work on this issue over the last few months. The overarching goal here with this proposal is to promote innovation in the insurance sector and there's really nobody that challenges or questions that. I think where you find yourselves at this point is not whether to act on a proposal like this but exactly how the details of how to go about doing that and the reality is that there are some important legal and public policy

questions that come with the adoption of a sandbox proposal of this nature. The core feature of this is that it allows insurance regulators to exempt from statutory requirements certain marketplace actors. So, the statutory requirements that you've set as legislators, regulators for the first time would have the ability to say that they are waived for purposes of certain marketplace players and not others.

So, that's a big power and with that power there needs to be some reasonable protections and some of those were already in the initial proposal that was filed and I'm pleased to say that in the alternative proposal, the issues that we've testified on in the past, we think that all those protections are now found. Things like transparency, identifying certain types of requirements that are essentially un-waivable because they are so impactful to consumers. So, our view of the alternative proposal is that Rep. Rowland and the Committee have done a good job of threading the needle. It accomplishes the core objective of promoting innovation and to satisfy those goals that the sponsors were trying to accomplish but at the same time also implementing some modest safeguards. So, I don't know what your intentions are as a Committee whether you're going to adopt this today or at the next meeting but we'd urge you at the point that you do to take the alternative that's been submitted and we appreciate your willingness to consider some of those more detailed points that we've raised in the past. I think the product that will ultimately be adopted we hope is going to be benefited by the thoughtful work that you've undertaken and we greatly appreciate that.
Rep. Rowland stated that he is curious if any of the panelists have any thoughts on the two options for reciprocity that are in the binders today. Mr. Wieske stated that for me shorter is always better and the first alternative seems to hit where it should go from my sense and we support either and we support the Model and the new version as it stands but I think it makes a lot of sense to allow the state to sort of define itself whether or not it meets those standards. Rep. Rowland stated that I think we're in a good spot and I appreciate everyone's continued work on this issue and I feel like we're in a good spot to hopefully pass this Model in November.

Rep. Thomas stated to Dr. Kamrava that I have a question about your closing your business down and you said you can't afford to go through the regulatory process. Is that primarily the regulatory process of all the states or is it you can't even get it through one state? So, what I'm trying to evaluate is the value of a compact that is multi-state versus a single state. Dr. Kamrava stated that it depends on the state. So, in the good state of Kentucky we actually found a working solution that we were able to come to agreement on and had been working on and we had other states and each regulatory department of each state takes their own process and their own way of doing it. Dealing with Kentucky versus Washington was a very different ball and chain. We have six inquiries coming in from different states and each of those inquiries is an entire different process. When I started it, I basically met with a group of different attorneys and said, "Look, this is what I'm seeing happening in healthcare, I want to fix these things." And every time they said, you can't as the regulations won't let insurance do this. So, I finally went to Orrick which is one of the most expensive law firms for startups and I said, "Listen, I'm a physician, I by no means want to break the law or go to jail but there has to be a way, and I know that there's models." So, for instance in California, my malpractice insurance is under California Mutual Protection Trust. It's not considered insurance but it's the largest malpractice coverage in the state. How are they able to be considered not insurance but be allowed to be used? And there's multiple examples of this. I want to know all ways others have done this across all the states and then I will build based on that so that we're following the code.

Regardless of how good we have done it I still have to face the inquiries. So, for instance, in one of the states after a year of calls and legal expenses they said we have tried to catch you on multiple ways and we have failed. You have actually done this right but we think you're insurance and you'll have to beat us in court. And I can't afford that. And so, it stopped. And as each state comes that becomes are they willing to work with us or not? And it's very hard because it's really up to each dep't of insurance but the reality is we don't have a license. I couldn't get one if I wanted it. I don't have paper, and it's because the way we are structured it's impossible to do so. Not because the model doesn't have worth to be considered but because these are the processes that we knew would happen. That one day, we'd have to be here talking about how do we start making these parts there? So, we said let's prove the concept, show that it works, and then hope to get it where we need to get it. So, we're not closing the business but closing that book and hoping to continue to be here to work with you.

Mr. Wieske stated that I would just note that there is a wide difference between states and product to product. We had one case in Wisconsin with an existing insurer that is under some financial strain and there's a state that does not have significant risk but is holding millions of dollars of deposits in lieu that they don't need that would be helpful to the operation of this company because they feel that it's their right to hold this in case the policyholders need it. So, states vary significantly on this and product to product and part of the key to having something like this is forcing a dep't of insurance to have a conversation with somebody upfront and making staff available to be able to have that conversation to move forward.

Rep. Thomas stated that I think what I'm trying to get at is if an individual state adopts this, is that enough to spur innovation or is it necessary to have multiple states? Because if you can only do one state, is it too difficult in the rest of the states where it does not work? Obviously you did it in Wisconsin. We don't have it in Pennsylvania, so there's some value. Mr. Wieske stated that the relationship on a state to state basis is such that insurance is regulated on a state by state basis. There are some commonalities and financial rights as a piece of it that is sort of part of the state's system that is sort of helpful but still there's deposits, minimum capital requirements, and other things that are in play and you can have some variations of that if it's outside the accreditation standards of the NAIC. So, there is some flexibility there on a state by state basis. So, even having one state is helpful and it helps demonstrate, and there are other alternative payment models that certainly some departments resist, forcing the department to have a conversation to definitively say yes or no up front which can save a lot of time and effort for folks who want to take a look at this because the statues may not be clear and they may have rules in play that you don't know about that create problems behind the scenes or create a situation like the one that was just highlighted.

Rep. Thomas stated that as co-sponsor of the Model I believe in this idea but I think the value of doing it here at NCOIL is that we will have multiple states adopt it from here and then everybody wins. I do think if we do it individually we'll have limited success but if we can do it more broadly the success will be greater for everyone. Rep. Jordan stated that he agrees.

Rep. Jim Dunnigan (UT), Vice Chair of the Committee, asked Mr. Bissett for his thoughts on the alternativ version of the Model introduced today. Mr. Bissett stated that our view is that the latest version is worthy of adoption. It addresses many of the issues that

we've testified about in the past and with regard to the question about which of the two options on reciprocity make more sense, I fully concur with Mr. Wieske. We're sort of agnostic about the two reciprocity options but 'm kind of one of those people that says if the shorter version works, maybe that's the one to go with. It seems to also give states a little more flexibility perhaps when it comes to reciprocity. So, we'd probably maybe lean a little bit towards option one over option two but option two is not inherently troubling in any way.

Rep. Jordan asked Mr. Wieske regarding startups, what are the barriers being faced as far as things like capital requirements and other things. What other barriers are these startups facing? Mr. Wieske stated that there's a couple of issues. Two of our sponsoring members of the organization are in artificial intelligence (AI) and they're having some issues with getting carriers to use their services because they're afraid of what the Departments of Insurance will look at and they're no sort of standards in play. So, part of what they're looking at in that case is they are a non-insurance product. A lot of the startups are non-insurance product but are insurance adjacent and so they're looking to understand how this will work with the insurance entity and to get a little bit more of a mother may I. To be brutally honest a lot of insurers are extremely adverse risk adverse despite the fact that they're in the risk business, and tend to not take a lot of chances. And from a capital standpoint, to get an insurance license is expensive and there's a minimum capital that attaches. It varies state to state. I believe it's around $3 million in some states that you have to have available from a capital requirement. They can make some sort of allowances on that as they go through. There are some reinsurance and other agreements you can do to sort of get there. There are fronting arrangements. But, functionally, if you're required to have an insurance license, you've got to get a little creative or find a fronting arrangement to sort of get there and then you have to go to you point through a bunch of states to get your insurance licensed. The other bit is if you're doing sort of a risk sharing sort of approach with your members, that falls definitionally potentially inside insurance but may not be legal under the sense of the rules of the insurance license as it stands. So, you get caught in a catch twenty-two that you're doing something that is more in favor of the consumer but that you don't have the ability if you're a licensed entity you can't do that because it's against the law structurally. So, there are a lot of issues that sort of potentially attach, but around capital, it's significant.

Rep. Stephen Meskers (CT) stated that I'm trying to understand the business model and the scope of a nationwide sandbox or multi-state sandbox because I'm trying to figure out what level of capital you're going to not keep as reserves but capital you're going to deploy and what number of consumers you're going to look to cover. What level of risk are you going to have? And then, who is going to be the regulatory authority within that sandbox at some point to say, "Okay, you've used venture capital, private equity, you've done your sandbox, and you've launched your product." And when do you graduate to work in a business model with the level of reserves? Because you can build a book of business in a sandbox where the exposure is so high but there isn't a backup and all of a sudden there all of the constituents, all of the people who purchased the policy, can't get their claims resolved. So, I'd like to know what the progression is for when do you graduate from the sandbox into kindergarten or first grade? How much capital is needed and how big of a firm are you looking to create across this regulatory divide?

Mr. Wieske stated that I think from our standpoint there's a couple of pieces. I think there's a legitimate concern that when you're looking at the risk and you're looking at the

nature of some these products, that the level of risk and the level of reserves you're required to have is not commensurate with the risk level that the insurer's taking as a piece of it. That if you got to be that big, you'd probably be able to get those numbers but functionally, if you're looking at certain types of risk and certain types of products, what we're trying to get to is to try to figure out if you got electronics insurance, and you're only covering phones when they go to an airport in case they get stolen or broken in the airport. Your risk level there is a little bit different than say a standard electronics policy that's covering everything soup to nuts or may be attached to your homeowners policy. So, you're trying to figure out what is the risk level. There are adjustments there that you need to be able to make. Generally, from a financial perspective there is one main financial regulator in front of any insurer and that's where most of the capital is required to reside and then you farm out. So, that would still functionally be the same but there would have to be some agreement that allows you to grow the business because what you're looking at in a lot of these is more of a niche business and you're not looking at having necessarily millions of customers in the state of Wisconsin and not trying to grow there but you might be looking at hundreds of customers in Wisconsin and maybe thousands nationwide because your product's a little bit different.

So, I think what the goal would be is to figure out how you could sort of right size this and that requires a lot of regulatory hands on work as a piece of it. So, when we looked at it we had our chief of legal, we had our filing people involved in the products as well as leadership each time we touched these to have this discussion about how you sort of go through and do this. And then behind the scenes you have public and private agreements to sort of make sure that the consumers are protected because if you're in a sandbox, you're looking at waiving some insurance laws for one reason or another and so you want to be able to have some protections that are available to the consumer that you agree on. Not all of those are necessarily public. In some cases, we had insurers that were experimenting with new policies that the benefits would not be provided potentially for years but they wanted to see what the market was and so there was an agreement that they would refund the entire amount of the premium back to the consumer if they didn't have any claims. And obviously if the consumer knew that, that's an issue. But that required a behind the scenes agreement. So I think you need a lot of regulatory touches and I think the Model sort of reflects that.

Rep. Meskers stated that the concern I have is, you'll build out a model and the question is in that regulatory sandbox, is anyone in oversight or does it work out to be basically a private contractual relationship between the sandbox and all the individual consumers with no oversight? So, it might be a different regulatory framework but to me it either graduates into an insurance product or a consumer product and it has to have some oversight at some point. Mr. Wieske stated that we had a philosophy when we looked at it that if you could not get out of the sandbox eventually there was no point in us having a discussion. We had a couple of companies that wanted to sell specific products without licensed agents which would obviously concern a lot of people and we turned those down because the law required the use of agents for good reason. So, you have to take a look at that as to whether or not they can actually get out of the sandbox, what you're waiving and why. And sometimes there's some statutory requirements that you just can't waive even though you could waive it theoretically, functionally they can't spend the entire life cycle of the product inside the sandbox. They need to find a way to get out.

PRESENTATION ON NORTH CAROLINA DEPARTMENT OF INSURANCE EFFORTS FIGHTING INSURANCE FRAUD

The Hon. Mike Causey, North Carolina Insurance Commissioner, thanked the Committee for the opportunity to speak and stated that I'll talk to you a little bit about insurance fraud and what we're doing in North Carolina. It's an honor for me to serve as Insurance Commissioner and State Fire Marshal. I was elected in 2016 and took office January 1st of 2017 and the first group that I visited at the Department of Insurance was our criminal investigation division. Now, my career in law enforcement amounted to Military Police School with the United States Army serving overseas briefly as Military Police but I have worked closely with a lot of law enforcement officers and the thing that got me interested in insurance fraud was during the months and years of campaigning across the state I kept hearing consumers bring the issue up – "You need to do something about insurance fraud." And what I found out, North Carolina was the first state in the United States to put law enforcement in a department of insurance and that happened in 1945. So, when I ask our criminal investigators how are we doing on insurance fraud when it comes to investigations, prosecutions and convictions, they let me know that North Carolina was receiving between 20 and 30 fraud referrals every day – 5,000 to 6,000 each year.

When I asked them how we were doing on investigations they said well we're only able to fully investigate about 12% So, to me that was a problem – 88% of fraud referrals not being fully investigated. So, I knew we needed more people, more sworn law enforcement. The other problem was even when they had a case and they tried to take it to court, some of the counties, some of the district attorneys were so overwhelmed they just sort of put insurance fraud on the back burner and I said, "Well, what if we hired our own prosecuting attorneys that can work with the district attorneys to help move these cases through?" And they thought that would be a good idea so I worked with our legislature and when I took office, we only had 18 or 19 sworn law enforcement officers and today we have 49 sworn law enforcement officers and three civilian investigators and arson investigators. We also have an arson dog, a K-9 that a grant from State Farm made possible. But we hired those three prosecuting attorneys in 2017 and that's made all the difference in the world. We had cases that were just sitting on the dockets. One case had been there for two and half years and we talked with the district attorney, we reopened the case and actually took it to court and got a conviction.

And you can go to our website and get more information but I would just encourage any of the legislators or elected officials here or any of the insurance companies if you want more information about what we're doing in North Carolina, we'll be glad to talk with you about it. The one thing that I would encourage the insurance companies to do is be more proactive about referring suspected fraud. Our general statutes in North Carolina say you don't have to know it's fraud, it doesn't have to be known fraud. But if you think something's not quite right, you are required by our state statutes to refer that to the department of insurance. Some companies do a wonderful job of that. I'll go ahead and say Nationwide is head and shoulders above every other company. We get 125 to 130 fraud referrals every month from Nationwide. We had a partnership with SAS Institute in Cary, North Carolina. They developed a reporting system and a North Carolina criminal information database that we work with law enforcement with to get all the law enforcement agencies and it's worked very well. And I just encourage people to get tough on insurance fraud because we're all paying for it and according to the Coalition Against Insurance Fraud, that's around $308 billion dollars a year.

Rep. Jordan asked of those thousands of referrals that you get per year, how many are on the auto side versus homeowners, and versus commercial? Cmsr. Causey stated that I don't have those numbers in front of me but can get them for you but I'd say the majority probably is automobile. We have a lot of staged accidents. I know one company, this was a claims clerk in an office of an insurance company noticed they had a claim, it was about $900 and they were going to pay it and they thought, well I believe I paid this claim before or something similar and the young lady went and looked and pulled the file and they had paid this woman and her son over $10,000 over the course of about 14 months on the same two vehicles. They were repeatedly filing the same claim and she just happened to pick it up. So, they had already collected over $10,000. We made the arrest on that. We have a lot of roofing contractors where these roofing contractors go around door to door. If you don't have a problem with a roof, they'll make one. We have one case that's ongoing that turned out to be a first degree murder case out of Gaston County where the husband killed his wife using eye drops so we call it the eye drop murder case and the district attorney in Gaston County asked us to prosecute that one when it goes to trial. But we'll get the breakdown for you on the actual numbers.

Rep. Jordan asked how that last case mentioned falls under the office of the department of insurance? Cmsr. Causey stated that this young lady that died was 34 years old and eight months after her death her mother called our office and begged us to look into this. It turned out that the husband had purchased a $200,000-plus life insurance policy right before she died. The family had asked for an autopsy. The husband refused and had her cremated as quickly as he could. And there were some other things. The husband had a girlfriend that came out of the closet right after the wife died and so there was just a lot of other things that we were looking at and two weeks prior to that a woman in South Carolina had been charged with killing her husband with eye drops. So, there might be a connection but we ended up making the arrest and the man had on his computer a lot of research on how many eye drops does it take to kill a person.

Sen. Beverly Gossage (KS) stated that I guess I'm trying to understand why it is the department of insurance is involved. It seems to me like with insurance companies having a large department on fraud, waste and abuse that they would have their own attorneys and they would be going after this. Cmsr. Causey stated that's a good question and some companies do have an aggressive special investigations unit but our state statute requires insurance companies with any suspected fraud or anything that might be a question to report it to the department of insurance. I get a list every day that shows every company that's made a fraud referral. The health insurance companies generally were not doing a very good job with that. So, I called one, a very large health insurer in our state, in 2017 and said, "Look, you're not reporting insurance fraud, it's required." And they brought in their attorneys and their SIU investigators and said this is how we're handling it and they were handling it but they still weren't turning it in.

So, they started working with our criminal investigations division and talked about it for about two years but never did anything about it. We never saw any results. I got a little mad one day about a report we got from a consumer and I called the company's lobbyist, and I said, "I'm going to issue the largest fine ever issued against this company in the State of North Carolina. Our statute say we can fine up to $1,000 per day and the case went back several years." And so, this was going to be a significant fine and this representative said, "Hold up. Let us come talk to you." And they did and we met in our

board room and they said if you'll give us 45 days we'll go back through our files for four years and pull everything that we ever had a question about and we'll have you 60 fraud referrals within the next 60 days. And so we agreed to do that and now, they're on board and one of our best referrers. And sometimes, it's just a matter of we look at it and it doesn't rise to the level of criminal so they get a letter. We had a case down in Fort Bragg, North Carolina with a soldier had let his car insurance lapse. He had an accident but didn't report it but decided to go buy a policy then report it and we worked with Fort Bragg and sent out letters. They created a poster, and once that message got out there we never got another fraud referral. Now that doesn't mean there wasn't any fraud there but we think it's very effective, and we've got a pretty good track record. I've got the numbers but it might take too long to look them up. But we have investigators and we're just scratching the surface and we have investigators out there every day that are making arrests, and it is making a difference because you have to have the deterrence, if you're going to stop the fraud.

Rep. Tammy Nuccio (CT) stated that I recently read between 25% and 27% of health insurance claims are waste or abuse. So, how is your office working with insurance companies to identify that? Is that something that would fall under your area? And how do we work to improve that so we can improve the cost of healthcare? Cmsr. Causey stated that I wouldn't doubt those numbers but we believe that regardless of what kind of claim it is, we believe that about one out of ten has some degree of fraud in it. And again, not everything rises to the level of criminal but we just ask if whether the consumer knows about it, or a medical provider, or the insurance company, whoever knows about it just tell us and report it. We can set the insurers up with the reporting database that they can just go in each day and punch a button and send it to us and we'll check it out.

UPDATE ON DEVELOPMENTS IN ELECTRONIC DELIVERY OF INSURANCE DOCUMENTS

Karen Melchert, Regional VP of State Relations at the American Council of Life Insurers (ACLI) thanked the Committee for the opportunity to speak and stated that I gave a brief update during the November meeting of this Committee in Scottsdale on where we were on electronic delivery and other improvements and innovations in insurance document delivery and the like following COVID and what we had been working on. But I'm here to introduce John Feeney, VP of External Affairs at Prudential Financial and co-chair of the ACLI Innovation Subcommittee and he's going to give a much more detailed presentation on those issues.

Mr. Feeney thanked the Committee for the opportunity to speak and stated that I'll provide a brief update on some of the activity the sub-committee has been doing around modernizing e-commerce statutes. So, before COVID kicked in both NCOIL and the NAIC had acknowledged that there was a need to modernize e-commerce statutes. Obviously, we have the insurance e-commerce model act that that was passed here at NCOIL and adopted here in March of 2020. It started right before the world locked down. And the NAIC created its innovation and technology subcommittee which has been doing a lot of work around innovation and modernization. And they were looking at different insurer practices and updating that. So, there have been a lot of discussion around sort of the need for industry to address that issue.

So, there's nothing like a pandemic to kind of focus on that issue and there was a lot of focus on the requirements of the regulations in the industry and we worked together with the NAIC to address that. There was a lot of work that had to be done because the world as they say sort of overnight went into lockdown and so what we didn't have was a playbook. As you see the picture on the right how the New York City subway looked one day, and then how it looked the next day. You can just kind of take that picture and imagine insurance companies, or all companies and regulators, how their offices looked the next day after we shut down. And so there really was a need to address how we were going to go forward in this. As you see on the left the number of the regulations and actions that the regulators took to help us through for consumers and for insurance companies. And there was a lot of initiation, cooperation, discussion between the NAIC and the ACLI and its members to address these issues because there really was no playbook at this point on how we were going to address the lockdown and then how we were going to be able to do required filings and get information to our consumers.

As this points out, 1999 is when the Uniform Electronic Transactions Act (UETA) was first adopted and as you go back and look the palm pilot was all the rage. Fax machines were cutting edge. And fast forward twenty years later to 2019 to see how things have drastically changed with the ability of computers. Since the iPhone was adopted in 2007 there has been widespread adoption to the iPhone even by seniors. So, UETA has been on the books for well over 20 years and industry technology has significantly advanced. Unfortunately, the regulations just haven't followed suit. As we sit here in 2022, consumers are very comfortable using technology. The lock down from COVID really enhanced that. I mean people who were uncomfortable using technology before, they were forced to learn it and they became very comfortable with using technology. A whole generation of consumers grew up in an electronic world. They're very comfortable using technology and they do experience some pain points when they cannot do the things they want to do using technology. And as I said, COVID really did accelerate the shift to online engagement and I think everybody in this room has probably heard this before but consumers are increasingly expecting an Amazon-like experience when they deal with companies.

They always talk about two clicks in two days. That's what people expect. And so, when they don't have that experience working with insurers, they get a little frustrated. And I'll use the one example with my own kids. I have three children in their 20s and everything they do is on their phone and they don't receive any mail. The mail they get comes into their phones. If they get any mail, it's junk mail. So, we're lagging behind where a number of consumers are in their expectations and really their desires to interact with the financial services industry. I just want to give a sort of update of all things that have taken place on this modernization march forward. As I previously mentioned, NCOIL has adopted their Model back in 2020. The E-sign Modernization Act has been introduced twice in Congress. There is a lot of interest around it but it hasn't moved but there at least has been Federal engagement on the need to modernize their laws. The financial services industry, in addition to what the ACLI's been doing, has had engagement at the Securities and Exchange Commission (SEC) level on the need to modernize how the SEC delivers documents. Again, it's namely a paper delivery but we're really pushing for electronic delivery of those documents.

And as I mentioned previously, we have worked closely with the NAIC and back in 2021 the NAIC did develop an e-commerce working group and recently they submitted a survey asking input from insurers as well as the states on sort of what can be done to

improve e-commerce and what prohibits or impedes electronic commerce. And a number of the ACLI members did reply to that survey and really what we've heard from them was very loud and clear - the need to change the default. So, right now if you are getting documents unless you affirmatively consent and show with reasonable demonstration how to get those documents, you have to get them through paper and not through electronic means. And even if we do update the statutes eventually, what it will not be addressing is a lot of the legacy policyholders who still get things paper and will not take the steps really necessary to change it from paper to e-delivery. So, we're still talking about thinking about how to tackle this. We have some ideas. I know what we plan to do is continue legislative and regulatory outreach. We know we have to engage with the consumer groups. There are a number of groups that are opposed to the changes to going from paper to e-delivery. Groups like the timber industry, as you can probably appreciate. The U.S. Postal Service has some issues with that as well. And so, what I really want to do is sit down and engage with them because the desire is out there. The consumers are really wanting to have these documents delivered electronically. We'll never ever take paper away. There's always going to be a portion of consumers who want it or maybe don't have access to the internet, and we understand that. Or maybe they just prefer paper to hold something and look at something. But as each year passes, that number decreases significantly.

And so, all we're saying is it's time for industry to catch up to where technology is and as I sit here today, I don't have an ask for NCOIL today. What considerations we may be coming back with are maybe to seek amendments to the NCOIL insurance e-commerce Model once we know specifically how we want to attack this language-wise. It may require a new Model. But my purpose here today is to let you know about the work we are doing with the NAIC and the engagement there. We will eventually be hearing back from them as I mentioned they have that survey and they're still looking at the survey results. Ultimately, they're going to put together a game plan on how to tackle this but there's going to be a legislative need. There's a regulatory need and there's going to be a legislative need. And so, I'll continue to update this Committee as we move forward but I wanted to at least get you on sort of the same level of where we are, and what we as an industry are doing and then kind of go forward from there.

Rep. Jordan stated that it's important to always be mindful and cognizant of rural areas because I can tell you in Louisiana we have a lot of places that are rural areas that don't have broadband. And that's always an issue of concern for us and I know it's an issue as well in other parts of the country. Mr. Feeney stated that the industry understands that and ultimately it would be if we decide to say make electronic delivery the standard there's always going to be an opt out so that people who don't want to get things electronically, they just say continue to send paper. So, that's why I wanted to make sure I said today this initiative is never going to take paper away because we understand and appreciate that paper is always going to be the primary method for some people. But as I said, as each year passes, technology advances and people just want to be able to be kept up with where technology has gone.

DISCUSSION ON TRENDS IN THE USE OF ARTIFICIAL INTELLIGENCE IN INSURANCE UNDERWRITING

Neil Spector, President of Underwriting Solutions at Verisk thanked the Committee for the opportunity to speak and stated that my role is to lead really all the products and services that Verisk has in the property and casualty business to insurers. And so, today

I was asked to come and talk a little bit about the use of automation and AI and the customer experience in insurance. So, before I get started, I did want to say that consumer expectations are changing and when we think about this topic we have to start with what do consumers want. I think about myself and my personal situation, I'm sure many of you are in the same situation. I'm probably on the Amazon website at least every other day and the Amazon truck is coming to my house multiple times a week. It's a good experience. You get on, you find what you want. They are using AI and machine learning to figure out what things I need and they're sharing that so any time I go to a streaming site to watch a movie I get recommendations for different things that I might be interested in watching. And so, I think as consumers our expectation of how we interact is changing. Even the last time I took my car in for service, I did everything through an app. I scheduled the appointment, I interacted with the dealership with what I wanted and I never talked to a person and so I think it's important that we understand that as an industry insurers are living in that world. We're living with consumers who are expecting much more digital experiences and I think over the last two and half years it's just accelerated with the pandemic with people just getting more used to virtual and remote needs and wants.

So, as we think about the underwriting process and the application process for insurance and I'm sure we have all had experiences whether it's your car or home, or life insurance, the application process can be frustrating. Partially, it's frustrating because insurers ask a lot of questions that consumers don't have the answer to and it's hard when you are trying to buy a complex product and you're not really sure what the information is. And in the case of life insurance, you may have to go get a medical exam, or get blood tests so the process for the consumer is not an ideal process. And so, one of the things that the industry and Verisk as a partner is trying to do is to make that experience easier for the consumer and in today's world when you think about the availability of data there's a lot of data out there that you can get access to, to help that process that it makes a better process because the end result for the consumer might be the wrong coverage. I don't know how many of you know what the shape of the roof of your house is, but it actually matters because the cost to replace that roof is dependent on what shape that roof is. Most people don't know what it is. A lot of people don't know how old their house is. But those are all factors that insurers need to understand. So, I think it's very important that we look at this technology as a way to improve both the experience for the consumer in getting insurance but also getting the coverages that they need.

There's other things that are impacting with this new kind of consumer experience and some of them are what I would consider emerging risks that both insurers and consumers have to deal with. Some of those are just the risk of cybersecurity. And you think about cyber risk, today it's big cyber attacks is a big concern for all of us but also the growth of the gig economy and sharing economy. You've got people driving for Uber or using their home or apartment as an Airbnb. It changes the nature of risk and these are all changing the challenges that insurers have in order to properly insure. And then, today's consumer, because they expect to interact using technology, insurers have to be able to offer those solutions. So, one of the things that Verisk does is help our customers by leveraging the technology so the consumer gets a better experience so they can use a smartphone to adjudicate a claim or to do underwriting and to change their policy and make changes to their policy. There's a lot of new data that is available today that insurers are using that give rise to this type of technology. I'll just mention a couple of them. We're all familiar with usage based technology and usage based

insurance. You know, it started out with technology, it could plug into a vehicle. It evolves to smartphones that can be used to help track driving behavior and to direct connections with Original Equipment Manufacturer (OEMs) and auto manufacturers to driving history behavior.

This is something that's of great value and I think you become more interesting to consumers as people drive less, they work home more. Their interest in having some of this driving being shared with their insurers so that they get the benefits of the safer conditions and again, we're working with OEMs to be able to provide that information to insurers. I do want to highlight that consumer consent is a very important process when it comes to insurance-based solutions - or the internet of things and telematics. Both getting the consumer's consent to collect the data, and also getting their consent to use the data. But usually when that is done well, the consumer benefits through insurance discounts. Virtual technology became very popular two years ago when we were faced with shutdowns and insurers could not get out to the homes of their policyholders and so using a smartphone app to interact with a customer to be able to both interact on underwriting insurance and also adjudicating claims became something that was very important. If you think about the process of having to schedule somebody to come out and see your home and do an inspection of your home, I think most people would rather have a smartphone and be able to go around and take some pictures and video and interact with their insurance company that way at their convenience. So that's another example of how this technology can benefit consumers.

And then there's data that's available, public data such as building permit data for example that Verisk has access to that can help identify that a roof's been replaced recently. Or the home systems, maybe it's an older home but the plumbing systems and the wiring systems have all been updated. That's important information for an insurer to know. You can get a price knowing that those systems are newer. So again, that data can help both from a consumer and from an insurer perspective. And then, the unstructured data that's available out there and I'll use an example of small businesses. Insurers are really trying to provide better solutions for small business owners to either be able to get coverage online or be able to get more coverage quickly and they can use information that you can glean about a business to be able to identify the risks and be able to properly price that risk without the business owner having to answer 100 questions about their business. And so again, this ends up a much better experience. So, these are just all good examples of how AI can be used in the underwriting process in a good way.

Life insurance is another industry that can benefit a lot from this technology. I would argue that the life insurance underwriting process is probably at least a decade behind P&C as far as the type of experience and also the analytics that get used. There's definitely a coverage gap and it's difficult for life insurers to get the message out about the importance of it and I think that given the last two years probably the need for life insurance has grown. So, being able to help those customers with better digital experiences and be able to provide people with a better way to get life insurance from some of the traditional tools is something that's very important and something that life insurers are looking to do so that they can both grow their business and also address the coverage gaps that exist out there. During the pandemic what we saw is an increased demand for life coverage. You've seen a growth in premiums and you've seen a growth in the number of policies over the last two years but the front end process by which people get life insurance really hasn't changed that much and so as I mentioned earlier,

some of the ways technology can be used is with consumer consent. Being able to use electronic health records rather than having to go for medical exams. Being able to use voice recognition models to determine if someone's a smoker or not to avoid having them take a blood test when you can tell that they are not a non-smoker. So, these are just some examples of ways that the consumer experience can be better. You can have more growth in there using this technology. But it's done in a consumer private and friendly way.

Data quality is obviously really important as you're doing this type of automation and better customer experience. It really relies on quality data because obviously data is driving a lot of this and if the data's incomplete or outdated or it's not in insurance ready use so that the company can make use of it then you're not going to be able to achieve the benefits. So, from that perspective you need to really understand how the data gets sourced and the data needs to be curated in a way that insurers can benefit and use it. So, one of the things that we do as an organization for example, is collect a lot of these data sets from various either third parties or collect it ourselves and then be able to provide a level of data standardization data quality. The other thing around the side of this is really protection of the data as well because I think that you need to make sure that you have the right protections in place. And so, as data stewards, I'll just say that it's important from our perspective you need to safeguard the data to make sure the data is safe. You need to invest in strong internal governance process so that you understand how the data's being used and then you have to strictly abide by all applicable laws and regulations. So, you need a team of people, we have a team at Verisk that interacts with the regulatory community so that we understand those rules because they change and they are changing. This is an area of great discussion and debate, and change, so we need to make sure that we stay ahead and comply with all of the rules that are out there as far as how the data gets used.

And then, look to build consistency and transparency with how the data's used. I think that consumers are willing to have this data used to their benefit as long as they understand how the data's being used and they have the ability to have a say in it. And so, from a commitment standpoint, we make the commitment to protect the data both from a data security and data privacy standpoint. I'll just say that as time goes on, the type and volume of data that's available in the world is growing exponentially. The data that we have access today, when you think about data from vehicles, data from images captured from the sky, data from internet of things from your wearables. It's proliferating everywhere. And so, therefore there's a lot of opportunity with that data to do good things but it has to be done in a responsible way. It has to be protected and it has to be done in a way that follows regulations with transparency. And so, I think while the opportunity is great, the responsibility is also great for anyone that's a data provider or a data user and for the industry as a whole and how they use it.

Sen. Bob Hackett (OH) stated that all of us here know the issues with underwriting. Do you think consumers are aware of how much AI and data is being used in underwriting? Mr. Spector stated that I would say that data's being used in two ways. One is aggregated data. So, what do I mean by aggregated data? It's where you're going to take all the policies and all the claims from a large population, you're going to work on the data. I don't think the average consumer fully understands how that works in an insurance mechanism but then there's data in a very specific way. It's Neil is driving his car and he's signed into a telematics program and he understands that the insurance company has access to his data and I think from that perspective the consumers do

have a good understanding because the industries have done a good job of making sure that in the insurance process those permissions are there whether it's to pull a credit report or look at a motor vehicle report. You know, you need to make the consumer aware of the things that you're going to be getting on their behalf. So, I think from that level there's pretty good transparency but I'm not sure at the aggregated level that people appreciate how much data is out there in the world and then I would just say that I'm not sure we've all sat down and thought of the implications of our wearables. But certainly, the fact that I exercise every day, if that's going to be a benefit for my life insurance company to know and lower my premiums that's something I would consider sharing but I also want to understand what exactly are they getting access to. Are they getting access to a general score, or do they know how long my workout was this morning? So, I think transparency's going to be important to make people comfortable.

Rep. Rowland stated that my retail insurance agency recently contracted with an InsurTech startup called Openly and they do homeowners insurance and they kind of sold themselves to us on the fact that we for most quotes, we only need to enter three pieces of data. The name, the date of birth, the address, and they've got the rest of it. As AI becomes more available and technology becomes more available to insurance carriers, do you see a trend of the carriers are going to move towards less data entry by the agents or the consumers to get those quotes because it'll all be available to them behind the scenes. Mr. Spector replied absolutely. That is definitely the way things are going. I think that it's still important that you give the consumer the opportunity to confirm. So, if you give your name and address and they give you a quote, they should tell you what they base that quote on and if you look at it and you say, well you based it on a 3,000 square foot home, and my home is only 2,000 square feet then they need to have that adjustment. So, there's definitely a confirmation step that needs to take place but yes I think that this is the way it's going because I think consumers don't want to fill out a 50 page form. And like I said, a lot of data that they ask for is data you don't have easily accessible. Even in an auto insurance quote, I don't want to run down to my car and look at the VIN off of it or pull up my prior policy. If they have that information, I'd rather just have them pre-fill it.

Rep. Rowland stated that there's a lot of data out there. There's going to be even more data. How is that data protected? Mr. Spector stated that I can speak to how Verisk thinks about protecting data and I think every organization has a responsibility to protect the data that we have. We look at protection from a couple perspectives. One is the physical protection of the data because there's a lot of cyber attacks out there and you want to make sure that the data's protected from both internal and external threats. So, we think about encryption and even tokenization which is an even higher level of protection that encryption. You want to look at who has access to data and make sure that you have good governance so that only people that are appropriate have access to data. That's quite costly and actually quite rigorous and you also have to make sure that all of your systems are patched regularly and that you're keeping up to date with all the cyber alters out there and even with all of that, companies still have issues but that's why data encryption and tokenization is so critical because if bad guys get access to the data, they don't get anything of value so there's that physical security. But more than just physical security, there's data privacy and there's also the reason by which you got data. So, many companies contribute data to Verisk and they contribute it for specific purposes so we need to make sure from a governance perspective that we're only using the data in the ways that it was given to us and that requires a level of internal governance and a set of controls. We have audits that come in and audit the business

on a regular basis to make sure that nothing's changed since the prior audit. So, data security and data protection is a big deal and I would say it's one of the most important things that go one at Verisk because we view ourselves as data stewards and I would hope any company that has access to data would treat it that way.

Rep. Brian Lampton (OH) asked how do you verify the accuracy of all of that? Mr. Spector stated that accuracy of data is a challenge because there's always the potential that data is inaccurate. So, one of the ways you can do that is triangulate multiple data sources. So, one of the things we do at Verisk is we get data from a lot of different places and if we have multiple data sources for a single piece of data, we'll compare them and if three sources of data all say Neil's home was built in 1972 and we see it from three different sources, we have a higher level of confidence then one. The other way is quite frankly just feedback loop. So, you get feedback from either the customer, the agent, or we do field inspections for commercial buildings. We go out and we're constantly updating the data. So, I think it's a constant feedback mechanism to keep the data quality high.

Rep. Jordan stated that I think we all love the fact that AI creates less friction within the transactions but I'm curious as to what steps are being taken to mitigate some of the biases within AI. Mr. Spector stated that it's a challenge because you build the AI to do something specific,so I'll give you an example. We have a product which we call a risk analyzer and creates a set of territories for insurance that are at census block level. So, a very fine level. And you worry that by doing that you're going to create some kind of bias in there. So, one of the things we did was we looked at urban density and we said, well urban density can be a problem because you go to some cities where there's more population of people and you're going to have some disparate impacts from that. So, we actually created an algorithm to take that out and we basically removed population density from the model so that it was no longer used. So, you constantly need to be looking at the models that you're building and you need to look at them against what disparate actions or outcomes could happen and then you need to make the appropriate adjustments. So, the most important step is testing the models to make sure that you don't have any of that in there and you need the data. So, in many cases you can have census data but you need the data on the risks themselves to be able to understand if you're having a disparate impact in the first place.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lampton and seconded by Sen. Hackett, the Committee adjourned at 5:15 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Insurance Regualtory Sandbox Model Act

Draft as of October 18, 2022. To be discussed and considered by the Financial Services & Multi-Lines Issues Committee on November 18, 2022.
Sponsored by Rep. Bart Rowland (KY)
Co-sponsored by Rep. Wendi Thomas (PA) and Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer

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Section 1. Title

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

Section 2. Regulatory Sandbox and Innovation Waivers

(a) The Commissioner may grant a variance or waiver with respect to the specific requirements of any insurance law, regulation, or bulletin if a person subject to that law, regulation, or bulletin demonstrates to the Commissioner's satisfaction that:

(1) the application of the law, regulation, or bulletin would prohibit the introduction of an innovative or more efficient insurance product or service that the applicant intends to offer during the period for which the proposed waiver is granted;

(2) the public policy goals of the law, regulation, or bulletin will be or have been achieved by other means;

(3) the waiver will not substantially or unreasonably increase any risk to consumers; and

(4) the waiver is in the public interest.

(b) An application for an innovation waiver shall include the following information:

(1) the identity of the person applying for the waiver;

(2) the identity of the directors and executive officers of the applicant, any persons who are beneficial owners of ten percent or more of the voting securities of the applicant, and any individuals with power to direct the management and policies of the applicant;

(3) a description of the product or service to be offered if the waiver is granted, including how the product or service functions and the manner and terms on which it will be offered;

(4) a description of the potential benefits to consumers of the product or service;

(5) a description of the potential risks to consumers posed by the product or service or the approval of the proposed waiver and how the applicant proposes to mitigate such risks;

(6) an identification of the statutory or regulatory provision that prohibits the introduction, sale, or offering of the product or service;

(7) a filing fee of $_____; and

(8) any additional information required by the Commissioner.

(c) (1) An innovation waiver shall be granted for an initial period of up to 12 months, as deemed appropriate by the Commissioner.

(2) Prior to the end of the initial waiver period, the Commissioner may grant a one-time extension for up to an additional 12 months. An extension request shall be made to the Commissioner at least 30 days prior to the end of the initial waiver period and shall include the length of the extension period requested and specific reasons why the extension is necessary. The Commissioner shall grant or deny an extension request before the end of the initial waiver period.

(d) An innovation waiver shall include any terms, conditions, and limitations deemed appropriate by the Commissioner, including limits on the amount of premium that may be

written in relation to the underlying product or service and the number of consumers that may purchase or utilize the underlying product or service; provided that in no event shall a product or service subject to an innovation waiver be purchased or utilized by more than 10,000 consumers.

(e) A product or service offered pursuant to an innovation waiver shall include the following written disclosures to consumers in clear and conspicuous form:

(1) the name and contact information of the person providing the product or service;

(2) that the product or service is authorized pursuant to an innovation waiver for a temporary period of time and may be discontinued at the end of the waiver period, the date of which shall be specified;

(3) contact information for the Department, including how a consumer may file a complaint with the Department regarding the product or service; and

(4) any additional disclosures required by the Commissioner.

(f) The Commissioner's decision to grant or deny a waiver or extension shall not be subject to the contested-case provisions of the [insert reference to the state administrative procedure act].

(g) (1) The Commissioner shall not grant a waiver with respect to any of the following:

(A) any law, regulation, bulletin, or other provision that is not subject to the Commissioner's jurisdiction under [insert reference to the title(s) that make up the insurance code];

(B) any law, regulation, bulletin, or other provision concerning the assets, deposits, investments, capital, surplus, or other solvency requirements applicable to insurers;

(C) the required participation in any assigned risk plan, residual market, or guaranty fund;

(D) [insert references to the provisions of the insurance code related to insurance licensing requirements, insurance trade practices, particular lines of insurance or insurance products (e.g. health insurance, workers' compensation insurance), etc.];

(E) any law, regulation, or bulletin required for the Department to maintain its accreditation by the National Association of Insurance Commissioners unless the law or regulation permits variances or waivers;

(F) the application of any taxes or fees; and
(G) any other law, regulation, or bulletin deemed ineligible by the Commissioner.

(2) The authority granted to the Commissioner under this section shall not be construed to allow the Commissioner to grant or extend a waiver that would abridge the recovery rights of consumers.

(h) A person who receives a waiver under this section shall be required to possess or obtain one or a combination of the following in an amount subject to such conditions and for such purposes as the Commissioner determines necessary for the protection of consumers:

(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 [insert reference to appropriate state law]; or

(6) Another form of security authorized by the Commissioner

(i) (1) At least 30 days prior to granting an innovation waiver, the Commissioner shall provide public notice of the draft waiver by publishing the following information:

(A) the specific statute, regulation, or bulletin to which the draft waiver applies;

(B) the proposed terms, conditions, and limitations of the draft waiver;

(C) the proposed duration of the draft waiver; and

(D) any additional information deemed appropriate by the Commissioner.

(2) The notice requirement of this subsection may be satisfied by publication on the Department's website.

(j) (1) If a waiver is granted pursuant to this section, the Commissioner shall provide public notice of the existence of the waiver by providing the following information:

(A) the specific statute, regulation, or bulletin to which the waiver applies;

(B) the name of the person who applied for and received the waiver;

(C) the duration of and any other terms, conditions, or limitations of the waiver; and

(D) any additional information deemed appropriate by the Commissioner.

(2) The notice requirement of this subsection may be satisfied by publication on the Department's website.

(k) (1) The Commissioner may revoke a waiver if the person who obtains the waiver fails to comply with any terms, conditions, or limitations established by the Commissioner or the requirements of this section or if the waiver is causing consumer harm.

(2) In addition to any other sanctions and penalties permitted by the law, the Commissioner may impose a fine of not more than $_____ on any person who obtains a waiver that fails to comply with any terms, conditions, or limitations established by the Commissioner or the requirements of this section.

(l) The Commissioner, by regulation, shall adopt procedures for the submission, granting, denying, monitoring, and revocation of petitions for a waiver pursuant to this section. The procedures shall set forth requirements for the ongoing monitoring, examination, and supervision of, and reporting by, each person granted a waiver under this section and shall permit the Commissioner to attach reasonable conditions or limitations on the conduct permitted pursuant to a waiver. The procedures shall provide for an expedited application process for a product or service that is substantially similar to one for which a waiver has previously been granted by the Commissioner. The procedures shall include an opportunity for public comment on draft waivers under consideration by the Commissioner.

(m) Upon expiration of an innovation waiver, the person who obtained the waiver shall cease all activities that were permitted only as a result of the waiver and comply with all generally applicable laws and regulations.

(n) The ability to grant a waiver under this section shall not be interpreted to limit or otherwise affect the authority of the Commissioner to exercise discretion to waive or enforce requirements as permitted under any other section of this title or any regulation.

(o) The Commissioner shall submit a report annually to the [insert reference to state legislature] providing the following information:

(1) the total number of applications for waivers that have been received, granted, and denied by the Commissioner;

(2) for each waiver granted by the Commissioner, the information specified under paragraph (j)(1);

(3) a list of any regulations or bulletins that have been adopted or amended as a result of or in connection with a waiver granted under this section;

(4) with respect to each statute to which a waiver applies, the Commissioner's recommendation as to whether such statute should be continued, eliminated, or amended in order to promote innovation and establish a uniform regulatory system for all regulated entities; and

(5) a list of any waivers that have lapsed or been revoked and, if revoked, a description of other regulatory or disciplinary actions, if any, that resulted in, accompanied, or resulted from such revocation.

(p) No new waivers or extensions shall be granted after July 1, _____.

(q) This section shall be repealed on July 1, _____.

Section 3. Reciprocity

The Commissioner may enter into agreements with other States that have enacted laws that are substantially similar to this Act in order to advance the purposes of this Act and to facilitate the consideration of applications for innovation waivers from persons that have satisfied the requirements of this Act and received similar waivers in other States.

Section 4. Rules

The Commissioner is authorized to promulgate rules necessary to effectuate the purposes of this Act.

Section 5. Effective Date

This Act shall take effect xxxxxx

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model Act to Support State Regulation of Insurance by Requiring Competition Among Rating Agencies

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Adopted by the NCOIL Financial Services Committee on November 16, 2017
Adopted with amendments by the NCOIL Executive Committee on November 19, 2017
Sponsored by Rep. Steve Riggs (KY) and Sen. Bob Hackett (OH)

****To be considered for re-adoption with proposed amendments during the Financial Services & Multi-Lines Issues Committee meeting on November 18, 2022.***

****Proposed amendments sponsored by Sen. Bob Hackett (OH)***

Section 1. Short Title

Model Act to Support State Regulation of Insurance by Requiring Competition among Insurance Rating Agencies

Section 2. Findings and Purpose

The Legislature finds that:

1) Protecting consumers and ensuring the safety and soundness of insurance companies in the United States have been the prime objectives of state insurance regulation for over 150 years.
2) The states have sole authority for the regulation of the business of insurance as provided under the McCarren-Ferguson Act.
3) State insurance regulation has been successful and effective.
4) State insurance regulation has in place on-going substantive procedures, processes, and protocols to license, regulate and supervise insurers.
5) There is no requirement that duly licensed insurance companies be rated and that among those that are, companies make choices about rating organizations

based on management's evaluation of the perceived strengths of each rating organization as it relates to their markets and business models.

6) The test of insurer ratings is whether in the long run the company performs as expected, and in that regard each of these rating organizations on the whole have a consistent record of accurately gauging the ability of the companies to pay claims and service their customers.
7) An unintended yet direct consequence of designating a single, exclusive insurer rating requirement in laws, statutes, bulletins or other public material is the diminution of "public regulation by public authority" and an implication of private regulation of insurance.
8) A response to this threat to public regulation is necessary.
9) Multiple, competent insurer rating organizations exist.

It is the purpose of this Act to:

To require competition in insurer ratings to benefit consumers, duly licensed insurance companies, producers, and other third-party stakeholders by promulgating and embracing insurer rating requirements in laws and regulations that incorporate the enumeration of multiple, competent insurer rating organizations.

Section 3. Definitions

As used in this Act:

1) "Competent Rating Agency" means ~~A.M. Best Rating Services, Inc. Company; Demotech, Inc.; Fitch Group; Moody's Investor Service; Kroll Bond Rating Agency; Standard and Poor's Financial Services LLC or another~~ <u>any</u> rating agency <u>approved and registered as a Nationally Recognized Statistical Rating Organization (NRSRO) by the U.S. Securities and Exchange Commission (SEC), under Section 15E of the Securities Exchange Act, or any other national recognized rating organization that maintains business practices that include</u> ~~certified or approved by a national entity that engages in such a process. The process shall include, but not necessarily be limited to,~~ the following requirements:

    a. A requirement for the rating agency to register and provide an annual updated filing;
    b. Record retention requirements;
    c. Financial reporting requirements;
    d. Policies for the prevention of misuse of material nonpublic information;
    e. Management of conflicts of interest, including prohibited conflicts;
    f. Prohibited acts practices;
    g. Disclosure requirements;
    h. Required policies, practices, and internal controls;
    i. Standards of training, experience and competence for credit analysts.

2) “Public Entity” means any department, agency, special purpose district, or other instrumentality of this State and county or local government in this State.

Section 4. Requirements

No public entity shall bar any competent rating agency in designating the use of insurer rating requirements in laws, statutes, regulations, rules, bulletins, or other public materials.

Section 5. Effective Date

This Act shall take effect immediately.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes

Adopted by the NCOIL Financial Services Committee on November 16, 2017
Adopted by the NCOIL Executive Committee on November 19, 2017
****Sponsored by Rep. Steve Riggs (KY)***
****To be considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 18, 2022***

Drafting Note: Every State has enacted legislation allowing consumers to place a "security freeze" on their credit report through a consumer reporting agency. Most States currently permit consumer reporting agencies to charge consumers a fee for the placement and removal of such a security freeze. This Model Act is intended to amend existing law in those States that permit fees to be charged, so that consumers will not face any charges from a consumer reporting agency when requesting the placement, removal, temporary lifting, or reinstatement of a security freeze.

Section 1. Short Title

This Act shall be known as the "Model Act Prohibiting Consumer Reporting Agencies from Charging Fees Related to Security Freezes."

Section 2. Prohibition on Fees Related to Security Freezes

A consumer reporting agency may not impose a fee or any type of charge on a consumer for placing a security freeze, removing a security freeze, temporarily lifting a security freeze, or reinstating a security freeze.

Section 3. Effective Date

This Act shall take effect immediately.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Credit Report Protection for Minors Model Act

Adopted by the NCOIL Financial Services Committee on November 17, 2016 and the Executive Committee on November 20, 2016.
Amendments adopted by the NCOIL Financial Services Committee on November 16, 2017 and the NCOIL Executive Committee on November 19, 2017
Sponsored by Rep. Steve Riggs (KY)
To be considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 18, 2022.

Section 1 Short Title

This Act shall be known and cited as the Credit Report Protection for Minors Act.

Section 2 Purpose

The purpose of this Act is to protect minors from the misuse of their personal financial information by those with the intent to defraud them, by allowing parents and legal guardians to place a security freeze on a minor's credit report.

Section 3 Definitions

For the purposes of this Act, the following words shall have the following meanings:

(A) "Consumer report" or "credit report" means any written, oral, or other communication of any information by a consumer reporting agency bearing on a consumer's credit worthiness, credit standing, credit score, credit capacity, character, general reputation, personal characteristics, or mode of living which is used or expected to be used or collected in whole or in part for the purpose of serving as a factor in establishing the consumer's eligibility for:

a. Credit or insurance to be used primarily for personal, family, or household purposes, except that nothing in this chapter authorizes the use of credit

evaluations, credit scoring or insurance scoring in the underwriting of personal lines of property or casualty insurance;

b. Employment purposes; or

c. Any other purpose authorized under section 15 U.S.C. § 1681b

(B) "Consumer reporting agency" means any person which, for monetary fees, for dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of assembling or evaluating consumer credit information or other information on consumers for the purpose of furnishing consumer reports to third parties and which uses any means or facility of interstate commerce for the purpose of preparing furnishing consumer reports.

(C) "Protected consumer" means an individual who is:

a. Under the age of 16 years at the time a request for the placement of a security freeze is made; or

b. An incapacitated person or a protected person for whom a guardian or conservator has been appointed.

(D) "Record" means a compilation of information that:

a. Identifies a protected consumer;

b. Is created by a consumer reporting agency solely for the purpose of complying with this section; and

c. May not be created or used to consider the protected consumer's credit worthiness, credit standing, credit capacity, character, general reputation, personal characteristics, or mode of living.

(E) "Representative" means an individual who provides to a consumer reporting agency sufficient proof of authority to act on behalf of a protected consumer.

(F) "Security freeze" means:

a. If a consumer reporting agency does not have a consumer report pertaining to a protected consumer, a restriction that:

i. Is placed on the protected consumer's record in accordance with this Act; and

ii. Prohibits the consumer reporting agency form releasing the protected consumer's record except as provided in this Act; or

b. If a consumer reporting agency has a consumer report pertaining to the protected consumer, a restriction that:

i. Is placed on the protected consumer's consumer report in accordance with this Act; and

ii. Prohibits the consumer reporting agency from releasing the protected consumer's consumer report or any information derived from the protected consumer's consumer report except as provided in this Act.

(G) "Sufficient proof of authority" means documentation that shows a representative has authority to act on behalf of a protected consumer, including but not limited to:

a. A court order granting custodianship, guardianship, or conservatorship;

b. A birth certificate;

c. A lawfully executed and valid power of attorney; or

d. A written, notarized statement signed by a representative that expressly describes the authority of the representative to act on behalf of a protected consumer.

(H) "Sufficient proof of identification" means documentation identifying a protected consumer or a representative. The term includes, but is not limited to:

a. A copy of a social security card;

b. A certified or official copy of a birth certificate; or

c. A copy of a valid driver's license, or a copy of a government-issued photo identification.

Section 4 Security Freeze for Protected Consumer

(A) A consumer reporting agency shall place a security freeze for a protected consumer if:

a. The consumer reporting agency receives a request from the protected consumer's representative for the placement of the security freeze under this section; and

b. The protected consumer's representative:

i. Submits the request to the consumer reporting agency at the address or other point of contact and in the manner specified by the consumer reporting agency;

ii. Provides to the consumer reporting agency sufficient proof of identification of the protected consumer and the representative;

iii. Provides to the consumer reporting agency sufficient proof of authority to act on behalf of the protected consumer; and

(B) If a consumer reporting agency does not have a consumer report pertaining to a protected consumer when the consumer reporting agency receives a request under this section, the consumer reporting agency shall create a record for the protected consumer.

(C) Within thirty (30) days after receiving a request pursuant to this section, a consumer reporting agency shall place a security freeze on the protected person's record or credit report.

(D) Unless a protected consumer security freeze is removed in accordance with Section 5 of this Act, a consumer reporting agency may not release the protected consumer's consumer report, any information derived from the protected consumer's consumer report, or any record created for the protected consumer.

(E) The consumer reporting agency shall send a written confirmation of the security freeze to the representative within 10 business days after instituting the security freeze on the consumer report or record and shall provide the representative with instructions for removing the security freeze.

Section 5 Removal of Security Freeze

(A) A consumer reporting agency shall remove a security freeze from a protected consumer's consumer report or record only under either of the following circumstances:

a. Upon the request of a representative or a protected consumer. A consumer reporting agency shall remove a security freeze within 30 days after receiving a request for removal from a protected consumer or his or her representative.

1. A representative submitting a request for removal must provide sufficient proof of identification of the representative and sufficient proof of authority as determined by the consumer reporting agency.

2. A protected consumer submitting a request for removal must provide all of the following:

i. Sufficient proof of identification of the protected consumer as determined by the consumer reporting agency.

ii. Documentation that the sufficient proof of authority of the protected consumer's representative to act on behalf of the protected consumer is no longer valid.

b. If the security freeze was instituted due to a material misrepresentation of fact. A consumer reporting agency that intends to remove a security freeze under this paragraph shall notify the representative and protected consumer in writing before removing the security freeze.

Section 6 Fees

(A) A consumer reporting agency may not charge a fee for each placement or removal of a security freeze on a protected consumer's record or credit report.

Section 7 Penalties

(A) (1) Any person who willfully fails to comply with any requirement imposed under this section with respect to any consumer is liable to that consumer in an amount equal to the sum of:

(a) Any actual damages sustained by the consumer as a result of the failure;

(b) Any liquidated damages of not less than one hundred dollars ($100) and not more than one thousand dollars ($1,000);

(c) Any punitive damages as the court may allow; and

(d) In the case of any successful action to enforce any liability under this section, the costs of the action together with reasonable attorney's fees as determined by the court.

(2) Any person, other than the named individual or individuals in the report, who obtains a consumer report, requests a security freeze, requests the temporary lift of a freeze, or requests the removal of a security freeze from a consumer reporting agency under false pretenses or in an attempt to violate federal or state law shall be liable to the consumer reporting agency for actual damages sustained by the consumer reporting agency or one thousand dollars ($1,000), whichever is greater.

Section 6 Applicability and Scope

(A) This Act does not apply to a protected consumer's credit report or record provided to:

(a) A federal, state, or local governmental entity, including a law enforcement agency, or court, or their agents or assigns;

(b) A private collection agency for the sole purpose of assisting in the collection of an existing debt of the consumer who is the subject of the consumer report requested;

(c) A person or entity, or a subsidiary, affiliate, or agent of that person or entity, or an assignee of a financial obligation owing by the consumer to that person or entity, or a prospective assignee of a financial obligation owing by the consumer to that person or entity in conjunction with the proposed purchase of the financial obligation, with which the consumer has or had prior to assignment an account or contract, including a demand deposit account, or to whom the consumer issued a negotiable instrument, for the purposes of reviewing the account or collecting the financial obligation owing for the account, contract, or negotiable instrument. For purposes of this subparagraph, "reviewing the account" includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements;

(d) A person, for the purposes of prescreening as provided by the federal Fair Credit Reporting Act, 15 U.S.C. sec. 1681 et seq.;

(e) A consumer reporting agency for the purposes of providing a consumer with a copy of his or her own report on his or her request;

(f) A child support enforcement agency;

(g) A consumer reporting agency that acts only as a reseller of credit information by assembling and merging information contained in the database of another consumer reporting agency or multiple credit reporting agencies and does not maintain a permanent database of credit information from which new consumer reports are produced. However, a consumer reporting agency acting as a reseller shall honor any security freeze placed on a consumer report by another consumer reporting agency;

(h) A check services or fraud prevention services company, which issues reports on incidents of fraud or authorizations for the purpose of approving or processing negotiable instruments, electronic funds transfers, or similar methods of payments;

(i) A deposit account information service company, which issues reports regarding account closures due to fraud, substantial overdrafts, ATM abuse, or similar negative information regarding a consumer to inquiring banks or other financial institutions for use only in reviewing a consumer request for a deposit account at the inquiring bank or financial institution;

(j) Any person or entity using a consumer report in preparation for a civil or criminal action, or an insurance company in investigation of a claim; or

(k) 1. Any insurance company for setting or adjusting a rate or underwriting for property and casualty insurance purposes; or

2. Any consumer reporting agency database or file which consists solely of consumer information concerning, and used solely for:

a. Criminal record information;

b. Personal loss history information;

c. Fraud prevention or detection;

d. Employment screening; or

e. Tenant screening.

Section 7 Effective Date

This Act shall take effect 90 days after enactment.

616 Fifth Avenue, Unit 106
Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS

Credit Default Insurance Model Legislation

Adopted by the NCOIL Executive Committee on July 11, 2010.
Amended by the NCOIL Financial Services & Investment Products Committee on July 8, 2010. Adopted by the NCOIL Executive Committee on November 22, 2009.
Re-adopted by the NCOIL Financial Services Committee on November 16, 2017, and the NCOIL Executive Committee on November 19, 2017
Sponsored by Assem. Joseph Morelle (NY)
****To be considered for re-adoption during the Financial Services & Multi-Lines Issues Committee on November 18, 2022.***

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[Drafting Note: This model was developed for use in states without laws regulating credit default instruments. States that already oversee such instruments, including financial guaranty, surety, residual value and credit insurance, may want to update their statutes to reflect the model's intent—the supervision of legal credit default insurance and the banning of naked credit default swaps.]

Section 1. Definitions

(a) (1) "Credit default insurance" means a surety bond, or other contract, and any guarantee which is payable upon occurrence of financial loss, as a result of the

failure of any obligor on or issuer of any debt instrument or other monetary obligation to pay when due to be paid by the obligor or scheduled at the time insured to be received by the holder of the obligation, principal, interest, premium, dividend or purchase price of or on, or other amounts due or payable with respect to, such instrument or obligation, when such failure is the result of a financial default or insolvency, or other credit event, or, provided that such payment source is investment grade, any other failure to make payment, regardless of whether such obligation is incurred directly or as guarantor by or on behalf of another obligor that has also defaulted;

(2) Credit default insurance includes other events which the superintendent determines are substantially similar to any of the foregoing.

(3) Notwithstanding paragraph one of this subsection, "credit default insurance" shall not include:

(A) insurance of any loss resulting from any event described in paragraph one of this subsection if the loss is payable only upon occurrence of any of the following, as specified in a surety bond, insurance policy or indemnity contract;

(i) a fortuitous physical event;

(ii) failure of or deficiency in the operation of equipment; or

(iii) an inability to extract or recover a natural resource;

(B) fidelity and surety insurance as defined in [insert state statute defining fidelity and surety];

(C) credit insurance as defined in [insert state statute defining credit insurance], including credit life, credit disability, credit property, credit unemployment, involuntary unemployment, mortgage life, mortgage guaranty, mortgage disability, guaranteed automobile protection (gap) insurance, and any other form of insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation that the insurance commissioner designates a form of credit insurance.;

(D) residual value insurance as defined in [insert state statute defining residual value insurance];

(E) guaranteed investment contracts issued by life insurance companies which provide that the life insurer itself will make specified payments in exchange for specific premiums or contributions;

(F) indemnity contracts or similar guaranties, to the extent that they are not otherwise limited or proscribed by this chapter:

(i) in which a life insurer or an insurer subject to [insert relevant state law] guaranties its obligations or indebtedness or the obligations or indebtedness of a subsidiary (as defined in [insert relevant state law]), other than a financial guaranty insurance corporation, provided that:

(I) to the extent that any such obligations or indebtedness are backed by specific assets, such assets must at all times be owned by the insurer or the subsidiary; and

(II) in the case of the guaranty of the obligations or indebtedness of the subsidiary that are not backed by specific assets of such insurer, such guaranty terminates once the subsidiary ceases to be a subsidiary; or

(ii) in which a life insurer guaranties obligations or indebtedness (including the obligation to substitute assets where appropriate) with respect to specific assets acquired by such life insurer in the course of its normal investment activities and not for the purpose of resale with credit enhancement, or guaranties obligations or indebtedness acquired by its subsidiary, provided that the assets acquired pursuant to this item have been:

(I) acquired by a special purpose entity, whose sole purpose is to acquire specific assets of such life insurer or its subsidiary and issue securities or participation certificates backed by such assets; or

(II) sold to an independent third party; or

(iii) in which a life insurer guaranties obligations or indebtedness of an employee or insurance agent of such life insurer; or

(G) guarantees of higher education loans, unless written by a credit default insurance corporation;

(H) guarantees of insurance contracts, except for:

(i) guarantees authorized pursuant to [insert relevant state law regarding reinsurance business];

(ii) credit default insurance policies insuring guaranteed investment contracts issued by life insurers, provided that:

(I) the obligations under such contracts are not dependent on the continuance of human life;

(II) the credit default insurance policies do not guaranty death benefits provided by such contracts;
(III) the obligations insured by the credit default insurance policies are investment grade based on the rating of the life insurers or, in the case of separate account guaranteed investment contracts, based on the ratings of such separate accounts;

(IV) the credit default insurance policies shall not condition or delay payment of a claim with respect to such contracts upon the insured or beneficiary making a claim on the contracts with any insurance guaranty fund under this chapter or of any other jurisdiction; and

(V) the credit default insurance policies provide that if, prior to payment by the insurer under the credit default insurance policies, the guaranty fund has paid a claim under such contracts for an amount that, when added to the amount payable under the credit default insurance policies, would exceed the amount owed under such contracts, then the credit default insurer shall pay the portion of the amount payable in excess of the contract amounts to the guaranty fund instead of to the beneficiary under such contracts; or

(I) any other form of insurance covering risks which the superintendent determines to be substantially similar to any of the foregoing.

(b) “Credit default insurance corporation" or "corporation" means an insurer licensed to transact the business of credit default insurance in this state.

(c) "Affiliate" means a person which, directly or indirectly, owns at least ten percent but less than fifty percent of the credit default insurance corporation or which is at least ten percent but less than fifty percent, directly or indirectly, owned by a credit default insurance corporation.

(d) "Aggregate net liability" means the aggregate amount of insured unpaid principal, interest and other monetary payments, if any, of guarantied obligations insured or assumed, less reinsurance ceded and less collateral.

(e) "Asset-backed securities" means:

(1) securities or other financial obligations of an issuer provided that:

(A) the issuer is a special purpose corporation, trust or other entity, or (provided that the securities or other financial obligations constitute an insurable risk) is a bank, trust company or other financial institution, deposits in which are insured by the Bank Insurance Fund or the Savings Insurance Fund (or any successor thereto); and

(B) a pool of assets comprised of securities or other financial obligations expected to generate either cash flow or cash proceeds by the terms of the securities or other financial obligations, or pursuant to leases or other contractual rights, including any expected extensions or renewals thereof, or through a sale in a public or private market for proceeds sufficient to pay the insured obligations:

(i) has been conveyed, pledged or otherwise transferred to or is otherwise owned or acquired by the issuer;

(ii) such pool of assets backs the securities or other financial obligations issued; and

(iii) no asset in such pool, other than an asset directly payable by, guaranteed by or backed by the full faith and credit of the United States government or that otherwise qualifies as collateral under paragraph one or two of subsection (g) of this section, has a value exceeding twenty percent of the pool's aggregate value.

(f) "Average annual debt service" means the amount of insured unpaid principal and interest on an obligation, multiplied by the number of such insured obligations (assuming each obligation represents one thousand dollars par value), divided by the amount equal to the aggregate life of all such obligations (assuming each obligation represents one thousand dollars par value). This definition, expressed as a formula in regard to bonds, is as follows:

Average Annual Debt Service = Total Debt Service x No. of Bonds

_____

Bond Years

Total Debt Service = Insured Unpaid Principal + Interest

Number of Bonds = Total Insured Principal

_____

$1,000

Bond Years = Number of Bonds x Term in Years

Term in Years = Term to maturity based on scheduled amortization or, in the absence of a scheduled amortization in the case of asset-backed securities or other obligations lacking a scheduled amortization, expected amortization, in each case determined as of the date of issuance of the insurance policy based upon the amortization assumptions

employed in pricing the insured obligations or otherwise used by the insurer to determine aggregate net liability.

(g) "Collateral" means:

(1) cash;

(2) the cash flow from specific obligations which are not callable and scheduled to be received based on expected prepayment speed on or prior to the date of scheduled debt service (including scheduled redemptions or prepayments) on the insured obligation provided that (i) such specific obligations are directly payable by, guaranteed by or backed by the full faith and credit of the United States government, (ii) in the case of insured obligations denominated or payable in foreign currency as permitted under paragraph four of subsection (b) of section four of this Act, such specific obligations are directly payable by, guaranteed by or backed by the full faith and credit of such foreign government or the central bank thereof, or (iii) such specific obligations are insured by the same insurer that insures the obligations being collateralized, and the cash flows from such specific obligations are sufficient to cover the insured scheduled payments on the obligations being collateralized;

(3) the market value of investment grade obligations, other than obligations evidencing an interest in the project or projects financed with the proceeds of the insured obligations; or

(4) the face amount of each letter of credit that:

(A) is irrevocable;

(B) provides for payment under the letter of credit in lieu of or as reimbursement to the insurer for payment required under a credit default insurance policy;

(C) is issued, presentable and payable either:

(i) at an office of the letter of credit issuer in the United States; or

(ii) at an office of the letter of credit issuer located in the jurisdiction in which the trustee or paying agent for the insured obligation is located;

(D) contains a statement that either:

(i) identifies the insurer and any successor by operation of law, including any liquidator, rehabilitator, receiver or conservator, as the beneficiary; or

(ii) identifies the trustee or the paying agent for the insured obligation as the beneficiary;

(E) contains a statement to the effect that the obligation of the letter of credit issuer under the letter of credit is an individual obligation of such issuer and is in no way contingent upon reimbursement with respect thereto;

(F) contains an issue date and a date of expiration;

(G) either:

(i) has a term at least as long as the shorter of the term of the insured obligation or the term of the credit default insurance policy; or

(ii) provides that the letter of credit shall not expire without thirty days prior written notice to the beneficiary and allows for drawing under the letter of credit in the event that, prior to expiration, the letter of credit is not renewed or extended or a substitute letter of credit or alternate collateral meeting the requirements of this subsection is not provided;

(H) states that it is governed by the laws of the state of [insert state] or by the 1983 or 1993 Revision of the Uniform Customs and Practice for Documentary Credits of the International Chamber of Commerce (Publication 400 or 500) or any successor Revision if approved by the superintendent, and contains a provision for an extension of time, of not less than thirty days after resumption of business, to draw against the letter of credit in the event that one or more of the occurrences described in Article 19 of Publication 400 or 500 occurs; and

(I) is issued by a bank, trust company, or savings and loan association that:

(i) is organized and existing under the laws of the United States or any state thereof or, in the case of a non-domestic financial institution, has a branch or agency office licensed under the laws of the United States or any state thereof and is domiciled in a member country of the Organisation for Economic Co-operation and Development having a sovereign rating in one of the top two generic lettered rating classifications by a securities rating agency acceptable to the superintendent;

(ii) has (or is the principal operating subsidiary of a financial institution holding company that has) a long-term debt rating of at least investment grade; and

(iii) is not a parent, subsidiary or affiliate of the trustee or paying agent, if any, with respect to the insured obligation if such trustee of paying agent is the named beneficiary of the letter of credit.

(h) "Commercial real estate" means income producing real property other than residential property consisting of less than five units.

(i) (1) "Consumer debt obligations" guaranties means credit default insurance that indemnifies a purchaser or lender against loss or damage resulting from defaults on a pool of debts owed for extensions of credit (including in respect of installment purchase agreements and leases) to individuals, provided in the normal course of the purchaser's or lender's business, provided that (A) such pool meets the requirements of subparagraph (B) of paragraph 1 of subsection (e) of this section and (B) such pool has been determined to be investment grade.

(2) Consumer debt obligations guaranty policies shall contain a provision that all coverage under the policies terminates upon sale or transfer of the underlying consumer debt obligation to any transferee not insured by the same insurer under a similar policy.

(j) "Contingency reserve" means an additional liability reserve established to protect policyholders against the effects of adverse economic developments or cycles or other unforeseen circumstances.

(k) "Governmental unit" means the United States of America, Canada, a member country of the Organisation for Economic Co-operation and Development having a sovereign rating in one of the top two generic lettered rating classifications by a securities rating agency acceptable to the superintendent, a state, territory or possession of the United States of America, the District of Columbia, a province of Canada, a municipality, or a political subdivision of any of the foregoing, or any public agency or instrumentality thereof.

(l) "Excess spread" means, with respect to any insured issue of asset-backed securities, the excess of (A) the scheduled cash flow on the underlying assets that is reasonably projected to be available, over the term of the insured securities after payment of the expenses associated with the insured issue, to make debt service payments on the insured securities over (B) the scheduled debt service requirements on the insured securities, provided that such excess is held in the same manner as collateral is required to be held under subsection (g) of this section.

(m) "Industrial development bond" means any security or other instrument, other than a utility first mortgage obligation, under which a payment obligation is created, issued by

or on behalf of a governmental unit, to finance a project serving a private industrial, commercial or manufacturing purpose, and not payable or guarantied by a governmental unit.

(n) "Insurable risk" means, with respect to asset-backed securities, as defined in subsection (e) of this section, that such obligation on an uninsured basis has been determined to be not less than investment grade based solely on the pool of assets backing the insured obligation or securing the insurer, without consideration of the creditworthiness of the issuer.

(o) "Investment grade" means that:

(1) the obligation or parity obligation of the same issuer has been determined to be in one of the top four generic lettered rating classifications by a securities rating agency acceptable to the superintendent;

(2) the obligation or parity obligation of the same issuer has been identified in writing by such rating agency to be of investment grade quality; or

(3) if the obligation or parity obligation of the same issuer has not been submitted to any such rating agency, the obligation is determined to be investment grade (as indicated by a rating in category 1 or 2) by the Securities Valuation Office of the National Association of Insurance Commissioners.

(p) "Municipal bonds" means municipal obligation bonds and special revenue bonds.

(q) "Municipal obligation bond" means any security or other instrument, including a lease payable or guaranteed by the United States or another national government that qualifies as a governmental unit or any agency, department or instrumentality thereof, or by a state or an equivalent political subdivision of another national government that qualifies as a governmental unit, but not a lease of any other governmental unit, under which a payment obligation is created, issued by or on behalf of or payable or guaranteed by a governmental unit or issued by a special purpose corporation, special purpose trust or other special purpose legal entity to finance a project serving a substantial public purpose, and which is:

(1) (A) payable from tax revenues, but not tax allocations, within the jurisdiction of such governmental unit;

(B) payable or guaranteed by the United States or another national government that qualifies as a governmental unit, or any agency, department or instrumentality thereof, or by a housing agency of a state or an equivalent subdivision of another national government that qualifies as a governmental unit;

(C) payable from rates or charges (but not tolls) levied or collected in respect of a nonnuclear utility project, public transportation facility (other than an airport), or public higher education facility; or

(D) with respect to lease obligations, payable from future appropriations; and

(2) provided that, in the case of obligations of a special purpose corporation, special purpose trust or other special purpose legal entity, (A) such obligations are investment grade at the time of issuance; (B) such obligations are payable from sources enumerated in subparagraph (A), (B), (C) or (D) of paragraph one of this subsection; and (C) the project being financed or the tolls, tariffs, usage fees or other similar rates or charges for its use are subject to regulation or oversight by a governmental unit.

(r) "Reinsurance" means cessions qualifying for credit under section six of this Act.

(s) “Superintendent” means the Superintendent, Commissioner, or Director of the Department of Insurance.

(t) "Special revenue bond" means any security or other instrument, under which a payment obligation is created, issued by or on behalf of or payable or guaranteed by a governmental unit to finance a project serving a substantial public purpose, and not payable from any of the sources enumerated in subsection (q) of this section; or securities which are the functional equivalent of the foregoing issued by a not-for-profit corporation or a special purpose corporation, special purpose trust or other special purpose legal entity; provided that, in the case of obligations of a special purpose corporation, special purpose trust or other special purpose legal entity,

(1) such obligations are investment grade at the time of issuance;

(2) such obligations are not payable from the sources enumerated in subparagraph (A), (B), (C) or (D) of paragraph one of subsection (q) of this section; and

(3) the project being financed or the tolls, tariffs, usage fees or other similar rates or charges for its use are subject to regulation or oversight by a governmental unit.

(u) "Utility first mortgage obligation" means any obligation of an issuer secured by a first priority mortgage on utility property owned by or leased to an investor-owned or cooperative-owned utility company and located in the United States, Canada or a member country of the Organisation for Economic Co-operation and Development having a sovereign rating in one of the top two generic lettered rating classifications by a securities rating agency acceptable to the superintendent; provided that the utility or utility property or the usage fees or other similar utility rates or charges are subject to regulation or oversight by a governmental unit.

Section 2. Organization; Financial Requirements

(a) A credit default insurance corporation may be organized and licensed in the manner prescribed in section [insert relevant state law here] and a foreign insurer may be licensed in the manner prescribed in section [insert relevant state law here], except as modified by the following provisions:

(1) a corporation organized for the purpose of transacting credit default insurance may, subject to all the applicable provisions of this chapter, be licensed to transact only the following additional kinds of insurance:

(A) residual value insurance, as defined in [insert state statute defining residual value insurance];

(B) surety insurance, as defined in [insert state statute defining surety insurance]; and

(C) credit insurance, as defined in [insert state statute defining credit insurance]; and

(D) financial guaranty insurance, as defined in [insert state statute defining financial guaranty insurance].

[DRAFTING NOTE: Conversely, a financial guaranty insurer should be permitted to write credit default insurance, as financial guaranty insurance is similar in risk profile to credit default insurance, as defined in this act.]

(2) a credit default insurance corporation may only assume those kinds of insurance for which it is licensed to write direct business;

(3) prior to the issuance of a license, unless a plan of operation has been previously approved by the superintendent, a corporation shall submit for the approval of the superintendent a plan of operation, detailing the types and projected diversification of guaranties that will be issued, the underwriting procedures that will be followed, managerial oversight methods, investment policies, and such other matters as may be prescribed by the superintendent; and

(4) a credit default insurance corporation's investments in any one entity insured by that corporation shall not exceed four percent of its admitted assets at last year-end, except that this limit shall not apply to investments payable or guaranteed by a United States governmental unit or [insert state] state if such investments payable or guaranteed by the United States governmental unit or [insert state] shall be rated in one of the top two generic lettered rating classifications by a securities rating agency acceptable to the superintendent.

(b) A credit default insurance corporation shall not transact business unless it has paid-in capital of at least fifteen million dollars and paid-in surplus of at least one hundred and sixty-five million
dollars, and shall at all times thereafter maintain a minimum surplus to policyholders of at least one hundred and fifty million dollars.

(c) A credit default insurance company shall be deemed to be in compliance with [insert relevant state law here] if not less than sixty percent of the amount of the required minimum capital or minimum surplus to policyholder investments shall consist of the types specified in [insert relevant state law here] and direct government obligations of any state of the United States or of any county, district or municipality thereof, provided such government obligations have been given the highest quality designation of the Securities Valuation Office of the National Association of Insurance Commissioners. Before investing any part of the required minimum capital or surplus in direct government obligations of any other state of the United States or of any county, district or municipality thereof, such credit default insurance company shall have invested at least ten percent of such required minimum in government obligations of [insert state] state or of any county, district or municipality thereof. Only for purposes of meeting the required investment in government obligations of [insert state] state, the insurer may count investments in any government obligation of [insert state] state, whether direct or otherwise.

Section 3. Contingency, Loss and Unearned Premium Reserves; Collateral

(a) Contingency reserves.

> (1) A corporation shall establish and maintain contingency reserves for the protection of insureds and claimants against the effects of excessive losses occurring during adverse economic cycles.
>
> (2) With respect to credit default insurance of municipal obligation bonds, special revenue bonds, industrial development bonds and utility first mortgage obligations written on and after the first day of the next calendar quarter commencing after the date that this Act shall become law:
>
> > (A) the insurer shall establish and maintain a contingency reserve for all such insured issues in each calendar year for each category listed in subparagraph (B) of this paragraph;
> >
> > (B) the total contingency reserve required shall be the greater of fifty percent of premiums written for each such category or the following amount prescribed for each such category:
> >
> > > (i) municipal obligation bonds, 0.55 percent of principal guarantied;

(ii) special revenue bonds, and obligations demonstrated to the satisfaction of the superintendent to be the functional equivalent thereof, 0.85 percent of principal guarantied;

(iii) investment grade industrial development bonds, secured by collateral or having a term of seven years or less, and utility first mortgage obligations, 1.0 percent of principal guarantied;

(iv) other investment grade industrial development bonds, 1.5 percent of principal guarantied; and

(v) all other industrial development bonds, 2.5 percent of principal guarantied; and

(C) Contributions to the contingency reserve required by this paragraph, equal to one-eightieth of the total reserve required, shall be made each quarter for twenty years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in items (i) through (v) of subparagraph (B) of this paragraph exceeds the percentages contained in such items (i) through (v) when applied against unpaid principal.

(3) With respect to all other credit default insurance written on or after the first day of the next calendar quarter commencing after the date that this Act shall become law:

(A) the insurer shall establish and maintain a contingency reserve for all such insured issues in each calendar year for each such category listed in subparagraph (B) of this paragraph;

(B) the total contingency reserve required shall be the greater of fifty percent of premiums written for each such category or the following amount prescribed for each such category:

(i) investment grade obligations, secured by collateral or having a term of seven years or less, 1.0 percent of principal guarantied;

(ii) other investment grade obligations, 1.5 percent of principal guarantied;

(iii) non-investment grade consumer debt obligations, 2.0 percent of principal guarantied;

(iv) non-investment grade asset-backed securities, 2.0 percent of principal guarantied;

(v) other non-investment grade obligations, 2.5 percent of principal guarantied; and

(C) Contributions to the contingency reserve required by this paragraph, equal to one-sixtieth of the total reserve required, shall be made each quarter for fifteen years, provided, however, that contributions may be discontinued so long as the total reserve for all categories listed in items (i) through (v) of subparagraph (B) of this paragraph exceeds the percentages contained in such items (i) through (v) when applied against unpaid principal.

(4) Contingency reserves required in paragraphs two and three of this subsection may be established and maintained net of collateral and reinsurance, provided that, in the case of reinsurance, the reinsurance agreement requires that the reinsurer shall, on or after the effective date of the reinsurance, establish and maintain a reserve in an amount equal to the amount by which the insurer reduces its contingency reserve, and contingency reserves required in paragraphs two and three of this subsection may be maintained:

(A) net of refundings and refinancings to the extent the refunded or refinanced issue is paid off or secured by obligations which are directly payable or guarantied by the United States government and

(B) net of insured securities in a unit investment trust or mutual fund that have been sold from the trust or fund without insurance.

(5) The contingency reserves may be released thereafter in the same manner in which they were established and withdrawals therefrom, to the extent of any excess, may be made from the earliest contributions to such reserves remaining therein:

(A) with the prior written approval of the superintendent:

(i) if the actual incurred losses for the year, in the case of the categories of guaranties subject to paragraph two of this subsection exceeds thirty-five percent of earned premiums, or in the case of the categories of guaranties subject to paragraph three of this subsection exceed sixty-five percent of earned premiums; or

(ii) if the contingency reserve applicable to the categories of credit default insurance subject to paragraph two of this subsection has been in existence for less than forty quarters, or for less than thirty quarters for the categories of guaranties subject to paragraph three of this subsection, upon a demonstration satisfactory to the superintendent that the amount carried is excessive in relation to

the insurer's outstanding obligations under its credit default insurance.

(B) upon thirty days prior written notice to the superintendent, provide that the contingency reserve applicable to the categories of credit default insurance subject to paragraph two of this subsection has been in existence for forty quarters, or thirty quarters for categories of credit default insurance subject to paragraph three of this subsection, upon a demonstration satisfactory to the superintendent that the amount carried is excessive in relation to the insurer's outstanding obligations under its credit default insurance.

(6) An insurer providing credit default insurance may invest the contingency reserve in tax and loss bonds (or similar securities) purchased pursuant to section 832(e) of the Internal Revenue Code (or any successor provision), only to the extent of the tax savings resulting from the deduction for federal income tax purposes of a sum equal to the annual contributions to the contingency reserve. The contingency reserve shall otherwise be invested only in classes of securities or types of investments specified in [insert relevant state law here].

(b) Loss reserves.

(1) The case basis method or such other method as may be prescribed by the superintendent shall be used to establish and maintain loss reserves, net of collateral, for claims reported and unpaid, in a manner consistent with [insert relevant state law here]. A deduction from loss reserves shall be allowed for the time value of money by application of a discount rate equal to the average rate of return on the admitted assets of the insurer as of the date of the computation of any such reserves. The discount rate shall be adjusted at the end of each calendar year.

(2) If the insured principal and interest on a defaulted issue of obligations due and payable during any three years following the date of default exceeds ten percent of the insurer's surplus to policyholders and contingency reserves, its reserve so established shall be supported by a report from an independent source acceptable to the superintendent.

(c) Unearned premium reserve.
An unearned premium reserve shall be established and maintained net of reinsurance and collateral with respect to all credit default insurance premiums. Where credit default insurance premiums are paid on an installment basis, an unearned premium reserve shall be established and maintained, net of reinsurance and collateral, computed on a daily or monthly pro rata basis. All other credit default insurance premiums written shall be earned in proportion with the expiration of exposure, or by such other method as may be prescribed by the superintendent.

(d) Collateral must be deposited with the insurer; held in trust by a trustee or custodian acceptable to the superintendent for the benefit of the insurer; or held in trust pursuant to the bond indenture or
other trust arrangement, for the benefit of holders of insured obligations in the form of funds for the payment of insured obligations, sinking funds or other reserves which may be used for the payment of insured obligations and trustee and other administrative fees on a first priority basis established and continually maintained pursuant to the bond indenture or other trust arrangement by a trustee acceptable to the superintendent. The superintendent may promulgate regulations to limit the amount of collateral provided by obligations, letters of credit or credit default insurance contracts or to limit the amount of collateral provided by any single issuer, bank or counterparty as provided for in this subsection.

Section 4. Limitations

(a) Credit default insurance may be transacted in this state only by a corporation licensed for such purpose pursuant to section two of this Act.

(b) Permissible credit default insurance.

(1) The superintendent shall not permit the writing of credit default insurance except where the insured or beneficiary under the policy, bond or contract has, or is expected to have at the time of the default or other failure of the obligor under the debt instrument or other monetary obligation, a material interest in such default or other failure; and a corporation may insure the timely payment of United States dollar debt instruments, or other monetary obligations, only in the following categories:

(A) municipal obligation bonds;

(B) special revenue bonds;

(C) industrial development bonds;

(D) investment grade obligations of the government of a country, municipality, or a political subdivision of any of the foregoing, or any public agency or instrumentality thereof if that entity does not meet the definition of a governmental unit;

(E) obligations of corporations, trusts or other similar entities established under applicable law;

(F) partnership obligations;

(G) asset-backed securities, trust certificates and trust obligations, provided that,

(i) with respect to mortgage-backed securities secured by first mortgages on real property which are insurable by a mortgage guaranty insurer authorized under [insert relevant state law here]:

(I) such mortgages with loan-to-value ratios in excess of eighty percent are:

(aa) in the case of mortgages on property located in the state of [insert state], insured by mortgage guaranty insurers authorized under [insert relevant state law here];

(bb) in the case of mortgages on property located in a state other than the state of [insert state], insured by mortgage guaranty insurers authorized to do business in such other state; or

(cc) in an aggregate principal amount less than the single risk limits prescribed in paragraph five of subsection (d) of this section; or

(II) additional mortgages with principal balances, other collateral with a market value, or (provided the insured risk is investment grade) excess spread in an amount, in each instance at least equal to the coverage that would otherwise be provided by such mortgage guaranty insurers in accordance with clause (I) of this item are pledged as additional security for the asset-backed securities; or

(ii) with respect to any asset-backed securities backed by another pool of asset-backed securities:

(I) the pool of asset-backed securities shall be comprised of assetbacked securities having a right to payment and rights in insolvency that are not subordinated to any other security of the issuer, in the event of a payment default by, or rehabilitation or insolvency of, the issuer;

(II) the credit default insurer shall possess control and remediation rights substantially similar to those held by the most senior class of securities of the issuer of the insured obligations backed by the same pool of assets;

(III) the pool consists of asset-backed securities that are issued or guaranteed by a governmental unit, Federal

National Mortgage Association, Federal Home Loan Mortgage Corporation, Federal Home Loan Bank, the Federal Agricultural Mortgage Corporation, or the Federal Farm Credit System Banks as a consolidated debt obligation or a system wide debt obligation to the extent that the obligations are covered by the Farm Credit Insurance Fund;

(IV) the pool consists entirely of asset-backed securities insured by the credit default insurer; or

(V) the superintendent has determined that insuring the asset-backed securities does not present undue risk to the credit default insurer;

(H) installment purchase agreements executed as a condition of sale;

(I) consumer debt obligations;

(J) utility first mortgage obligations; and

(K) any other debt instrument or financial obligation that the superintendent determines to be substantially similar to any of the foregoing or shall otherwise be approved by the superintendent.

(2) An insurer may insure obligations enumerated in subparagraphs (A), (B), and (C) of paragraph one of this subsection that are not investment grade so long as at least ninetyfive percent of the insurer's aggregate net liability on the kinds of obligations enumerated in subparagraphs (A), (B) and (C) of paragraph one of this subsection shall be investment grade.

(3) A corporation may insure the timely payment of monetary obligations in any category designated in this subsection notwithstanding that such obligation may be insured by an insurance policy issued by another insurer. In the event that any obligation is insured by more than one credit default insurance policy, then each such insurance policy may by its terms specify its priority of payment in the event of a default under the obligation insured or any other insurance policy; provided that an insurer shall be entitled to take into account payment under another policy insuring such obligation for purposes of establishing and maintaining loss reserves only to the extent that the policy issued by such insurer provides for payment only in the event of payment default under both such obligation and the other policy.

(4) A corporation may also write credit default insurance as defined in paragraph one of subsection (a) of section one of this Act to insure the timely payment of non-United States dollar debt instruments or other monetary obligations denominated or payable in foreign currency, only for the categories listed in subparagraphs (A) through (K) of paragraph one of this subsection, provided that:

(A) such currency is that of an Organisation for Economic Co-operation and Development country or such other country (i) whose sovereign rating is investment grade or (ii) as shall not otherwise be disapproved by the superintendent within thirty days following receipt of written notification. The superintendent shall not disapprove such notification upon demonstration that there is no undue risk associated with insuring the timely payment of such instruments or obligations. In making such a determination the superintendent shall take into consideration the corporation's outstanding liabilities on noninvestment grade instruments and obligations in relation to its outstanding liabilities on all instruments and obligations and in relation to the amount of its surplus to policyholders;

(B) reserves required pursuant to section three of this Act in regard to such obligations shall be established and adjusted quarterly based upon the then current foreign exchange rates;

(C) such obligations shall not exceed twenty-five percent of an insurer's aggregate net liability; and

(D) the aggregate and single risk limitations prescribed by subsections (c) and (d) of this section shall be determined by applying the then current foreign exchange rates.

(c) Aggregate risk limits. The corporation must at all times maintain surplus to policyholders and contingency reserves in the aggregate no less than the sum of:

(1) (A) 0.3333 percent or 1/300th of the aggregate net liability under credit default insurance in which the underlying obligations are municipal bonds including obligations demonstrated to the satisfaction of the superintendent to be the functional equivalent thereof and investment grade utility first mortgage obligations; plus

(B) 0.6666 percent or 1/150th of the aggregate net liability under credit default insurance in which the underlying obligations are investment grade asset-backed securities; plus

(C) 1.0 percent or 1/100th of the aggregate net liability under credit default insurance in which the underlying obligations are secured by collateral or having a term of seven years or less, of:

(i) investment grade industrial development bonds,

(ii) other investment grade obligations; plus

(D)1.5 percent or 1/66.67th of the aggregate net liability under credit default insurance in which the underlying obligations are investment grade obligations; plus

(E) 2.0 percent or 1/50th of the aggregate net liability under credit default insurance in which the underlying obligations are:

(i) non-investment grade consumer debt obligations, and

(ii) non-investment grade asset-backed securities; plus

(F) 2.5 percent or 1/40th of the aggregate net liability under credit default insurance in which the underlying obligations are non-investment grade obligations secured by first mortgages on commercial real estate and having loan-to-value ratios of eighty percent or less; plus

(G) 4.0 percent or 1/25th of the aggregate net liability under credit default insurance in which the underlying obligations are other non-investment grade obligations; and

(H) if the amount of collateral required by subparagraph (C) of this paragraph is no longer maintained, that proportion of the obligation insured which is not so collateralized shall be subject to the aggregate limits specified in subparagraph (D) of this paragraph; and

(2) surplus to policyholders determined by the superintendent to be adequate to support the writing of residual value insurance, surety insurance and credit insurance, if the corporation has elected to transact such kinds of insurance pursuant to subsection (a) of section two of this Act.

(d) Single risk limits. A credit default insurance corporation shall limit its exposure to loss on any one risk insured by policies providing credit default insurance, net of collateral and reinsurance, as follows:

(1) for municipal obligation bonds, special revenue bonds, and obligations demonstrated to the satisfaction of the superintendent to be the functional equivalent thereof:

(A) the insured average annual debt service with respect to a single entity and backed by a single revenue source shall not exceed ten percent of the

aggregate of the insurer's surplus to policyholders and contingency reserve; and

(B) the insured unpaid principal issued by a single entity and backed by a single revenue source shall not exceed seventy-five percent of the aggregate of the insurer's surplus to policyholders and contingency reserve;

(2) for each issue of asset-backed securities issued by a single entity and for each pool of consumer debt obligations, the lesser of:

(A) insured average annual debt service; or

(B) insured unpaid principal (reduced by the extent to which the unpaid principal of the supporting assets and, provided the insured risk is investment grade, excess spread exceed the insured unpaid principal) divided by nine; shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve, provided that no asset in the pool supporting the asset-backed securities exceeds the single risk limits prescribed in paragraph five of this subsection, if insured; and provided further that, if the issuer of such insured asset-backed securities is a special purpose corporation, trust or other entity and such issuer shall have indebtedness outstanding with respect to any other pool of assets, either such other indebtedness shall be entitled to the benefits of a credit default insurance policy of the same insurer, or such other indebtedness shall: (i) be fully subordinated to the insured obligation, with respect to, or be non-recourse with respect to, the pool of assets that supports the insured obligation, (ii) be nonrecourse to the issuer other than with respect to the asset pool securing such other indebtedness and proceeds in excess of the proceeds necessary to pay the insured obligation ("excess proceeds") and (iii) not constitute a claim against the issuer to the extent that the asset pool securing such other indebtedness or excess proceeds are insufficient to pay such other indebtedness and provided further that, in the case of asset-backed securities that are subordinate, in right of payment in the event of an issuer insolvency, to any other securities of the issuer backed by the same pool of assets, for purposes of this subparagraph (2) only, the insured average annual debt service and insured unpaid principal shall be deemed to be the lesser of: (I) three hundred percent of the insured average annual debt service and insured unpaid principal respectively or (II) the insured average annual debt service and insured unpaid principal respectively if the scheduled principal of and interest on all senior securities of the issuer were included in the amount insured by the insurer for purposes of calculating insured average annual debt service and insured unpaid principal.

(3) for obligations issued by a single entity and secured by commercial real estate, and not meeting the definition of asset-backed securities, the insured unpaid principal less fifty percent of the appraised value of the underlying real estate shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve;

(4) for utility first mortgage obligations, the insured average annual debt service shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve; and

(5) for all other policies providing credit default insurance with respect to obligations issued by a single entity and backed by a single revenue source, the insured unpaid principal shall not exceed ten percent of the aggregate of the insurer's surplus to policyholders and contingency reserve.

(e) If an insurer at any time exceeds any limitation prescribed by subsection (c) or (d) of this section or the last sentence of paragraph one of subsection (b) of this section, the insurer shall within thirty days after the limitations are breached, submit a written plan to the superintendent detailing the steps that it will take or has taken to reduce its exposure to loss to no more than the permitted amounts, and if after notice and hearing the superintendent determines that an insurer has exceeded any limitation prescribed by this section, he may order such insurer to cease transacting any new credit default insurance business until its exposure to loss no longer exceeds said limitations or with respect to the limitations prescribed in the last sentence of paragraph one of subsection (b) of this section, may order such insurer to limit its writing of the types of credit default insurance permitted under subparagraphs (A), (B) and (C) of paragraph one of subsection (b) of this section to investment grade obligations until such time as it shall be in compliance with such limitations.

(f) No insurer authorized to transact the business of credit default insurance shall pay any commission or make any gift of money, property or other valuable thing to any employee, agent or representative of any potential purchaser of a credit default insurance policy, as an inducement to the purchase of such a policy, and no such employee, agent or representative of such potential purchaser shall receive any such payment or gift. Violation of the provisions of this section shall not, however, have the effect of rendering void the insurance policy issued by the insurer.

Section 5. Policy Forms and Rates

(a) Policy forms and any amendments thereto shall be filed with the superintendent within thirty days of their use by the insurer if not otherwise filed prior to the effective date of this Act.

(b) Every credit default insurance policy shall provide that, in the event of a payment default by or insolvency of the obligor, there shall be no acceleration of the payment

required to be made under such policy unless the acceleration is permitted by the credit default insurer at its sole option, exercised at the time of the payment.

(c) A credit default insurance policy shall not provide that commencement of rehabilitation, liquidation or conservatorship proceedings under [insert appropriate section of state law], bankruptcy or any other similar proceedings whether under the laws of this state or another state, with respect to a credit default insurer or the insured accelerates any payment required to be made under the policy, absent a payment default by the obligor or the insurer.

(d) A credit default insurance policy may provide that either the credit default insurer or the insured may terminate the policy as a consequence of the commencement of rehabilitation, liquidation or conservatorship proceedings under [insert appropriate section of state law], bankruptcy or any other similar proceedings, whether under the laws of this state or another state, with respect to a credit default insurer or the insured, provided that the termination:

(1) does not accelerate or otherwise increase the obligation of the credit default insurer to make scheduled payments when due under the policy; and

(2) does not require the insurer to make any additional payment to the insured by reason of the termination.

(e) The superintendent by regulation may prescribe minimum policy provisions determined by the superintendent to be necessary or appropriate to protect credit default insurers, policyholders, claimants, obligees or indemnitees or the people of this state.

(f) Rates shall not be excessive, inadequate, unfairly discriminatory, destructive of competition, detrimental to the solvency of the insurer, or otherwise unreasonable. In determining whether rates comply with the foregoing standards, the superintendent shall include all income earned by such insurer. Criteria and guidelines utilized by insurers in establishing rating categories and ranges of rates to be utilized shall be filed with the superintendent for information prior to their use by the insurer if not otherwise filed prior to the effective date of this Act.

(g) All such filings shall be available for public inspection at the insurance department.

Section 6. Reinsurance

(a) For credit default insurance that takes effect on or after the effective date of this Act, an insurer authorized to transact credit default insurance shall receive credit for reinsurance, in accordance with the provisions of this chapter applicable to property/casualty insurers, as an asset or as a reduction from liabilities provided that such reinsurance is subject to an agreement that, for its stated term and with respect to any such reinsured credit default insurance in force, the reinsurance agreement (facultative or treaty) may only be terminated or amended (i) at the option of the reinsurer or the ceding

insurer, if the reinsurance agreement provides that the liability of the reinsurer with respect to policies in effect at the date of termination shall continue until the expiration or cancellation of each such policy, or (ii) with the consent of the ceding company, if the reinsurance agreement provides for a cutoff of the reinsurance in force at the date of termination, or (iii) at the discretion of the superintendent acting as rehabilitator, liquidator or receiver of the ceding or assuming insurer; and provided that such reinsurance is:

(1) placed with a credit default insurance corporation licensed under this Act or an insurer writing only credit default insurance as is or would be permitted by this Act; or

(2) placed with a property/casualty insurer or an accredited reinsurer licensed or accredited to reinsure risks of every kind or description (including municipal obligation bonds), as set forth in [insert relevant p/c insurance section of state law here] of this chapter, if the reinsurance agreement with such insurer requires that such insurer:

(A) have and maintain surplus to policyholders of at least thirty-five million dollars;

(B) establish and maintain the reserves required in section three of this Act, except that if the reinsurance agreement is not pro rata the contribution to the contingency reserve shall be equal to fifty percent of the quarterly earned reinsurance premium. However, the assuming insurer need not establish and maintain such reserve to the extent that the ceding insurer has established and continues to maintain such reserve;

(C) comply with the provisions of subsection (c) of section four of this Act, except that the maximum total exposures reinsured net of retrocessions and collateral shall be one-half of that permitted for a credit default insurance corporation;

(D) if a parent of the insurer, another subsidiary of the parent of the insurer, or a subsidiary of the insurer, then the aggregate of all risks assumed by such reinsurers shall not exceed ten percent of the insurer's exposures, net of retrocessions and collateral. Direct or indirect ownership interests of fifty percent or more shall be deemed a parent/subsidiary relationship;

(E) if an affiliate of the insurer, such affiliate shall not assume a percentage of the insurer's total exposures insured net of retrocessions and collateral in excess of its percentage of equity interest in the insurer; and

(F) assumes from the credit default insurance corporation and any affiliate, parent of the insurer, another subsidiary of the parent of the insurer, or

subsidiary of the insurer that is a credit default insurance corporation or an insurer writing only
credit default insurance as is or would be permitted by this Act, together with all other reinsurers subject to this paragraph, less than fifty percent of the total exposures insured by the credit default insurance corporation and such affiliates, parents or subsidiaries of the insurer, net of collateral, remaining after deducting any reinsurance placed with another credit default insurance corporation that is not an affiliate, a parent of the credit default insurance corporation, another subsidiary of the parent of the insurer, or a subsidiary of the insurer or a credit default insurance corporation writing only credit default insurance as is or would be permitted by this Act that is not an affiliate, a parent of the credit default insurance corporation, another subsidiary of the parent of the insurer, or a subsidiary of the insurer; or

(3) if placed with an unauthorized or unaccredited reinsurer which otherwise meets the requirements of either the opening paragraph of this subsection and paragraph one of this subsection, or the opening paragraph of this subsection and subparagraphs (A), (D), (E) and (F) of paragraph two of this subsection, in an amount not exceeding the liabilities carried by the ceding insurer for amounts withheld under a reinsurance treaty with such reinsurer or amounts deposited by such reinsurer as security for the payment of obligations under the treaty if such funds or deposit are held subject to withdrawal by, and under the control of, the ceding insurer.

(b) In determining whether the insurer meets the aggregate risk limitations, in addition to credit for other types of qualifying reinsurance, the insurer's aggregate risk may be reduced to the extent of the limit for aggregate excess reinsurance, but in no event in an amount greater than the amount of the aggregate risks which will become due during the unexpired term of such reinsurance agreement in excess of the insurer's retention pursuant to such reinsurance agreement.

Section 7. Applicability of Other Laws

An insurer issuing policies of credit default insurance shall be subject to all of the provisions of this chapter applicable to property/casualty insurers to the extent that such provisions are not inconsistent with the provisions of this Act.

Section 8. Relationship to Security Fund

No insurer or agent of an insurer may deliver a policy of credit default insurance unless such policy and any prospectus delivered on or after the effective date of this Act with respect to the insured obligations clearly discloses that the policy is not covered by the property/casualty insurance security fund specified in [insert relevant state law here].

Section 9. Penalties

(a) It is a violation of this Act for any credit default insurance corporation, affiliate, or any other party related to the business of credit default insurance to sell credit default insurance not permissible under section four of this Act.

(b) For criminal liability purposes, every violation of any provision of this Act shall, unless the same constitutes a felony, be a misdemeanor.

(c) The superintendent shall be empowered to levy a civil penalty not exceeding [insert appropriate state fine] and the amount of the claim for each violation upon any person who is found to have violated any provision of this Act.

(d) The license of a person licensed under this Act that sells credit default insurance not permissible under section four of this Act shall be revoked for a period of at least [insert appropriate state penalty].

Section 10. Transition Provision

(a) (1) A company organized for the purpose of transacting financial guaranty insurance in its state of domicile or any other state on the effective date of this Act and licensed and operating in this state as a provider of surety insurance on the effective date of this Act, upon application by such company within one year of the effective date of this Act, shall be issued a license pursuant to Section 2 of this Act and, before and after such license is issued, may engage in the business of credit default insurance, provided that such company meets all requirements of this Act, except the requirements described in subparagraph (2) of this paragraph, before (insert effective date) to transact business as a credit default insurance corporation in this state.

(2) A company described in (a)(1) of this section must meet all of the requirements of this Act, with the following exceptions:

(A) Such company shall not be deemed to be in violation of any provision of this Act with respect to credit default insurance policies outstanding prior to the effective date of this Act, if the insurer was in compliance with the applicable provisions relating to financial guaranty insurance in its state of domicile at the time that the credit default insurance policy was issued, provided that this Act shall apply to such policies that are amended or replaced on or after the effective date of this Act if such amendment of the original policy extends the term or the replacement policy provides a new term that extends beyond the term of the original policy in effect on the effective date of this Act, unless such amendment or replacement complies with subparagraph (B) of this paragraph;

(B) Such company shall not be deemed to be in violation of any provision of this Act with respect to any amendment or replacement of a credit

default insurance policy issued prior to the effective date of this Act, provided that:

(i) the amendment or replacement of the original policy is executed in good faith to mitigate losses or reduce exposure to future losses under the original policy; and

(ii) the company provides notice to the superintendent of such amendment or replacement within ten (10) business days of the amendment or replacement;

(C) before (insert date ten years after effective date) the following requirements of this Act shall not apply to such company:

(i) Section 2(b) regarding paid-in capital and surplus requirements and minimum surplus to policyholders;

(ii) Section 4(c), (d), and (e) regarding aggregate and single risk limits.

(3) The superintendent may:

(A) extend the transition time permitted in (a)(2)(C) an additional six (6) months if the superintendent determines that it would not pose a hazard to the insurer, its policyholders or to the public and there are unusual or unique circumstances that justify the extension;

(B) decrease the transition time permitted in (a)(2)(C) if he/she determines, after notice and an opportunity to be heard, that permitting a company to continue transacting credit default insurance poses a hazard to the insurer, its policyholders, or the public;

(4) A company that does not comply with (a)(1) and (2) of this subsection shall cease writing any new credit default insurance.

(b) A company not licensed as an insurance company in this state pursuant to [insert state financial guaranty or surety law, if applicable] on the effective date of this Act may not engage in the business of credit default insurance until such date as the company shall have received a license from this state pursuant to Section 2 of this Act.

Section 11. Effective Date

(a) This Act shall be effective for all credit default insurance entered into or materially changed as of [insert date]

NCOIL – NAIC DIALOGUE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 15, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Hyatt Regency in Jersey City, New Jersey on Friday, July 15, 2022 at 11:15 a.m.

Representative Tom Oliverson, M.D. of Texas, NCOIL Treasurer and Vice Chair of the Committee, presided.

Other members of the Committee present were:

Asm. Ken Cooley (CA)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Rep. Joe Fischer (KY)
Rep. Brenda Carter (MI)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Brian Lampton (OH)
Rep. Lacey Hull (TX)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Tim Grayson (CA)
Rep. Kerry Wood (CT)
Sen. Mike McLenson (MS)
Sen. Walter Michel (MS)
Rep. Hank Zuber (MS)
Sen. Nellie Pou (NJ)
Rep. Wendi Thomas (PA)

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 Rep. Brian Lampton (OH), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection to adopt the minutes of its March 4, 2022 meeting in Las Vegas, NV.

INTRODUCTORY COMMENTS

Rep. Oliverson stated that as the first time that I've had an opportunity to chair this meeting, I would be remiss if I didn't mention that the Chair, Asm. Kevin Cahill (NY),

NCOIL Vice President, couldn't be with us and we wish him well and wish he was here with us and he is missed. And I'm also very excited that the first time I get to preside over this committee meeting that there is a record attendance level by Insurance Commissioners and I am truly blessed to see all these faces here from all of these different states - big states, small states, blue states, red states. Rep. Oliverson then asked each participating Commissioner to introduce themselves.

DISCUSSION ON INITIATIVES TO PROMOTE HEALTH EQUITY

Rep. Oliverson stated that we wanted to begin today's dialogue with a brief update. Earlier this year the Pennsylvania Insurance Department announced a statement of policy that it would permit entities issuing insurance products regulated by the Department to collect information about race and ethnicity on an application from for diversity, equity and inclusion (DEI) purposes. And colleagues you can find on page 152 in your binders that directive. Commissioner Humphreys I was just wondering if you could give us a brief update as to what led to that and what's the end game here in terms of where we're going with this. The Hon. Mike Humphreys, Acting Pennsylvania Insurance Commissioner, thanked the Committee for the opportunity to speak and stated that it we did issue that statement of policy in April of this year as a result of a number of different kind of conversations. Last year, former PA Commissioner Jessica Altman was the chair of the National Association of Insurance Commissioners (NAIC's) Special Committee on Race and Insurance Workstream on Health. We also separately in Pennsylvania had a series of meetings with our health insurance community in particular to talk about race and ethnicity and DEI efforts in the health space. And there's also a federal component here that I'll get to in a minute. The health insurers actually came to us and asked to be able to collect race and ethnicity data as part of their efforts to advance health equity. They call it the "golden record" similar to what they have in Medicare. Golden record meaning information that's directly provided by the member versus information that health carriers may come to today through providers or other third parties. So, the carriers came to us and at the same time earlier this year the federal government issued its notice of benefit and payment parameters (NBPP) and in that NBPP for next year is a requirement to report data that includes race and ethnicity information.

So, there's a phase-in in how insurers are going to be reporting that but kind of coupled with the federal requirement and now a request from insurers it felt like it was time and what the statement of policy did is it announced non-enforcement of a prohibition that was issued by the Department as guidance in 1969 so it predated our rule process that's in effect today. It has since been treated as a rule. So, in kind of promulgating the statement of policy we did work with the legislative staff and made clear that really this is the short term solution to allow companies to ask the question about race or ethnicity on applications but we would be following up with a more formal process that would go through kind of a rulemaking-like process. So, part of the reason that we felt comfortable and felt it appropriate to issue the statement of policy was it was 1969, a different era, and the policy was effectively superseded by the unfair insurance practices Act that was enacted in Pennsylvania five years later and that Act explicitly prohibits the use of race and ethnicity in underwriting or eligibility. So the protections remain from kind of nefarious uses of information outside of the guidance that that we issued at the time and what I want to stress is there's no requirement related to the statement of policy - not on health companies, not on property & casualty (P&C) companies. We didn't come out and say you must collect. We simply said you may collect and if you're going

to collect when you do that, as kind of best practices you should clearly articulate why you're requesting the information. How it's going to promote equitable care efforts? How are you going to be maintaining it as private?

Rep. Oliverson stated that my only question is if they're not asking the question, you can be pretty sure that they're not using it in underwriting or for nefarious purposes, right? But if they're now going to be able to ask the question, how do you as a department determine the reason and the authenticity I guess or the veracity of why they're asking the question and what they're doing with the data that they're gathering? How are you going to maintain oversight over that? Cmsr. Humphreys stated that I think it would still play itself out in the rate and form filing process. As you all know the companies come to us every year, they file rates, they tell us how they've developed their rates. If there's a suspicion or if we have triggers or complaints from the market analysis side, we could go into a company on the back end through a limited scope exam to see how exactly they're using the information but I think with that kind of frontend review and the opportunity for backend oversight that we feel comfortable that the carriers will be using it appropriately, certainly at the risk of running afoul with not only us at the Department but certainly on the health side at the Centers for Medicare and Medicaid Services (CMS) and the Federal Government.

DISCUSSION ON DEVELOPMENTS IN PRIVATE EQUITY'S ROLE IN THE INSURANCE MARKETPLACE

Rep. Oliverson stated to The Hon. Dean Cameron, NAIC President and Idaho Insurance Commissioner, that we had a pretty good discussion yesterday in a general session regarding private equity's influence and impact on the insurance industry. I think some important questions came out of that. I know the NAIC has been very involved in the area and there have been some letters back and forth with the U.S. Senate Banking Chair and colleagues you can find information on this starting on page 157 of your binder. I was just wondering what's your thought process on this and I know for some of us one of the questions that came up yesterday was sort of we don't see the problem here. What is the issue in terms of private equity versus the bond market or whatever. Dir. Cameron stated that before I answer that, The Hon. Glen Mulready, Oklahoma Insurance Commissioner, was going to go over some additional healthcare items and then we'll come to the private equity side of things.

Cmsr. Mulready stated that I'll provide a quick update on the NAIC's B Committee (health insurance and managed care committee) and some of things that we have been up to and we did send letters to Congress and to the Administration on a few key items. And just to highlight that one was the fix of the "family glitch" that really goes to the definition of affordable coverage and I think many of us saw that as a misinterpretation of affordability when it comes to family coverage and so I think most of you are familiar with that. We sent a letter asking them to fix that and literally a week later or days later the Administration came out with their fix on it. I think it was the week before we sent it out, it was all going through our process and so I joked that just the threat from the B Committee took action on the federal administration. So they have a proposal to that and that fix should provide some more affordability to upwards of five million people on that issue. A letter also went to the House and Senate Tax Committees to try to address that legislatively to try to protect against some legal appeals on that.

Another topic that we sent letters on was the health savings account (HSA) and copay accumulator issue, something NCOIL is familiar with. I know I've heard you talk about it numerous times and with help from our friends at the American Bankers Association (ABA) a number of states passed some legislation to try to address that and it has to do with coupons and third party payment and therefore not being eligible for high deductible health plans. So, we similarly sent letters out to Treasury and as well to the tax committees to try to address that legislatively. And the third item that was in those letters was the extension of the American Rescue Plan Act (ARPA) subsidies that are scheduled to expire at the end of this year and I've been calling it the perfect storm of the Medicaid unwinding. You heard quite a presentation yesterday from Miranda Motter of American's Health Insurance Plans (AHIP) on that and that plus the ARPA subsidies going away is going to be a perfect storm of a number of folks being left without coverage. And so, a letter was sent there encouraging them to extend those somewhat. A couple of other quick things. Medicare Advantage and some of the states have had great difficulty in being limited to only being able to address solvency on licensing issues and we received in our states a lot of complaints this year in the marketing side of things that some of those ads had misrepresentation, but our hands are tied on that. So, there's some effort to look to allow our states to try to address some of those things outside of solvency and licensing. So, a letter went to Congress urging them to allow us to do that. And then we had federal mental health parity. We are not having federal funding provided for that. There has been a letter sent to Congress encouraging grants to the states to help address that issue. The Medicaid unwinding is really front and center on our agenda and how that is going, as well as the No Surprises Act (NSA) and tracking how that is going within our states.

Rep. Oliverson asked Cmsr. Mulready if he has any specific thoughts or if the B committee had any specific thoughts as far as the end of the public health emergency (PHE) and the looming consequences and I feel like that's something we kind of need to be arm and arm in as lawmakers and regulators because there is some tremendous consequences around the bend. Has there been any effort on that as far as here's a roadmap, here's what we need next to get ready for that? Cmsr. Mulready stated that I'm glad you asked as that's part of our agenda in a few weeks here in Portland, Oregon for our next meeting. But prior to that at our previous meeting there was conversation and sort of a call to arms to regulators because I think some regulators weren't as tuned in as others. I think the thinking was well that's Medicaid, we don't regulate Medicaid but not understanding that our Medicaid folks, they understand Medicaid but they don't understand the private market. We understand the private market and what's happening there. So, I know in our state we've been doing a lot, we've been meeting regularly with leadership in our healthcare authority that oversees our Medicaid Agency and providing information to them that they're posting on their webpage. So, really educating out there I think is the key thing as far as our role in that. Rep. Oliverson stated that well they will certainly understand being uninsured and I think that's the thing I worry about coming from a non-expansion state and having a lot of folks that are currently on the rolls that in a non-public health emergency state what sort of the consequences are. I think we all would love to work with the NAIC on making sure that we're kind of prepared for that. Cmsr. Mulready stated that the numbers are a little staggering. I mean you're talking anywhere from five to 14 million people. I know in our state it's over 200,000 that we're expecting to fall off those rolls.

Cmsr. Humphreys stated that Pennsylvania might recommend that when you go back home maybe talk to your Medicaid agencies. CMS has actually issued some guidance

that clarifies that Medicaid managed care organizations (MCO's) with affiliated qualified health plans (QHP's) so both the Medicaid side and now the commercial side, that they can provide members with information about the exchange during that redetermination process. As Cmsr. in Pennsylvania I also chair of our exchange board so the communication between those two groups is very important and I think to the extent that Medicaid agencies may be interested in at least exploring whether to give the MCO's the ability to go and let their members know what the exchange is, that may be something that states would want to consider. Dir. Cameron stated that I would just add that there are some states, ours being one of them, where the exchange is actually working on a direct transfer, a direct pipeline if you will, to help mitigate some of that. And it won't solve all of it because there will still be some people that have to pay for something whereas under Medicaid they weren't but I think we're really gearing up. The Hon. Lori Wing-Heier, Alaska Insurance Director, is leading an effort for the Commissioners to be prepared and we will do a better job of communicating what we're doing with you so that we're all on the same page.

The Hon. Marlene Caride, New Jersey Banking and Insurance Commissioner, stated that here in New Jersey, we've been working with Human Services and we have worked on information that's going to be sent to the individuals who will probably be weaned off of Medicaid so that they have information on the exchange. So, we have been working together on this a long time in order to avoid losing folks and having uninsured individuals as you mentioned. If I may as well, with regards to ARPA, we here in New Jersey were able to use those funds to provide subsidies to individuals that were earning income up to the 600% of the federal poverty level so we had individuals that were making $77,000 that were able to get subsidies to help them pay and make insurance affordable. If we lose the ARPA, we're going to have to readjust all of that and we're going to go back to having a lot of individuals that will not be able to afford insurance so anything that you and your colleagues can do to get that message across at the federal level would be greatly appreciated at least for me because I run the exchange here in New Jersey and I want to recognize Sen. Nellie Pou (NJ) who I worked with very long as an NJ Assemblywoman and now I have the pleasure of working with her as the Commissioner.

Dir. Cameron stated to Rep. Oliverson let's move to private equity and I would say that we as Commissioners generally agree with you. There are things that give us some concern that we're watching but we don't know that there's an action for us as Commissioners just yet. I'm going to turn the time over to Dir. Wing-Heier who will give you more details. Dir. Wing-Heier stated that Dir. Cameron hit the nail on the head. This isn't necessarily a bad thing. Private equity, we need it in the insurance industry not only to look at startups or new products but also existing companies and providing financing where needed. This is not new to the NAIC and in our state framework we have been dealing with this since 2013. We already have guidelines in place to address the corporate structure, risk-based capital, and looking at the financial statements of not only the private equity firm but also in the insurance company within and those that are investing in it. Admittedly, the transactions have become more complex in the last few years and we are currently reevaluating through the NAIC Macroprudential Working Group if we need to go a little bit further delving into the transactions but we do think that at this time we're not seeing a red herring. We're not seeing a hair on fire that this is a bad thing for the industry. It's new, it's becoming more complex, there's becoming more transactions and the NAIC is up to the task. All of us are keeping up with these transactions, the Macroprudential Working Group as well as others such as the Life

Actuarial Task Force are all keeping abreast of the trends and current statutory accounting principles and other guidelines that are in place. They apply to these too and we are watching it.

Rep. Oliverson stated that I appreciate your comments and I have been giving this a lot of thought in the run up to this meeting and then of course with our presentation yesterday and I think the question in my mind that I haven't really heard a good answer to and I'm wondering if you have any thoughts on it is that with private equity when we're talking about modern private equity firms, we're not talking about the corporate raiders of the 80s and 90s where they buy something just to bust it up and sell off the assets and stuff like that. Normally, when private equity gets called into an industry it's because there's an opportunity to improve efficiency, enhance profitability, and I would use the word save that sector and so I the question in my mind is, and I asked this yesterday, what's prompting this? Does the NAIC have any thoughts as to why now? Why all of a sudden is there a role for private equity in insurance marketplaces in our states? Dir. Wing-Heier stated that my personal opinion is that I think that with the low interest rates that have been in for the last decade or so, it's a means for them to get additional capital from those that they're either qualified investors, or an accredited purchaser, and maybe I have the terms wrong but you have to have the wherewithal behind you to come into private equity and I think it's an easier way for some of the insurance companies to raise capital to continue operations when the interest rates in the past few years have been so low they have not been able to make the returns that they hoped they could. So, I think it's another means for them to maintain solvency to pay the clams of the future, particularly in life insurance companies, but we're seeing it in other areas too.

Sen. Beverly Gossage (KS) stated that yesterday it was brought up about Security Benefit Life in Kansas and I called The Hon. Vicky Schmidt, Kansas Insurance Commissioner, and she said that yes this got her team on board and they said this was 2010. It was a real positive for the private equity company to come in and help out and they've just seen nothing but growth and it basically saved that insurer. So, we've seen good results with that in our state. Dir. Wing-Heier thanked Sen. Gossage and stated that when they step up to the plate, they help the companies, and just like any other company or new buyer of an insurance company, we're going to watch it.

Rep. Stephen Meskers (CT) stated that I've sat on the Insurance Committee in Connecticut for four years and what I'm looking for from guidance from the NAIC is either at the State or Federal level what kind of regulatory framework we need to improve transparency and pricing? I worry about the insurance industry and it's in the healthcare industry particularly and the sustainability of the business model where the expenses are compounding somewhere between 7% and 15% a year for insurance coverage and we've moved around the needle with higher deductible plans, transferring the risk from the corporate to the individual policyowner to try to cost contain. But I don't see any transparency in the hospital industry at all and I can't price a standard hip replacement or shoulder replacement which without being the mathematical genius I'd say 90% of which are going to be pretty standard. And I can't go online and figure out which hospital is going to price me where. So, even my high deductible plan I don't know what my deductible looks like and what the cost looks like. And on the pharmaceutical model, right now we're paying four times what the Organization for Economic Cooperation and Development (OECD) countries are paying for pharmaceuticals and that's either something we need to be looking at the state level or I need you to be pushing forward at the federal level. So, where do we go, because if we

don't solve the problem of affordable insurance we end up with a public option which is not necessarily any more affordable, we're just shifting the burden. So, I'd love some of your thoughts on where we need to go on that on a regulatory framework or political framework.

Dir. Wing-Heier stated that part of the problem is we don't regulate hospitals. We don't regulate providers. So, I can't go to one of the big hospitals in Alaska and say "you must." Now, what I will tell you is that the federal NSA that was passed a year or two ago does require hospitals and other providers to disclose and there is a transparency component to it. It has not really rolled out yet for us to be able to tell you how well it's going to work but right now that's probably our best shot. I know that various states have passed transparency laws regarding the cost of healthcare that have to be provided to the consumer but it is very hard for a consumer to go to the hospital and say, "how much is a hip replacement?" and then go to their insurance company and say how much are you going to pay? And nobody took into consideration did you meet your deductible or not or what your copay is. It becomes very confusing for the consumer. And so I think because of the NSA and the requirements that are going to go on the insurance companies as well as the providers hopefully we'll see a path forward between those two. I don't know that it's going to be perfect, but I think it's a step forward from what we have now.

Cmsr. Mulready stated that the difficulty on our end is that we don't regulate medical providers or drug companies as far as the pricing on that end and that's what makes it difficult and has made it difficult with the NSA when they were looking to us to say who's going to enforce that, well we have no statutory authority to take care of that with the medical providers. And so, unfortunately, we've had to defer to the federal gov't on that with the NSA on the actual enforcement. There is some progress being made and in fact Surgical Center of Oklahoma has been a national leader on this for at least a decade with full transparent online pricing of every procedure they do. So they literally have created a medical tourism for replacements like you're talking about and things like that and there's some third party applications as well but it's nowhere near where it needs to be to your point and hopefully it will improve with the Federal action and anything you can take at the state level on a transparency standpoint. I personally have been in the health insurance field for the last 25 years and I think it's a critical piece that's missing. I often when I speak publicly joke about being able to go online and find out more about my $200 watch then I do about a $20,000 procedure that I'm about to have. That's a problem.

The Hon. Kathleen Birrane, Maryland Insurance Commissioner stated that I would just mention that Maryland actually does regulate hospitals so we have an all payer system that's been in place for a long time and it's very clear and precise and hospitals are not allowed to deviate except within a very small margin for very specific reasons and that is extremely helpful. There are pros and cons. The pro is the transparency and the consistency and we believe that over time it has kept rates lower, and costs lower in Maryland. The flip side of that is that we have a 14% uptake in Medicare Advantage Plans compared to the average of 40% or more in other states and that is because Medicare Advantage Plans are not able to negotiate hospital costs and rates so you do have to look and balance and that's something that we're addressing right now in Maryland is how to support Medicare Advantage Plans but keep our all payer total cost of care system in our waiver with CMS with regard to that. We're also now beginning to explore other things as our legislature has asked the insurance administration and other

groups to begin to look at whether there are other kinds of areas or different types of providers where it would be appropriate to have similar sorts of guidelines around what appropriate pricing is.

Cmsr. Caride stated that in New Jersey through the Governor's office we put together a committee and the purpose of that is to bring together the industry, hospitals, pharmaceuticals, and providers to discuss how can we be more transparent and how do we make insurance affordable? So, we just started this process through the Governor's office and I know that this has been an issue for our legislature as well from my time in the legislature where we've been trying to figure out how do we make it affordable, and they've been good partners to work with with regards to legislation. But we're in the process right now of working and having communications and we're going to start beginning to take data down and look at it to see how can we make it transparent and how can we make insurance affordable and at that point in time I'm sure our Senators and our Assemblymembers will get involved as well.

Rep. Oliverson stated that I would just point out as well that a number of states now have established all payer claims databases including my home state of Texas. And Rep. Meskers, if this is something you'd be interested in, I'd be honored to work with you on it. There has been bipartisanship both at the federal level and the state level as far as advancing policies that actually require hospital price transparency. We had a good executive order passed by the previous presidential administration which has now been strengthened by the Biden administration. And similarly we have both the state of Texas as well as the state of Colorado have advanced very strong comprehensive hospital price transparency laws that require publication of contracted rate information and giving patients the ability to shop competitively in a manner where the information has to be immediately publicly available. So, I know those things are out there and maybe that might be something that would be worth bringing to NCOIL for a future meeting as model policy if that's something you're interested in working on. I'd love to work with you on it. Rep. Meskers stated that it sounds like a deal.

Sen. Gossage stated that I helped pioneer HSA's with President Bush and at that time one of things we really wanted to talk about was transparency because people were getting these big $1,200 deductibles. Now we all laugh now, because $1,200 would be considered a small deductible today. So, one of the things I did was work with insurance companies about cost comparison tools. Aetna was one of the first ones to invite me to Baltimore to look at what they were offering which was fabulous - all the different hospitals within their network and the basic common procedures and how much it is. I wrote an article that came out I think it was in the USA Today called "how much is a tonsillectomy and how you can find out." But when people say, and I've been a health insurance agent for 20 years, well why is it I can find out how much is a television at Walmart but I can't find out how much it is for a knee replacement? True. But at Walmart they don't say, "how much is your income and then we'll tell you how much a TV is." And there's not a middle person buying this TV for you, negotiating the TV for you which is insurance companies. As I explained to the Trump administration when I testified there and that is you're looking at the wrong entity. If I have a contract regarding my medical services it's not with this hospital. My contract is with my insurance company. My insurance company negotiated with the hospital. The transparency should come from the insurance companies, and you all regulate them.

So, a hospital to be able to tell you, okay let's see what insurance plan you have with your employer that's self-funded - there are hundreds and hundreds of those plans out there. But a carrier knows exactly which plans they have, they know how much it would be, they can know your deductible. So, back to this cost comparison tool, it was amazing. So, I went back to Aetna and I said, "you should go to the Trump administration and show them your amazing cost comparison tool you guys have because if you don't they're going to be coming down on you and saying it has to look like this, and must be like this." He goes, "Well, I wouldn't want to show it him now." I asked "Why?" He said "Well, took a lot of people to keep that up and going and then after two years we realized that we only had 2% of our members that ever even looked at it." So, if we're going to ask them to do that, again we need to educate the public on where to go but I think if we look at the insurance companies, many of them are gearing up with it and again, I believe in looking at private solutions. Sometimes if we're lawmakers we have a big hammer that says government and everything looks like a nail and we need to have private ways in which we can be able to do this. So, just food for thought, let's look at insurance companies. They should be able to tell their members here if you go to these hospitals whether that's a phone call, whether that's online or both.

DISCUSSION ON NAIC EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) (B) WORKING GROUP

Rep. Oliverson stated that he would like to now turn things over to the work of the NAIC's Employee Income Security Act of 1974 (ERISA) Working Group and noted that NCOIL has been on record as supporting an amendment to (ERISA that would allow states to regulate self-funded plans where the entirety of that plan is essentially intra-state commerce not interstate. And I think this has sort of been a glaring oversight and I know many in this room, myself included, are unfortunately all too familiar with the concept of what we refer to as ERISA creep in this sort of regulatory expansion over time that it's blossomed into something far beyond. And I think when we look at the U.S. Supreme Court ruling in Rutledge and some of the actual statements that were made in that decision it's pretty clear that even the Court feels very strongly that ERISA has grown far beyond what lawmakers that created that statute in the 1970s could have ever contemplated that it would grow into. We actually had an NCOIL D.C. fly-in recently and I'm proud to report that the members that were there and myself actually got a lot overt positive feedback from Members of Congress that this was something that they were open to. So, I was just wondering to kind of get the NAIC's take on that and also without trying to put anyone on the spot, to just sort of see if you all are generally amenable to the idea of joining with us and asking Congress to give us this flexibility back.

Dir. Cameron stated that we certainly are and we have very much the same sentiments and the same concerns and that's why we sent the letter that we did. I'm going to have Georgia Insurance Commissioner John King report on it but to answer your question directly, we're more than happy and willing to work with you on it. Cmsr. King thanked the Committee for the opportunity to talk about this because this is something that that we all know that the complaints either come to our legislators or come to the insurance department in our states. And so we feel, especially in Georgia, that we are the right vehicles to get this problem solved but obviously the companies throw ERISA down our throats very quickly and so the first thing that we did in Georgia is the legislature passed very strong laws. And so what we did is we took a very judicial and very proactive approach of first educating the industry that operates in Georgia for them to understand

where the line is and where the difference is and of course they don't like any new regulations that come into play and people are really uncomfortable with change. And so we really at the end of the day focus on protecting our consumers in our states and I think there's a lot in common with NCOIL and NAIC and we're looking at working with the federal government to allow us to be the arm to get this done because we think we're closest to the people and we think we can be a lot more effective at getting through this. But I would welcome assistance in getting the federal government to give us authorization because a lot of these companies are hiding behind that cloak of a federal approach and we feel that we're much better at this than they are.

Rep. Oliverson stated that something you said that really resonated with me as a lawmaker is we go to the legislature to "fix a problem" for the constituents that want some problem fixed and we say, "Yay, we fixed it." And then we get folks that are coming to our office months or a year later saying I thought you fixed this and come to find out that it doesn't apply to me. And that's a growing problem in a number of states. I think in my home state of Texas now we're down to around 20% of our health insured patients actually have a fully insured product that our commissioner can actually regulate which is pretty embarrassing and I know there's drivers and factors that are sort of effecting that and I try to be sensitive to that obviously that there are reasons for that but it's concerning. Rep. Wendi Thomas (PA) stated that I just wanted to add not only is it a problem for constituents but the lawmakers who are doing these laws often are not involved in insurance so I find myself educating my other lawmakers that what you're passing is only going to be three of seven of your constituents who have to abide by this and I think it's been a major ongoing point of confusion and issue and it would be great if it got resolved. Sen. Gossage stated that I 100% agree. I write small group plans all the time and more and more of them are going to this level funded, self-funded plans because that gives them lower rates and then yes, we pass laws that don't really affect them. I'm very interested and I didn't realize that we had this idea from NCOIL and I very much support that. I've said for a long time I'd love to be able to say could the states have back level funded type plans instead of the high-risk self-funded plans. Those could still be ERISA plans but those level funded plans maybe could still be regulated at the state level.

UPDATE ON NAIC SPECIAL COMMITTEE ON RACE AND INSURANCE

Rep. Oliverson asked if we could get an update on the NAIC Special Committee on Race and Insurance. I know you've had several meetings since the charges were laid out and I'm wondering if there's a consensus or a timeline for the committee to finish its work. Dir. Cameron stated that I wish I could say there was a consensus. Our timeline is it's one of those things where it's done when it's done. I'm going to turn the time to Cmsr. Caride who's going to give you an overview and then I may make some additional comments at the end.

Cmsr. Caride stated that we at the NAIC have always been careful and curious about how the insurance products are being directed to the underserved or individuals of color and I think in our roles as Commissioners make sure that we're looking at it closely. However, events that happened in 2020 highlighted it and we at the NAIC have taken a very strong look at this and we have five workstream committees that are looking at it. Our first workstream is looking at the level of diversity and inclusion within the insurance sector and how it's being promoted and we're making recommendations at some point in time to the industry on that. Workstream two is looking at the actual departments

throughout the country and how are we making sure that we are diversified and we are inclusive in our departments and again there have been many meetings and there is no final answer yet but we are looking at it very closely to make sure that as regulators we ourselves have a diverse department so that we can basically understand what individuals in our state are going through when they don't have the product or they don't have access to the product.

Workstream three has to do with property and casualty. Homeowners Insurance, vehicle, auto insurance and stuff like that and what they're looking at is making sure that individuals are not being unfairly discriminated against. There's a lot of different methods that are being used in the underwriting and we have a forum on the algorithm auditing to make sure that when companies are looking at their products and offering it to the community that they're not unfairly discriminating against underrepresented communities or individuals of color, proxy discrimination. So, they're looking at all of that and we hope to have more information on that after the forum. Workstream four is the one that I chair and we're looking at the life products and we've had a lot of conversations on access to those products. How it is a product that can also be something that can be an inheritance, a life insurance policy. You leave an inheritance and at one point in time underrepresented communities used that as an inheritance as taking care of funeral costs which is a burden. But somehow, we've moved away from that. So, we're looking at the industry closely and getting agents out there. Why aren't they making those products available to individuals? And we've had numerous meetings on that. The last one we had was a meeting with FARE, which is the Financial Alliance for Racial Equity and we discussed different things that they're doing to encourage individuals and agents to sell to our underrepresented communities, individuals of color and making the product affordable for everyone. I've had conversations where folks just don't want to sell it to my community, I'm Hispanic, because they feel that we can't afford it. Well, did you take the time to talk to me? So, those are things that we're looking at.

Workstream five is looking at how the products in the health field are being issued and provided to communities - if it's diversified, if it's inclusive, if it's affordable. So, we'll have more information on that. I'm very proud that under Dir. Cameron's leadership this year we did form a foundation that's called New Avenues in Insurance Careers Foundation and that foundation looks to foster interest in the career of insurance and we're looking at individuals and students that are primarily going to come from a diverse background or the underrepresented and bringing them into this particular area, whether it's as a regulator or as an agent. So, we're working on that and here's more to come on that. And one of things that I have heard in my committee is that we don't have agents wanting to go and sell to these communities because they don't feel they're going to make a profit. So, a lot of education needs to be brought in to make these products accessible to our communities of color and to the underrepresented.

Dir. Cameron stated that first of all let me recognize that we have several of the chairs of each of those workstreams here sitting at the table so we've got strong representation of this effort and I would also tell you that when we looked at the start of my year we looked at it from two angles and the foundation was one angle that we really felt like there was a real opportunity for people to change their lives in the insurance regulatory field. They can be actuaries, examiners, they may have great Math skills but there's not a pathway to doing that. Very few people, no offense to any of the actuaries who might be in the room, but nobody goes to school necessarily thinking I want to grow up to be an actuary but you kind of fall into it. So, we wanted to provide an avenue and we've made the

application and we're trying to get that through the Treasury through the IRS. So, our intent is to start offering scholarships, internships, and apprenticeships to help young people of different races and ethnicities be able to participant in this world. The second aspect is I have a super strong belief in insurance changing people's lives and insurance being able to allow our economy and our states to move forward. And it bothered me as we started talking about these issues that we couldn't figure out what was keeping people from buying insurance. What were the barriers that were keeping individuals in the Hispanic culture, or the African American culture, or whatever from buying coverage? Frankly, some of it's because we have federal guidelines that try and put one size fits all on things and so what we've done with each of our task forces is we've tasked them with looking at what are the barriers for people being able to buy all types of coverages and how do we mitigate them or remove them so that those individuals can participate in this market? Are the barriers regulatory? If so, let's talk about them. Are the barriers legislative? Are they product design? Are they the way we communicate those products? So, all of those items we are delving into and I wish I could say the finish line would be X date but It won't be as we didn't get here overnight and we won't rectify this overnight.

Rep. Oliverson stated that it's a complex topic and I don't think that there are any easy answers but I'm encouraged to hear that you're taking a measured approach and you're sort of looking at the data. I do believe there's truth to be found. I do believe that there's objective things that can be learned and so we can do this differently here. We can change this and this would make a difference and it's just one of those things where sometimes separating the objectivity from the emotional things that we all feel and directions that we've all been taught that we need to go is important. It's a process and it requires I think a careful examination of the facts as they are and trying to stay objective and I just applaud you for doing that.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that on this issue NCOIL took up the same task and had our team look at this. It's not an issue that's going to go away tomorrow but I think that the one thing I think is kind of an issue out there and we have to probably discuss at some point is the term proxy discrimination because that seems to be the one that we get hung up on and how's that defined? And, "proxy" was the term "proxy" before it got attached to discrimination so we don't want to go down a path where we just ignore it but I think we have to have an open discussion at some point about what does truly that definition mean? We defined it and I think that that wasn't as well accepted as what we maybe hoped for so I am just curious if that's still an issue that's being discussed at NAIC.

Cmsr. Caride stated that I can tell you that we agree with you that when we talk to insurance companies, when we talk to consumers there are a variety of terms one being proxy discrimination and we need to settle what it means and where it's applicable and we are working on that. When we leave here most of us are headed to Kansas City for two days of delving into discrimination, proxy discrimination, and disparity impact and looking at the algorithms and algorithmic bias within the models that we're receiving in filings, particularly rate filings. And we don't have an answer for you today but we're most definitely working on it. You're absolutely right. Defining some of these terms so that we're all playing or singing from the same hymn book is going to be very important. Rep. Lehman stated that I would put out the offer that we're willing to work with you on this so the more that you can involve us, the better and I know between Asm. Ken

Cooley (CA), NCOIL President, and others that we're very open to having those continued discussions so thank you.

Rep. Brenda Carter (MI) stated that my question piggybacks on what Rep. Lehman said. In my state of Michigan we are focusing on proxy discrimination and I was going to ask Dir. Cameron which committee deals with proxy discrimination and I'd like to have a conversation with you after this is over.

UPDATE ON WORK OF NEW NAIC INNOVATION CYBERSECURITY AND TECHNOLOGY (H) COMMITTEE

Rep. Oliverson stated that for the first time in several years the NAIC formed a new letter committee, the H committee, which has jurisdiction over cybersecurity, innovation, data security, privacy protection, and emerging technologies. We heard some from Steven Seitz, Director of the Federal Insurance Office (FIO) earlier and I think it sort of percolated through several meetings today and yesterday that the concept of cybersecurity and its importance and what we do because we do have access to so much protected information. I know as a healthcare worker having been bound under the terms of Health Insurance Portability and Accountability Act (HIPAA) for many years I take that kind of stuff very seriously as I know a lot of healthcare workers do but I'm just wondering can you give us an update on the committee's work, and the plans going forward for this committee?

Dir. Cameron replied certainly and before I turn it over to the Chair of that Committee, Cmsr. Birrane, I just want to note that we announced that concept and that idea here at an NCOIL meeting and we did so with reason. It is such a huge topic with multiple facets. We want to be protective of our consumers and protective of the industry and at the same time we want to be pro-innovation. We think there are solutions to some of the problems that ail us with innovation and we trying to find that right balance. So perhaps one of the most difficult decisions I had to make when I became NAIC President is who is going to chair this new committee and who had the wisdom and the ability to handle this and I turned to Cmsr. Birrane. She is an outstanding woman and has a good background both within the industry and otherwise but I also as I turn to her I want you to know as we work through the issues, we want to work with NCOIL because we recognize you make the public policy decision on some of these issues and so it's a balancing act and we'll work closely with you.

Cmsr. Birrane stated that as Dir. Cameron indicated we set up the H Committee last December and we got formally started in early February and I'm happy to report that I think we've made great progress so far this year. It takes awhile to develop the infrastructure for a brand new letter committee. The H Committee is essentially the place under which the NAIC will be doing the bulk of its work with regard to our regulation of industry in the areas of innovation, cybersecurity and technology. That doesn't mean that there won't be any other working groups and other committees that are continuing their work in these areas but what it does mean is that we sort of have a common home where we can make sure that our work is efficient, consistent, and most importantly that it's collaborative and that we're working from consensus. So, that is sort of one of the largest charges. I'm going to talk in just a second about the individual working groups and what they're doing but I wanted to start with the idea of what are we doing at the committee level so you've got a little bit of a preview of that from others that have talked about what is essentially our collaboration forum.

So, if we're going to try to be consistent and efficient and work together collaboratively and from consensus, we need to talk to each other and so when we have issues like, for example, algorithmic bias and things like proxy discrimination, we need to understand where across all of the different working groups people are touching that issue in one way or another. Whether it's P&C, or fraud, or market conduct, or accelerated underwriting, where is that work being done? And when we know that it's being done in many places, the methodology that we developed for managing that work effectively is what we're calling a collaboration forum. And the first collaboration forum that we're doing is on algorithmic bias. And so that forum's bringing together about ten different working groups within the NAIC including workstream three of the committee on race and insurance to talk now about what is algorithmic bias and how can it lead to illegal discrimination and unfair distinctions in people? Where does it live within the insurance ecosystem from marketing through fraud identification and claims administration? And as regulators, what is the appropriate response to that? So, the purpose of the forum is not to necessarily decide each and all of those issues. The purpose of the forum is to come together and do three things. One, to make sure that we all know what each other is doing and that you all know what we are doing so that there is a place where you can come and you can say these are the working groups that are working on these types of issues and here's what they are doing and we're informing each other and we're making sure that we're not stumbling over each other and we're not being inconsistent with each other. So, that's the first purpose of the forum.

The second purpose of the forum is to educate. To make sure that we are keeping each other educated not just about what we're doing but about the foundational elements. You know, insurance regulators are really, really smart and aware and capable in understanding insurance, and insurance laws but we are not necessarily as educated with regard to technology and complex concepts about how algorithms are developed or how artificial intelligence (AI) and machine learning drive decision making, and what's in that Blackbox. Or more importantly, what goes into and how do you test what comes out of it? So, we have embarked upon a very careful set of educational initiatives which is what is happening at the fly-in that Dir. Wing-Heier just mentioned. So in Kansas City we'll be spending a day laser focused on making sure at the commissioner level that there is education around the continuum of what data is, what data comes in, how bias creeps in. What is bias? What is algorithmic bias? How does it lead to illegal discrimination? So lots of emphasis on education and part of that process is we are identifying all of the terms that we need to define and then working on those definitions together.

The third purpose of the forum is to be able to work toward a common vocabulary so that when we say words we all know what we mean and we mean the same thing when we as the NAIC say them and to identify what are the common elements, the foundational elements of a common framework for responsible regulation of the use of AI. So, those are the goals of the collaboration forum. We are well on our way. We hope to begin to put out real work product by probably the December meeting we'll begin to show our work. We will begin to have public meetings in Portland for those of you who may be attending in Portland and we will be having webinars and we'll also be doing presentations at the insurance summit. So, this will be an evolving task. In addition to that, there are two other things at the committee level that I'll just mention. The first is I talked about this idea of who's doing what? So, we're going to have what we're going to call the ITC Hub so that people will have a single portal that you can go to and

understand what committees are doing, all the research work, the papers, etc. will be housed there as well. It's a very efficient way to get information about innovation and technology and cybersecurity and data privacy work at the NAIC.

And then the other thing we're doing at the committee level is a supervisory tech sharing sort of lunch and learn but we make sure that we as regulators meet on a regular basis to share how we are using technology effectively to serve our constituents better and make sure that our work gets done more quickly and efficiently. Then if I just look briefly at the work of the working groups. We have five working groups within the H Committee. I'll focus on cybersecurity because that's always a very large concern. The NAIC did pass a model data security Act in 2017 which has now been enacted in I think we're up to 21 states at this point, and more to come. Part of what the cybersecurity group is now going to do is look at what are the resources that regulators need when companies report cybersecurity events and how do we have the right tools, the right resources, the right information to investigate and respond to what's happening with regard to those events. So, this is also an educational year from the cybersecurity working group to make sure that we understand what kinds of events are happening and that we are equipped to respond to them. Our e-commerce working group is really focused on looking at antiquated laws and regulations that no longer really serve consumer interest but only impede the use of e-commerce in the insurance world. We all learned very quickly because of COVID just how much technology can do in terms of keeping the world moving and insurance regulators had to suspend the operation of many laws in order to allow things to happen electronically. We're now using that experience to accelerate getting rid of those antiquated laws and making sure that we're all operating in the 21st century in ways that however still continue to protect consumers and recognize the fact that not everybody has the same access to technology.

The third area is our innovation in technology and regulation working group. Which is a lot of, I think, fun in the sense that it is the place where we learn as regulators what is the cutting edge? So, it's inviting people in and it's informing other educators and other people about what is it that the industry is doing so it's kind of the insurtech world and making sure that we're up to speed on what companies are doing. Our privacy protection work group is engaged in about an 18 month to two year process of modernizing the two models that are the privacy protection models that the NAIC adopted and our big data and artificial intelligence work group which is the place where a lot of the on the ground work is with the NAIC dealing with how we regulate the use of big data and AI is focused on four things. An important one is moving our AI principles into AI guidelines and really looking at the work with third party vendors and what is the appropriate regulatory regime with regard to either the vendors themselves or the use of their work product by insurers. And then the survey work that that working group has done in looking at how AI is specifically being used. We did a survey on private passenger auto and a second survey is being done with homeowners, and with life insurance companies, so that we understand the use cases which then allows us to further drive our own investigative efforts and begin to think about differentiation in regulating those lines and those use cases. So, that is a whole lot of information that I hope you find interesting and helpful but we are always happy and willing to collaborate with you really in any of those areas.

ADJOURNMENT
Hearing no further business, upon a motion made by Asm. Cooley and seconded by Sen. Gossage, the Committee adjourned at 12:30 p.m.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 16, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Hyatt Regency in Jersey City, New Jersey on Saturday, July 16, 2022 at 9:00 a.m.

Representative Bart Rowland of Kentucky, 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. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Mike McLendon (MS)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Lacy Hull (TX)
Rep. Dennis Paul (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Tammy Nuccio (CT)
Rep. Kerry Wood (CT)
Sen. Beverly Gossage (KS)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. Kevin Ford (MS)
Asm. Roy Freiman (NJ)
Rep. Wendi Thomas (PA)
Rep. Jim Dunnigan (UT)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Carl Anderson (SC),and seconded by Rep. Matt Lehman (IN), 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. Lehman and seconded by Asm. Ken Cooley (CA), NCOIL President, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 5, 2022 meeting in Las Vegas, NV.

USING BLOCKCHAIN TECHNOLOGY TO LOWER STATE UNINSURED MOTORIST POPULATIONS

Robin Westcott, Vice President of Gov't Affairs, Legal & Compliance at the American Association of Insurance Services (AAIS) thanked the Committee for the opportunity to speak and stated that my background is from the great state of Florida which I still live in, residing in Tallahassee. I was a regulator there for a number of years especially on the property and casualty side and as the consumer advocate for the State of Florida many of my presentations as a consumer advocate were to working groups, to committees, and legislators for our state. That was the beginning of when I really began to be interested in what data can do and how it works in our state and as I left the State of Florida, the Department of Insurance there, I moved to AAIS and many of you are probably like, "Oh who are they?" AAIS, the best way I can describe it to you is that we are the only alternative program to the Insurance Services Office (ISO) throughout the country for many of the property and casualty lines. So, we're an advisory organization and statistical organization so data's kind of our life blood. We make forms, loss costs and manuals for many of the P&C lines. So, that's who we are and that's why data's interesting to us and when I came to AAIS, we started working around how do we procure more data? How do we do better with data that we have in order to help us build programs for the industry? So, we kind of took our head up out of the sand and looked around and realized that the entire industry has a problem around data. Many times it's very proprietary and over the past ten years we've seen where data breaches and other activity makes data, especially that of our consumers, vulnerable. And as insurance companies my kind of take on that is that we should be good stewards of the data that we have on behalf of our consumers. I never kind of left that whole consumer interest behind.

So, to bring us forward I want to talk very briefly and it's very difficult to talk about the North Dakota project without talking a little bit about the beginning of open IDL. Which is the open insurance data link. It is a distributed ledger blockchain technology that will help us with data in our industry. In about 2018 we began to look at using this type of technology for data. We had designed thinking sessions, many of the states that are represented here such as Mississippi, Connecticut, Virginia, California, Ohio participated in those design thinking sessions along with some very large carriers such as Travelers, Hartford, and Selective and other insurance organizations like Chubb, and began to look at how we could potentially use a blockchain network to solve some of our data issues. Now, that was how open IDL was born and we're still a not for profit at AAIS and because of our extreme commitment to trying to bring open source community into the insurance industry, we decided that the best way to protect the open IDL and keep it as an open source community would be to talk to the largest open source community in the world, the Lennox Foundation, which if you have a tablet, a phone, or a laptop here, you're probably running on some sort of Lennox underpinning. So, the Lennox Foundation accepted the open IDL as a project at Lennox and we donated all of the technology that we had designed into the open IDL project. So, open IDL actually does live now at the Lennox Foundation and we are very active with our organizational members of the Hartford, Travelers, Hanover, and others to start to build the network. Specifically, to begin with for regulatory reporting. As a stat agent we wanted to bring the first part of the network up around how do we get transparency and how do we answer questions that many times a regulator has that's kind of immediate and you guys can't wait two years for us to do a data call to make public policy. I think COVID was a very good example of that. We needed answers and we needed to understand some of the things around our industry but it was very difficult because there's no immediate access to data. You have to start thinking about the data call and how you do that.

So, let me briefly touch on the technology itself and the design because you have to understand what it is before you can understand the power and the potential that exists for blockchain ledger technology. So, everything you know about bitcoin and any of this other type of thing in the market and you think you know about blockchain, please forget it. That's not what we're talking about here. This is a private permissioned network where no raw data ever goes on the network. Okay, so how's that possible? When we have an open IDL network, a blockchain distributed ledger network, we take these really interesting things called nodes and it's kind of like a data warehouse or data respiratory. And those nodes live inside the carrier's security walls. So, instead of you doing data calls or a state doing other data calls and there are already other projects around getting a lot of data and these huge data warehouses, instead of doing that, why don't we set up these individual data repositories inside and behind the walls of some very complicated and complex security at each company. And instead of passing data back and forth to answer questions, why don't we send the question to where the data lives and get an answer? Is that possible? Yes, it is. Why is this important to do it in a blockchain network? Because the answer that's given in response to the question can be created as what we call a hash or identity is given - given to the answer. And that is what is written to the blockchain. So, it's an immutable record, one block on top of each other. You can't change the blocks. You can make a new entry to show that something changed in the data but that lifecycle of that whole entire transaction can be completely captured on the blockchain without one piece of raw data being transferred so that's very important. Some of the criticisms that have come, especially as we've looked at the North Dakota project, have really been around, "Oh, you know, you're going to put people's data on the blockchain." No, we're not. We're actually going to make it more secure because we're going to create a situation where data does not have to be transferred outside of the environment that it's most secure.

What does that mean for data breaches and cyber security issues that we have in front of us today? Well, that means that instead of having large breaches for everyone's consolidated data that's living in some warehouse, which might be a very secure environment and they're always going to be attempts and places where people are going to try to get in and access that data, let's just keep it as individual data so that there's not an industry wide breach. It might be a specific breach but what it also means is that this network that the place to get in looks a lot like that. So, we're creating a network that allows for the security measures to stay much more in place for the data that we really think is important to store for our insurance consumers. So what are we doing in North Dakota and why is this important? In North Dakota, Commissioner Jon Godfread, who I have to absolutely commend and really appreciate the work and the attention that he's given on this project through his staff and I'd be remiss in not saying the same thing about Mississippi Insurance Commissioner Mike Chaney and Connecticut Insurance Commissioner Andrew Mais and some other commissioners who have been very committed to this project. But with Cmsr. Godfread, we actually had one of the design thinking sessions in North Dakota and he called in many of his top carriers, and we started talking about what would be a good use case? We've got all this work going on at the open IDL where we're building that data model and the data model's important because you want the data in those repositories to have a structure that can be easily identified. So, that work's going on over at the open IDL but we've already built the auto data reporting module which means that we have a format that people can, and carriers can start loading that auto data into their private nodes and the repository can be there. But one of the things that we wanted to do was to start to test the network - does this really work the way we think it will work? So, Cmsr. Godfread has gone through the

legislative process and was able to establish a proof of concept specifically around the uninsured motorist problem.

Now, one of the things that we've seen is that there are already a dozen or so states that have certain reporting requirements for auto insurance carriers to send data. It's probably on a quarterly basis. It may be more frequent than that but there's an upload, and it's a large data warehouse. These types of activities are burdensome and expensive for insurance carriers, every data call, every stat reporting activity. And we're a lot of times replicating data and we're reporting it to different places. So, the auto data is a good example of that and so you have states that have already said, "Hey we want to know if there's a policy in force" for this vehicle identification number (VIN) number. So, Cmsr. Godfread's proof of concept that has come forward is to let's see if we can do this very simply on a blockchain. We don't need the companies to load the entire auto statistical data plan, we just need a couple elements of data, one of them being the VIN number. Is this VIN number insured by this carrier? And what that means is that we can do that call and the way we do that is we send what we call a smart contract or extraction pattern and it asks a question of that data node that carrier has and it gives an answer. Now, right now, what we will be doing is setting up what we call an analytics node. So, the answers to whether or not that there was a match can go into this analytics node for reporting purposes and that sort of thing. The same thing would happen with statistical reporting. You would actually have some of the answers to your questions about the data such as how many roofs do you have and how many claims and how many hurricane claims? Some of those answers can go in that analytics node and then be reported back out. So, the North Dakota project, and the proof concept of it is to start with one thing, this idea of matching the VINs for the Department of Transportation that they hold in North Dakota with the VIN numbers for a policy with the insurance carrier.

Now, one of the great things that we can say about that is once we prove that this can be done, and we're pretty confident as we've run tests on the network before with the business interruption claims for COVID, and we know that this technology can work what that means is that the insurance carrier can then load that information starting monthly. You can actually go down to weekly. Eventually, this network could support a daily load of that type of day load data which means almost real time results on whether or not this vehicle was insured. Now, the proof of concept is limited to the ten top carriers for the state. We're not going to get a comprehensive answer for every VIN on this proof of concept. It's not designed to do that. The proof of concept is just to prove the technology works and that it can be expanded upon and scaled up and scaled out to create this connection and that we can eventually go to near real time data being reported. What's great about that is that you don't need to know a lot of information about the person, you just need to know whether they insured the car. So, just imagine if you can do that on a real time basis and you could understand that scope and the implication of how we could expand the blockchain network. Now, one of the things I'll also point out about the North Dakota project specifically is that if you look at almost every one of the agenda items that you've had throughout this conference, and probably if you went back the last ten conferences, it has some implication around how we handle data and how hard it is in our industry.

So, if you can think of almost every one of these instances whether it's a cyber security issue or whether it's pet insurance, or whether it's health insurance, or around insurability issues, if you thought about the ability to create these networks where

insights from data could be shared very quickly without compromising the individual's data, how powerful would that be for our industry? And so, I'll close on that and I'm happy to answer any questions you have. We have a timeline now with the North Dakota project. We're already loading on our test node. We have a meeting in about two weeks in North Dakota with many of the carriers that are participating. One of the carriers, North Star whose actually an AAIS member has said, "Yeah we're good. Tell us how to do this and we're ready." But we will be meeting with the other carriers that are going to be participating in this. We're very excited about it. This is about building a network. This is about trying to make sure that we can protect our consumer data in a comprehensive way and giving great transparency and democratization, and I use that term with a different intent as I don't mean democratizing our data to run around and be free, of our data with control and responsibility, which is in my opinion, what democracy is about being as retained at the individual level.

Rep. Wendi Thomas (PA) stated that this is very interesting and sounds very good but my question is who controls the question that gets asked? Because that's the only flaw that comes to mind. The question is straightforward - is this insured or not insured, yes or no? I get that. But there are a number of questions which could get asked which come to mind could lead to assumptions that would be incorrect. Ms. Westcott stated that it really goes down to where I made the statement about it being a private secured network. One of things that happens in a private secured network is that the identity of the person asking the question has to be known to the other participants and permission has to be given or granted to allow that smart contract to execute against the individual data stores. That's why the work at the open IDL is so very important. It's where the permission tool is - the ability to create those questions and say, "Hey, I have a smart contract I'd like to execute against." That's where those parties are known to each other and you have to be a member of the network and there's a technical steering committee that will be responsible for much of the implementation of the security around that. But the interesting thing to that is that the open IDL, and everything we do, is transparent and built by the community for the network. Even those permission provisions. For this North Dakota project, AAIS will be developing the smart contract that we'll execute for this but I don't see a reason that as the network matures that you won't have others that will want to leverage that including the departments of insurance as they ask or issue data calls. It was really designed from the very beginning to answer data calls. But that environment, while the community can grow, the security controls around that are really built in the open source community. So how you do that, how you operate as a community, how you build something in a collective like that is controlled through that process.

Rep. Dennis Paul (TX) asked who would have access to this? Because like you said, there would be a group that would do it but would this just be insurance companies, that, in your example of the VIN number, say if I can find out all these VIN numbers don't have insurance I can just go ahead and market them and see if I can sell them insurance. Ms. Westcott replied yes, you can. Rep. Paul stated that but the government can have it and say, "Hey, these guys don't have VIN numbers, or don't have liability insurance" and our state requires liability insurance so I'm going to just go out and find these guys or ticket these guys at their house because they don't have insurance. Ms. Westcott stated that there are a number of possibilities that can happen. I think one of the important things we have to look at when you're building a network like this is that the insurance companies really need to have some benefit come out of it as well and one of the I think good examples of that is that we've been working with USAA in

Mississippi and in their emergency management so that if you could connect some of the very immediate information that comes out of the first responders at a disaster in a hurricane zone or in a flood zone and an insurance company could have that very quickly, that could be very valuable information back to an insurance company to help their policyholder.

And so I think that there will be applications, and I'd like for you to think about it sort of like how applications or business grew on top of the internet. AAIS Chief Operating Officer (COO) actually worked on the internet engineering task force for UC Davis in the data banks, Joan Zerkovich, and if you're really curious go find the AAIS YouTube channel and you can see her interview Vint Cerf who is considered one of the fathers of the internet and the idea that there are business applications that will grow on top of this network, it's the same principle as it is for blockchain as it was for the development and evolution of the internet. The http protocols that runs the internet, that's open source and that's not hidden to people. You can have an identity on the internet. You can run that activity. But what people have done to build applications and business applications on top of the internet is very important and it's the same kind of concept. But there will be other industries we connect to. What if we can then connect to other industries like the automotive industry that will be collecting telematics data, not just on autos that we have right now, but autos of the future and self-driving autos. All these things we have to have the ability to connect to other networks of data and this is actually how we would do it and this is the beginning stages of it. Rep. Rowland thanked Ms. Westcott for her presentation and stated that this is an important topic. Kentucky has struggled to have real time verification of auto insurance for years. As a retail agent, it's a lot of work on our part to send proofs to the local county clerk's office when if it were real time, it would take that responsibility off of us.

CONTINUED DISCUSSION ON NCOIL DELIVERY NETWORK COMPANY (DNC) INSURANCE MODEL ACT (Model)

Rep. Rowland, sponsor of the Model, stated that we've been discussing this issue now for several months and in the 30 day materials for this meeting, the first draft of the Model was included which I am proud to be the sponsor of. That is going to appear in your binders on page 288, for those of you that want to follow along. I think the current version of the Model is great but we are certainly open to making changes to the Model to make sure we get this right before we consider voting on it at the November meeting in New Orleans. So, before we get started I'll recognize my colleague Del. Steve Westfall (WV) who would like to make some brief comments. Del. Westfall stated that I'd like to be added as co-sponsor to the Model. I've had some companies reach out to me during our January session wanting some structure and wanting some legislation and I told them to wait until we get an NCOIL model to go off of. So, for those reasons I think it's a good bill and I'd like to be co-sponsor.

Brad Nail, representing Lyft, thanked the Committee for the opportunity to speak and stated that I did help to organize and facilitate the stakeholder process to date and I think it'll be helpful for the committee to hear about that process and where this current draft stands relative to the recommendations made by that group. We had over a dozen organizations represented on our conference calls, including insures, the insurance trade groups, and different companies that are engaged in delivery activity. We learned that there are some important differences between the transportation network company (TNC) traditional Uber and Lyft business models that we're accustom to now, and these

DNC business models. In particular, there are no passengers being transported in DNC businesses, so the risk profile is different. Also, Lyft and Uber operated almost identically. So, rules that applied to one easily applied to the other. In the DNC world there are very different business models in play. So, we needed to think a little differently from the NCOIL TNC Model on a couple of areas to capture all the various business models and our language. Now, the draft before you includes definitions in section one that capture these various business models. In section two there's language that acknowledges that there may be existing federal or state laws governing the transport of certain types of materials. In particular, we're thinking about hazardous materials that have existing limitations or requirements in the law. So, we clarify in section two that those other laws still apply and supersede these terms if there's a conflict. Section three lays out the insurance requirements and some terms on how insurance policies might interact with each other when there is a claim. Section four includes the mandatory disclosures to drivers. And section five is the express authority for personal auto insurers to exclude coverage for this type of activity if that's what they want to do. So, this framework works for all of the stakeholders that we talked with. There are a couple of areas where the language within this framework differs from the language that the stakeholder group submitted and I think those differences are worth discussion here.

First, a definition was added in section 1F for" delivery available period" and that period is included in the insurance requirements in section three. Now, many of the delivery company business models do not include a delivery available period. They might have drivers working from a schedule or in other ways, but they don't have people driving around logged into the delivery app awaiting a delivery dispatch. Some do but some don't. So, I think the intent here is to make sure that those companies that don't do that are not captured by this requirement which is appropriate. But I think some of the stakeholders may have suggestions for clarifying this further and just ensuring that they're not unintentionally captured in the definition. A second difference between this draft and the stakeholder input is the insurance limit in section 3B. The stakeholders suggested a liability limit equal to your state's minimum auto insurance limit. The draft references state minimum limits but with a floor of at least $25,000/$50,000/$25,000. That structure's a little clunky for statutory construction and the model may benefit from just establishing a more definitive requirement. Also, there are 25 states where the state minimum is below $25,000/$50,000/$25,000 so half the states would not be able to just simply cross reference their existing statutes. Of course, it's ultimately your role as the policymakers to determine what the appropriate minimum amount of insurance for this delivery activity should be anyway.

In that same subsection there's a requirement of uninsured motorist (UM) coverage in the amount of $25,000/$50,000. I think it makes more sense to remove the explicit requirement and instead include a drafting note that any other state mandated coverage, such as uninsured motorist, or personal injury protection (PIP), if you're a PIP state, or Medpay, whatever else may be included in your state's requirements, should be addressed as well in the state bill. There's so much disparity and variety among the states that it's hard to capture all those various schemes in a single model. The third difference is the inclusion in subsection 3G that expressly allows policies written on commercial paper to satisfy these requirements. I suspect this was included to try to allay the concerns of Buckle, one of the stakeholders, and I believe that Buckle has an alternative where this subsection 3G can be removed and we also remove from the definition of "personal vehicle" the unnecessary reference to "autocab, taxi, limo…" That

was just borrowed from the TNC model and doesn't really apply squarely here. So, I think Buckle can speak more to this and the other stakeholders can render their opinions but that may be a satisfactory solution. So, I'll conclude here by just pointing out that we've had tremendous cooperation between all the interested parties and I think the Committee is in a good position to make final adjustments to the model and be able to adopt it at the November meeting.

Frank O'Brien, VP of State Gov't Relations at the American Property Casualty Insurance Association (APCIA) thanked the Committee for the opportunity to speak and stated that I'll leave it to others on this panel who will speak specifically to some of the comments that Mr. Nail has just laid out. I'd like to point out that NCOIL has developed a recognized expertise in the sharing economy space and this is the third or fourth model that NCOIL has been developing and we do expect that once this is in place that it will be moved forward in various states. The other thing I would note is the presence at the table here in front of you. Again, in recognition of NCOIL's leadership on this issue, you have the major players on this issue before you who are engaging in these discussions. And we appreciate your leadership, Rep. Rowland, in terms of helping us shape those discussions.

Andy Parr, Head of Insurance for North America at Uber, thanked the Committee for the opportunity to speak and stated that as Mr. Nail mentioned, we've been working as a group and have been very pleased and proud of the collaboration thus far on the model. I would say as a general comment, we're very supportive of model as it stands today and it is definitely a great start. We do think that there is room for improvement and more work to be done. Specifically, with respect to the coverages and limits as Mr. Nail alluded to. I'll specifically talk about the UM requirements under section 3B where today the model as drafted requires $25,000/$50,000 regardless of whether that standard is required of other drivers or commercial carriers in the state. I would say to clarify, Uber's position is that we don't believe that UM should be required for a DNC as it's not an inherent risk that would justify the requirement of such coverage. However, if the coverage were to be required, we believe it should go no further than the minimum financial responsibility requirements that are already contemplated in state law. And to the state law's in different jurisdictions that allow for rejection of UM coverage in some instances, we would expect DNC's to have the right to reject such coverage. And in those states where there's limits required we would expect DNC's to comply and to have and maintain those minimum limits. Today, the model goes a bit further with those minimum limits than even the TNC model that came from NCOIL which is a bit nonsensical. The TNC model is silent on the issue and defers to the states in their ability to set the requirements for UM and other coverages as required by other law and does not set a minimum for UM coverage.

If the DNC model were to go forward in its current form, you would have a couple of illogical outcomes, one being that DNC's would have more onerous coverage requirements than TNC's in certain states where UM is rejectable, which doesn't align with the relative risk of the two different business models. And then secondly, more broadly, DNCs would be treated differently than other drivers and even other commercial carriers like taxis in those states where UM is rejectable. There is no need to have a mandated UM minimum in a model and instead it would be better to defer to states to be able to handle that accordingly on an issue that they've largely already contemplated in the minimum financial responsibility laws. That said, we remain fully supportive of model legislation in this space. Obviously, there's still a little bit more work to be done before

we would be supportive of the model passage or adoption more broadly but we're certainly ready and willing to continue to work with everybody to make progress to that end and look to find some mutually agreeable language.

Jon Schnautz, Assistant VP, State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that NAMIC was part of the stakeholder group that the other speakers have alluded to and I think what everyone else has said is correct. The current version is very far along we think toward a workable model. I will say just from a general goal, NAMIC's goal here is to make sure that coverage is in place and that there's a clear legal framework to it and this is very far along toward doing that. I will mention one other issue that was in the stakeholder draft that is important to us, and we think important to include. And we don't think it's controversial at all but it's a lesson learned from the NCOIL peer-to-peer vehicle car sharing model. There's a provision in that model that addresses what happens if a driver crosses state lines. I'm from Austin, Texas so the idea of crossing a state line in a delivery is sort of far-fetched but in some states it's not and what that provision is there to say is that if that happens and you cross into a state with a higher limit, that the original insurance requirement would kick up to that higher limit so you wouldn't have a gap there. And the only thing I can figure is that was left out because someone may have thought the floating limit structure in the current version made that irrelevant and it doesn't necessarily because you still could have differences. We'll take back any other considerations from this discussion today and vet it with our membership, but I have no reason to think we can't get to something we can support in fairly short order and before the November meeting.

Jordan Bailey, Senior Legislative Policy Advisor at DoorDash, thanked the Committee for the opportunity to speak and stated that DoorDash, like others here, continues to support the development of a model bill. I think we recognize the importance of establishing guidance for states to look to when they're thinking about putting together standards for insurance for this industry. However, we hope that there can be continued discussion on several aspects of the model, some of which has been discussed here today. Another area I think is the extension of coverage requirements to the period when a driver is online and can review or reject trips but it hasn't agreed to provide any services which under the model is referred to as the delivery available period. I think from DoorDash's perspective our view is that the delivery available period is non-commercial commuting time for independent drivers, at least for the DoorDash business model, and I think for others in this industry it's the same such that during this period drivers can can review and reject trips all day. There's no minimum acceptance requirement. So, they really are able to do other things during this period and are likely to do so including commuting from home, to work, and maybe running other errands. We recognize that the NCOIL TNC model does cover online time but we think there are important differences between these two models which would lead to a possibly a different approach here. I think specifically, at least in the delivery context, delivery is much more likely to be supplemental versus more of a full or part time work, or gig work. Dashers, for example, are working less than four hours a week on the platform on average. So, you can imagine it really is filling gaps in other kind of commitments or personal activities. I also think the fraud risk during the delivery available period is higher in the delivery context because there's a much lower barrier to entry to get on the app. So, you can imagine it's very easy to sign up for the app, turn it on, and then at least under the current model get higher than minimum financial responsibility insurance coverage at least in some states while you're doing your personal activities or

commuting work. I know we're limited on time so I'll leave my comments at that and just say we really have appreciated being part of the working group with others here and look forward to continued discussions to get to a model by the end of the year.

Marty Young, Co-founder and CEO of Buckle, thanked the Committee for the opportunity to speak and stated that Buckle is providing taxi, limo, personal lines, as well as our signature buckle gig product to drivers in over 20 states, and servicing over 50% of the U.S. population. We have thousands of appointed agents. Rep. Rowland, as an agent yourself, you know some very common questions that a perspective insured asks their agent such as "how much coverage do I need?" And "what happens when I turn on an app?" And I'll tell you the answer to that second question is, "I don't know" or "it depends." And that is a very honest and true answer. So, when we went down this process, we did it with a goal of creating clarity in that agent's office, clarity as an insurance company so we can provide products like other insurance companies that meet the needs of the insureds whether they're doing taxi, limo, personal, or gig. All of the above. I think we have gotten to a model framework with a lot of detail in it that is I think over a 95% solution. We're really close. My suggestion is that, as a career Army Officer one of the principles I learned in the Army was KISS – "keep it simple stupid." And I would suggest that as Mr. Nail mentioned, let's keep it as simple as possible. So, we had originally asked and suggested, "hey commercial already works." Taxis and limos are already doing this but it's probably easier to explain to somebody in that agent's office all commercial is included or all commercial is excluded from this model.

I think each state will do what it wants. That's a very easy conversation and I think the default of all vehicles are included in this is really easy to explain by an agent. The second thing is, we would suggest not to make any changes to statutory coverages whether those are new coverages beyond what a state requires by law today or changes in limits beyond what a state requires by law today. Again, I go back to the agent's office, I want to equip our thousands of agents to say, "Sir, these are the statutory coverages you're required. And when you turn on an app those statutory coverages remain." And that is as easy as it gets for an agent to explain. So, we would simply say we think we're almost there in terms of the model. Let's keep it simple in support of our thousands of agents trying to basically do the right thing and explain these coverages in order to provide our ultimate goal which is clarity to insureds and to the public and we would suggest that approach.

Daniel Guzman, General Counsel at Favor Delivery, thanked the Committee for the opportunity to speak and stated that I agree with a lot of what's already been said, so I'll be pretty brief. I do think this is a great framework. I do think this is some necessary legislation to close the coverage gap that currently exists and I'll probably echo a lot of the same feedback that my colleagues at Uber and DoorDash had as to the details of the bill. I'm confident that we can work out the few tweaks that are needed to get this done by the next session. So, in general, we're just very supportive of the Model and happy to be a part of the process.

Rep. Rowland asked Mr. Young if he is ok with the language that is in section 3G of the model that says a commercial automobile policy that provides coverage for these deliveries may be used as long as the policy complies with the model? Mr. Young stated that I think it's superfluous. If we go back to the definition of a personal vehicle and remove (e)(3) - if you strike that clause "not an autocab, taxi, limo, autobus, jitney, motor bus or other hired vehicle," the commercial exclusion is essentially pulled out. So, this

applies to all vehicles whether personal or commercial and again, that's easy for an agent to explain. So, we would simply suggest that if you strike that, it gets simpler. There is a question of well what happens if I'm driving a "taxi cab" with a medallion on a certain geography - which other laws kick in effect where I have to have higher than a $50,000 limit in certain states? Well, this is what Mr. Nail pointed out in section two, "interaction with other law." Then it would be incumbent on the delivery network company, if the commercial insurance did not apply to basically make sure that liability was in place. Rep. Rowland thanked Mr. Young and stated that I'm glad to hear that and I think it makes it easy for your retail agents to say, "Look, just to be safe, if you want to be in compliance with the DNC model and the law, buy our product, we're following each state's law. You know you're covered." Mr. Young replied, that's right. As you know, explaining this to folks with clarity and confidence is essential so it's important that we set up our agents for success.

Rep. Rowland stated that to comments that Mr. Bailey made around the delivery available period, my only concern is if the app is on and you got a driver that's surfing for different deliveries and he's excluding those all day long, he has an accident and during the discovery period someone finds out he had that app on. What if the personal auto policy excludes that and there's no coverage either place. How's that going to be addressed? Mr. Bailey stated that I think that's something maybe we can further discuss in the working group. I'm curious if there's changes around the exclusions in the model that we can make to address that issue. I think there's also probably tweaks to the definition of "online time" that we can make as well that would address some of our concerns.

Rep. Stephen Meskers (CT) stated that I have concerns about the business model and they're simply concerns as an individual as I sit on my insurance committee and I represent my constituents. We've got a business model where people are using an individual car for deliveries, right? And we're switching from their personal insurance to a professional or commercial insurance and with different caps. So, I think an accurate look at the business model and a conversation with property and casualty insurers that are dealing with the personal car owners' insurance is important. I want to make sure when we increase the circulation of cars that are delivering on a commercial basis, I want to know what their coverage is versus personal cars because we increase the delivery service and we have essentially a market that is potentially underinsured. We're going to end up with claims that end up on the personal car owners when we have a crash and the cars in circulation and the accidents on the commercial vehicles don't protect the individual car owner who's involved in those crashes.

So, I'd like to know what the loss histories look for the delivery services. I'd like to know whether that's borne by the individual consumers who have personal car insurance in those accidents so that we have the adequate levels of insurance. I understand, that taxi and limousine dynamic. My son was involved in a three way accident, no fault of his own. The coverage limit was $10,000 so that ended up on my policy. So, my concern is going to be are we transferring the risk and the profitability into food delivery service companies and taking the homeowner, or the individual personal liability car owner is paying for that. So, I'd like to know what the loss histories look like and make sure that we're doing an adequate assessment and not just using a business model that may or may not work. I mean, we're talking about a volume of traffic that's going to be transferring and all those drivers going from their personal coverage into professional coverage to do this business. And if I'm bearing the risk as the individual insured on a

non-commercial vehicle, I'm not happy that I'm doing a transfer there. So, I'd look for some guidance from maybe NCOIL or from the property & casualty industry for losses on commercial versus personal vehicles when they're being involved in this kind of business model.

Mr. Nail stated that I think the issue that you've pointed out is a relevant one and it's one that we did really tackle in the TNC model debate, where someone is transitioning from using a personal auto on a personal auto policy to commercial activity under a commercial policy. I think we have enough experience under our belt in the TNC context that we know how to make that work where the individual insurers can cover or exclude that activity as they wish. It's clearly communicated in the policy. And with a model like this we know that there has to be coverage in place to step in in for those circumstances. Rep. Meskers stated that I appreciate there is coverage. My question is, is the coverage adequate to cover the damage don or are you transferring risk to the third party involved in the accident because the delivery coverage doesn't cover the damage done? That's a problem I think already in the taxi and limousine business that it's transference and I'm just worried.

Mr. Young stated that we support taxi and limo in over 20 states right now. We are currently covering not just livery people, but also delivery. A lot of our taxis are doing delivery right now. And for example, in Chicago, $300,000 are the minimum limits to do taxi. The way this is constructed, as Mr. Nail explained, is that if one of these taxi's in the future is doing delivery and we're not covering it because they are taxi with a medallion in the City of Chicago, there would still be a $300,000 limit because they would have to comply with the law, section three in the model. So, the idea isn't that if you're doing taxi or limo your limits will go down because you're doing taxi and limo and it's already regulated by other regimes. In most cases, the limits are going to be significantly higher than what this model may contemplate specifically for taxi and limo. Rep. Meskers stated that I want to make sure we're not transferring risk from a business model with commercial insurance now to individual car owners with their liability insurance because the accidents are going to be involved with the delivery guy, with you and me driving down the street with our family. And I want to make sure of the coverage because we're increasing the circulation under different a coverage level and I want to make sure it's adequate and that business model has to be looked at.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that maybe to build on that, we were very instrumental and worked really hard on that TNC model language and I think where we landed in the end was we put $1,000,000 of coverage to kind of address the issue of having adequate coverage. So, I know some of the pushback has been well there's a difference between hauling people and hauling stuff but I'm more concerned on the third party and I'm the guy that gets hit either by an Uber driver with someone in it or a DoorDash with food in it. I'm still a third party. So, I'm a little concerned that we're kind of defaulting to state minimum. I'd like to just continue down the path of why it's different for the driver who's hauling people versus stuff and that would have that automatically default to a lower limit. The second issue I have is on the UM coverage. I know we didn't address that in the TNC model, and with UM there's so many nuances state to state, but I guess I want to go to the issue of from a rejection standpoint. Because I'm a broker, but I look at it in terms of rejecting coverage by the entity on their drivers. I write a lot of trucking risks. They reject on behalf of all their drivers because they're the owner of the policy, they're the named insured. They then in turn are providing coverage for those drivers via Workers' Compensation because while

they're driving, they get a Work Comp claim. If I'm an UberEats driver, or a DoorDash driver and you've waived the UM, what protection do I now have as the driver if I'm involved in a UM claim?

Mr. Young stated that I'll answer the first part of your question because we do a bunch of very different risks in the so-called gig economy. We would simply observe, and anecdotally I think you can all relate to this - you really don't want to order some food from some place 20 miles away. You're not going to do that. Most of the delivery that's going on is hyper local. It's grocery stores really close and restaurants really close. You're not going to order something that's more than a few miles away and so what you see is the driving is actually a very different risk class than so-called rideshare where people are taking rides to airports. I've even taken a rideshare from here to my home in Pennsylvania and that's a very different risk when you're doing big highway miles but most of delivery is very hyper local. It's trips to the grocery store, it's trips to the dry cleaners, it's trips to things that are just within a few miles and so these are not in general high velocity activities. Mr. Parr stated that and with respect to UM, I would highlight a few things, one being that the difference between the TNCs and the DNCs when you speak about UM, UM for DNCs is specific to the driver as you correctly pointed out. There are no passengers in the vehicle and those drivers would be aware of the coverage that's afforded to them by notices and by the platform before their participation so they'd be fully aware of the coverages that are there and this would be in states where drivers have the option to purchase UM perhaps, but many drivers may also reject that on their personal auto policy and I think there are other options that are available for those drivers if they choose to participate on a platform and still want protection. There are occupational accident coverages that are either included by some platforms by default or for optional purchase that would be able to help fill the gap for those drivers that did want to do so. Mr. Young stated that and as an insurance company we view that as our job to create such products.

Rep. Lehman stated that I have a question regarding the products. I've heard that some sort of occupational coverage is offered. Is that in compliance with work comp statutes within the states? Mr. Parr stated that it's not a Workers' Compensation product. It offers similar protections for injuries and wage replacement but it's not necessarily the same as Workers' Compensation. Rep. Lehman stated that I want to go back to when the comment was made regarding it being a different exposure. I'll push back a little bit on that because taking you to Pennsylvania's different than someone driving five blocks to my house but if I'm the person that gets hit because they ran through a stop sign one block from my house, I'm still at a state minimum limit and I'm going to end up back on my policy under a UM claim. So, I know the exposure's different but when you have the word "dash" in your name it tells me you're moving at a pretty good pace. And I'll be honest with you, we were in Indianapolis and there was a Jimmy John's and they delivered. This guy pulls out from his Jimmy John's pickup spot, cuts across six lanes of traffic and runs a red light. I don't know where he's going. He might have only been going two blocks, but there was no traffic. So, my question is if there's traffic and he still runs a red light, he's only one block from delivery, but he could have caused a serious accident that now by this model he would be defaulting to state minimum limits. I think that's an issue we really have to discuss before we get to a conclusion. Mr. Young stated that we generally build products that address what I call 98% of the situations. There will always be those situations where you do have bad actors, you do have fraudsters, you do have people that really probably shouldn't even be on the road. As a commercial insurance company, we try to match price to risk but certainly, I believe all

the TNC's and DNC's here are trying to find that driver and turn them off and certainly I think all the interests are line in doing that.

Rep. Paul stated that I'm from Texas also so this idea of other states was kind of throwing me off but, if we don't put a specific limit in the code like we were talking about, can the insurance companies sell this product? Because if you don't have an idea what state this guy might drive through, would you just automatically sell him at the highest minimum that it would be? If it's in New York with the highest minimum, I might be in California but I'm paying that because I might drive through New York one day. How do you set a price on that? Mr. Young stated that we ran a lot of Texas business in Houston and there are a lot of folks that go into Louisiana and vice versa. As an insurance company we know how to solve this problem and price appropriately based on where people live. It's a very common problem. So, although Texas is a big state, you do have some neighbors where we have a lot familiarity with not just building products but explaining to our customers how these things may interact not just when they go to different states but they drive into Mexico. So, we know these problems quite well and I believe as a commercial insurer, and as an industry we know how to solve that problem. Rep. Paul stated that I live in Houston so you're saying that my experience if I'm working in Houston, you'll take into account that 10% of the time I might go to Louisiana or might go to Mexico. You put that in your price and you solve it out that way? Mr. Young stated that's correct and again we do admitted lines, so everything we do is in partnership with the Texas Department of Insurance so we know how to do that. Mr. Nail stated that's the answer from the insurer perspective. From a statutory perspective most of your states are going to have deemer statutes or something in the law that already dictates that higher limits apply when you travel in another state. So, what Mr. Schnautz was speaking of would be replicating that here within this context so there's consistency between what happens on a personal auto policy and what happens here.

Rep. Rowland stated that your personal auto insurance policy works that way, actually. If you buy minimum limits, and I hope you're not buying minimum limits, but if you go to a state that has higher limits your personal auto insurance policy automatically defaults to the higher limits. Rep. Paul stated that's good to know because we had a situation where you have minimum limits but people hit you and the minimum limits aren't even enough so 90% of the time you must use your underinsured motorist coverage. Rep. Rowland thanked everyone and stated that I appreciate the discussion this morning and the work that working group has put together in providing your suggestions to us on what the model should look like. The Committee will keep working on this and we'll make some decisions on what we think the final product should like. I'm hopeful that during my last meeting as chairman of this Committee in November that we can pass this. If we need to have, I'm open to, having another interim Zoom meeting to work out some of these issues we've talked about today and we'll coordinate that with NCOIL staff.

INTRODUCTION AND DISCUSSION OF NCOIL DOG BREED INSUARNCE UNDERWRITING STUDY & BREED PROTECTION MODEL ACT

Rep. Rowland stated that we will move along to the next item on the agenda, which is the introduction and discussion of the NCOIL Dog Breed Insurance Underwriting study and breed protection model act (Model). The primary sponsor of this model, Asm. Kevin Cahill (NY), NCOIL Vice President, is not here today so we'll hold off on committee discussion of the model and instead hear briefly this morning from the co-sponsor of the Model, Rep. Tammy Nuccio (CT), and the speakers that we have on the agenda. After

today we will discuss with the sponsors how they would like to move forward with the model.

Rep. Nuccio stated that you can find the model on page 293 of your binder. I'm happy to bring forward this model as a co-sponsor and if necessary, I would be happy to serve as prime sponsor going forward. I know there's been discussion around whether or not it's wise to have both the underwriting provision, section 2, and the data collection provision, section 3, in the same model. Having both is a unique approach and states that have addressed this issue have basically chosen one or the other so this is definitely different from what we've seen in other states. I am supportive of breaking them out if necessary. If people don't know, not only am I an insurance legislator in Connecticut, but I also work in the industry and I believe that we have an accountability and a transparency requirement and if we're going to be pricing things differently than we should have verifiable and sustainable data to validate why we're pricing them differently. So, I think we have four states now that have passed legislation similar to what we have here without the two being mixed and two that are doing the data call approach. I do have some concerns around the data call that is out there and I would be willing to work with anybody to refine that down so we are actually looking at claims that are relevant to the pricing of different policies for different breeds. So, with that I'm interested in hearing from the speakers that we have here today as to what their thoughts are on the model as it stands or the possibility of splitting it out and I look forward to working with the committee in the future.

Ledy Vankavage, Senior Legislative Attorney for Best Friends Animal Society, thanked the Committee for the opportunity to speak and stated that we are supportive of a model because a framework is needed. This year Arizona was the latest state to pass a bill on this issue and last year, Nevada and New York also passed legislation. So, it's fitting that we're here in this shadow of the Statue of Liberty because Best Friends believes that responsible pet owners should have the right to own whatever breed of dog they choose and we know that dog breed is not a factor in bites. We had wonderful testimony on that in Scottsdale and since that time there was a study that was mentioned in Science Magazine where it says dog breed is generally a poor predictor of individual behavior and should not be used to inform decisions regarding the selection of a pet dog. So, we wholeheartedly believe that. We like the approach of section two of the model. We think that's a very good start but we do think that the data collection can be flawed, section three. Massachusetts has shown us that. We think the data is extremely problematic there, and breed of dog simply does not matter. So, we would prefer something like Nevada did where they said basically an insurer may not ask or inquire about a specific breed of dog. But again, we're excited about NCOIL taking this up because it is going to keep popping up. Over 60 million families own dogs and 95% of them view them as members of the family and when you get a dog, you don't think I need to contact my insurance agent. You just don't think about that before you adopt a dog. So, that's one of the things that we want to make sure consumers are protected and they don't have to lose their insurance or find another agent simply because they adopt a dog. And housing and insurance is the number one reason why dogs end up in animal shelters in the United States at a huge cost to our taxpayers.

Mr. O'Brien thanked the Committee for the opportunity to speak and stated that this issue has been at NCOIL over the past several meetings where we have had no shortage of controversy associated with it. Notwithstanding that controversy, and in keeping with the legislative and political process which we are all familiar with and a part

of, there were several opportunities for engagement in discussion amongst parties and that indeed did take place. Asm. Cahill was able to put together a draft which we believe on behalf of APCIA represents an excellent starting point for a continued discussion relative to this issue. From an insurance industry point of view, the fact that there is a dog in a premises does represent an increased risk. However, we do understand and appreciate that our customers' attitudes toward dogs and other pets in the household has changed, is changing, and will continue to change. Nonetheless, we believe that particularly section two of this particular model does contain language that provides us with the opportunity to have an appropriate balance between our need to evaluate risk and to price accordingly and as a result to provide the product. So, we expect to have continuing discussions relative to that. I'm optimistic that a solution can be accomplished and perhaps somewhat surprisingly given the level of controversy associated with this issue, I think there's a very good opportunity for a compromise between the parties to be available in time for the November meeting. Relative to the data provisions within the model and looking at them, there are significant differences of opinion amongst folks relative to the data provisions from APCIA's point of view. We believe that it would be an appropriate policy decision on the part of NCOIL to remove the data gathering provisions particularly if the language in the earlier part of the model is accommodating for all of the parties. So, to sum up, we believe that there is a model here that we can work with and once again, NCOIL has succeeded in bringing the parties to the table and producing a possible solution to a problem which has been highly controversial for a number of years.

Jessica Simpson, Senior Public Policy Specialist with the Humane Society of the United States, thanked the Committee for the opportunity to speak and stated that I am here in support of the proposed model. Growing consensus of public and private entities have acknowledged that dog breed is not a reliable indicator of behavior and that breed specific laws and regulations do not increase public safety. While historically the insurance industry has been allowed to impose exclusionary policies on dog owners without evidence that certain dog breeds are riskier than others, policies with limitations and restrictions on dog breeds severely reduce options for consumers, disproportionately affecting low-income households. These types of policies contribute to housing insecurity, unnecessarily use up finite resources of local animal shelters and cause undue harm to responsible dog owners. We appreciate the committee's consideration of this important policy. However, we are concerned about the data provisions within the model. There are no formal statistics on or reporting mechanism for dog bite incidences in the U.S. which means that often information collected is based on physical descriptions which are influenced by personal biases. Additionally, numerous peer reviewed studies show that dogs are individuals and that breed is a complex issue that doesn't neatly translate into predictive behavior patterns. Consequently, we believe it is not a good practice to rely on subjective, often unverifiable, information in an attempt to determine risk analysis. The flaws in this approach have been validated by much of the unhelpful data that Massachusetts has collected over the course of their three year period. So, rather than arbitrarily excluding certain dogs, we believe that insurance companies should identify individuals that have individual dogs that have a displayed dangerous behavior and use that information to evaluate risk.

Ngozi Nnaji, Principal of AKO Brokerage Services, thanked the Committee for the opportunity to speak and stated that although new to the legislative and regulatory space, I am not new to the insurance industry. With 25 years of experience, two

degrees in the insurance industry space holding various leadership positions including that of National Board Member of the National African American Insurance Association, I sit before you today as a black independent agency owner in Connecticut here to provide a different perspective. As you might be aware, America has a had a long history of negatively connecting dogs to race. Since slavery, society and government have feared the ownership of dogs by people of color. It has been documented that even the forefathers of our country, George Washington and Thomas Jefferson, whipped or even killed their slaves for having dogs, also hanging the dogs that slaves owned. Some states even wrote into law slave dog bans, like South Carolina in 1859. We see the same systemic racism occurring over time through pit-bull bans in Miami and Denver to keep Latinos and Cuban immigrants out and in Sterling Heights, Michigan where supporters of the ban felt it was necessary to keep inner city people out of their towns. With that, I'm sure you're asking why I care about breed specific underwriting practices. I am a black agent and I view this as a modern-day version of red lining. These policies adversely impact my ability as an agent to assist the black and brown families that I serve and help them live in the communities that they want to live in. It prevents me from helping them protect, in most cases, the largest asset that they own and create generational wealth. To underwrite to breed and not to behavior is discrimination and speaks to the inherent bias that exists in the data, the process, and the outcome. The National Caucus of Black Legislatures agreed and passed a resolution in support of eliminating these breed specific restrictions. I know the language that I'm using here is a little strong and I recognize insurance companies are not intentionally trying to discriminate against their insureds. However, my intent here is just to bring forth a perspective that needs to be considered and an appreciation around the implications that these restrictions have on race and discrimination. I have reviewed the language and I'm in support of what has been presented here.

Tony Cotto, Director of Auto and Underwriting Policy at NAMIC, thanked the Committee for the opportunity to speak and stated that on behalf of our more than 1,500 national, regional, and local carriers, I'm here to express significant concerns with section three of the model. As with virtually every other risk and rating factor in the extremely competitive homeowners and renters insurance markets, the propensity of dogs to cause damage or losses is one for which different insurers take different approaches based on the information available to them. The industry is far from monolithic here and this competition ultimately benefits consumers, especially the 60 million households with dogs that we heard about earlier around the country. Whether and to what degree a dog's breed affects a risk, its presence in a home creates, either for its propensity or for the extent of harm that it could cause, is a matter of ongoing debate. That debate however, will not be resolved by section three's mandated two year long data call with a collection of extensive detailed claims data particularly since the data in question may actually be impossible to verify or highly subjective and prone to conflicting accounts. I think that's actually something we've heard across the table, is the way that the data is collected and what data is being collected is highly subjective here especially when you talk about whether a dog in a particular claim was "provoked" there's going to be differing accounts of what happened there. Or whether it's been the subject of past training. There's a lot of different training out there. Or undefined complaints. People complain about a lot of things that are never substantiated when it comes to a lot of these pets. So, particularly in the current environment where we as an industry are facing evermore detailed data calls the investments of time and costs of this complex data collection effort would not be insignificant and would ultimately be borne by all policyholders. So, particularly in light of the fact that section two of the model already

reflects a certain level of policy judgment, NAMIC respectfully recommends the removal of section three. NAMIC is also committed to doing the work that needs to be done to get this to a decent place.

Rep. Rowland thanked everyone for their comments and stated that as noted earlier, we're not having committee discussion on it today, but we are going to work with the sponsors and see how they would like to proceed. It sounds like there might be the possibility that this model could be considered at the November meeting in New Orleans.

CONTINUED DISCUSSION ON NCOIL INSURANCE UNDERWRITING TRANSPARENCY MODEL ACT

Rep. Rowland stated that we'll move on to our final topic this morning which is the continued discussion on the NCOIL Insurance Underwriting Transparency Model Act (Model). This is another issue that we've been discussing for several months and a lot of work has gone into this. I'm going to turn it over to the sponsor of the model, Rep. Lehman.

Rep. Lehman stated that I want to thank everybody who has participated so far. I'd be lying if I didn't say I'm a little disappointed at how there's not been as much engagement as I thought there'd be from the industry. Long term, the collection and the use of consumer data by really any industry will continue to be scrutinized and viewed through this lens of privacy and transparency. It's either going to come from lawmakers or regulators. So, with that as the backdrop what I'm really after is if you look on page 284 in your binders, I laid out a letter there that basically lays out the current issues that we need to discuss. The latest version of the Model is also there and we do need feedback on this and I urge everyone involved including legislators and industry to give feedback on this as we get this into place for public policy. If you look at recent developments in terms of what's happened in the State of Washington, I think we're heading towards a sense of urgency to this and I think there needs to be this conversation on these issues because if not, I think the default is we just have to come up with a better answer to the question of what has impacted my rate? Why did my rate go up 20%? The answer of "we just don't know" is not acceptable. And part of the problem is I think silence and some ambiguity in those responses just creates massive amounts of doubt. So, when I tell my client "I'm really not sure. The company took an 8% rate increase across the board, but yours went up 18%." That's not an acceptable answer. And so immediately they go to, "well is it this?" And I don't know. So, I appreciate the industry's engagement in this and I think again, if you look on page 284 I think we're down really to about eight or ten issues that just need to be debated and resolved and I really want to get this to a place where we can put a model out and get this into some of the states before the regulatory response is, "it's just not going to work" and you get to where across the board there's some bans on things.

Mr. Schnautz stated that just for some level setting, early this morning we did send some comments in response to the memo that had been in the 30 day materials. Those comments cover in much more detail what I'm going to mention today. From a broad standpoint, NAMIC is very supportive of the concept that accurate, transparent information provided to consumers so that they can make intelligent decisions in the insurance marketplace is a very good thing. We also understand more specifically the concerns that Rep. Lehman just expressed about the need for more specific disclosures and I hope it's clear that we remain committed to trying to work towards something that

we think will have real value to consumers. With that said, I do want to be clear that we don't think the 30 day materials version is at that point yet and I'll try to be more specific in just hitting some of the high points of our concerns but again, the written comments that are available will go into that in more detail.

First, we think the disclosure is far too broad. There are basically two disclosures included. The first one appears to be a general disclosure that almost anyone can make and that would charge the insurer with determining what the ten most important factors are in calculating premiums and trying to respond. We don't really think that gets at the heart of the matter. It has concerns for proprietary information and all sorts of other points. I can elaborate on that if there are questions. On the more individualized concern, it is closer to what we think we could support and what industry can do but it also has a lot of issues. Namely, it injects this concept of "not inherently related to the risk." I'm sure that was well intended to try to limit the factors that are included here but it really interjects another subjective concept in the bill that we think we just makes it more complicated. Further to the point, it is not as clearly limited as it could be from our standpoint to external data, which we think is what this bill is basically about and we think there are ways to make that standard more objective. And then a final point. It is not an on-request process, that particular notice. And it also applies to things other than premium increases. And we think from a practicality perspective, and cost perspective, and value standpoint, the thing to focus on here would be premium increases, and premium increases that as Rep. Lehman alluded to, are not simply driven by "well their rates went up 10%, so yours did too." And we know that's not the goal but we think that concept can be nailed down a little bit more. And then the final point I would make is, understanding all the concerns that Rep. Lehman stated and being very much in sympathy with them, I do want to put out the concept that complexity and insurance pricing is not an inherently bad thing. What's going on here is insurers trying to use better data to better price their products and to better serve markets, and ultimately that benefits the insurance market and we think it benefits consumers. We know it's not the goal of this to in any way undercut that but we do think it's very important to try to strike the balance between processes that insurers can implement at a reasonable cost that will have actual value to consumers and that those goals stay in line and that we not do more harm here than good.

Mr. O'Brien stated that Rep. Lehman has put forward an issue that goes fundamentally to the heart of our relationship with both the producer community as well as with customers and he put his finger on one of the key items here, which is if you can't really explain how the price was arrived at, how's someone going to be able to take your word for it that the price that you arrived at is the correct price? And they're going to walk away with some doubt and that's a fundamental trust issue associated with the insurance transaction. Rep. Lehman expressed some disappointment with the industry relative to the level of engagement perhaps with him personally relative to this. We've had a number of conversations but I can assure Rep. Lehman and I can assure the committee that this issue is a little bit like an iceberg – 80% of it is below the surface. In my organization at APCIA we have multiple committees that are taking a look at this issue. There are significant operational and very practical challenges associated with this and there are some very interesting and very complicated questions that are being asked amongst our members.

The model in the 30 day materials proposes what we would refer to as a dynamic notice. That is a notice that is built for the particular consumer. That is significantly more

complicated than putting together an enhanced static notice. We're also wrestling with the issue given the complicated nature of multivariate rating factors and algorithmic based pricing practices. How do you put something together that is going to explain things to a consumer in such a way that it is understandable? And when I use the term understandable, please don't mistake my statement in that regard to suggest in any way shape or form that I'm denigrating the ability of a consumer to understand things. But if you don't put together something that's useful it ends in the circular file. How many different notices and whatnot have we seen that ended in a circular file? So, how do you balance the sometimes competing sometimes not competing need to provide an appropriate amount of disclosure and transparency? And do so in a way that's understandable and useful to consumers? It's not an easy thing, but I can assure you, and I know that in some ways I'm talking about generalities here, but we have some very smart people and multiple committees taking a look at this and we understand the urgency associated with this matter. NCOIL is again, taking a leading role in this. This is also an issue that is currently set to be, or is being considered at the NAIC and we are beginning to see an increasing number of individual states who are looking at this as well. So, we do expect that the states as well as others are going to be looking to NCOIL for leadership in this issue and we intend to remain very focused and we will be engaged with the committee and with the sponsor on this going forward.

Rep. Meskers stated that I think this goes to the heart of a question of both fairness and inclusiveness in terms of coverage and understanding what, at some level, that proprietary algorithmic model looks like. It's important to understand how you get to your pricing. I'd additionally add what would be helpful would be as a state legislator is to understand if you're looking at the insurance pools across state lines, what particular policies we as legislators should be looking at to enact to drive down the costs of insurance. So, what coverage are we covering whether it be in property and casualty or health insurance? How do we improve outcomes through legislation so we can drive the cost on policies? Trying to figure out how much you want to disclose of your model versus your competitor's models, it's a hard request, but it would be helpful to get something that deals with policy as well. Mr. O'Brien stated that I would point out that this debate and the companies that my organization represents, we're in the P&C space. And I know based upon your comments in previous committee hearings that you're particularly concerned about the health insurance space. Relative to costs and whatnot associated in the P&C space, yes we like to price our policies with a sharp pencil, if you will, to borrow that cliche. Having said that however, we are unfortunately in a high inflation environment. Costs are increasing for lots of things. Including lots of things that we pay for when we are covering a claim. We do endeavor to price our policies in such a way that they are attractive in the marketplace while we manage our risk. And your colleague who I believe is an actuary in the industry, can well appreciate that as well. So, it is a challenge and transparency and communicating with our policyholders as well as with the regulatory community is an important part of that.

Sen. Mary Felzkowski (WI) stated that this is kind of a comment more so than a question but I would like to know your opinion on it. I think we have to be very careful as regulators when we get inside these business models. Every insurance company has an appetite for different types of risks and as agents, we know that. So, we kind of gravitate towards that company. Maybe it's young drivers, maybe it's whatever. But we also have the ability, because renewals come out X number of days ahead of time, and if they come out with too high of an increase based on law, they have to come out 45 or 60 days ahead of time where we can take a look at that. Maybe we compare it to the next

company. Rates are going to fluctuate but if it's an excessive rate, it's got to get approved by the regulatory body in that state. So, trying to put the burden on insurance companies to say how every little rate is developed, it's not like the days of a pen and a pad where it was your age, the type of vehicle you drove, and what accidents you had. I can't even imagine everything that goes into developing the rates with a computer based system today. I just think we need to be cautious on what we're demanding and driving up the price even further when there are options within a competitive market for us as agents to be moving some of those risks around and answering those questions. And I'll be honest, I've never had an insurance company not send a letter to an insured with the explanation of why their rates went up if it was excessive, or we felt it was excessive.

Rep. Lehman thanked everyone for their comments and stated that let me rephrase how I started my conversation which was on the lack of engagement. I'll say it this way - I think those who are traditionally here at NCOIL have done a good job but I thought the industry might respond more as a whole. And to the issue of we have other options, I kind of put this into two categories, heavy lifting yet to do and light. I think of the light, we talk about what's going to be the trigger to disclose? What's going to be the percent that we have an increase? How many factors go into this? Is it going to be new or renewal? We already know it's P&C only. And then some definitions as well. I think the heavy lifting still is going to be narrowing the disclosure. And we want to make sure we're protecting the proprietary information of the carriers and that their secret sauce stays secret. Regarding Sen. Felzkowski's statement that she never had an insurer have an increase that they haven't disclosed, I'm from a state that doesn't have a mandatory disclosure of a certain amount of increase so some of mine just show up and hey I got my renewal in the mail and it went up 22%. Why? There's no requirement of a disclosure. So, I think every state's going to be a little bit different but I think that's going to be a heavy lift is what's in that disclosure. And that brings us to the operational challenges in how do we disclose when we have such nuances of rating and so many factors that do go into this and then do we put it in a format that's understandable to the public. You know, we had credit score, we've had that for years now and we said you have to disclose the main factors that went into that. So, we've been down this path before. The difference is on credit, almost everybody's factors are the same. You have too much credit, you haven't paid your bills, or there's been too many inquiries. But this is different. So, those are things that I think are more the heavy lifting. I look forward to working with both your organizations and your members.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Rowland stated that we'll move on to the final topic which is consideration of the readoption of five model laws: Auto Insurance Fraud Model Act; Asbestos Bankruptcy Trust Claims Transparency Model Act; Certificates of Insurance Model Act; Travel Insurance Model Act; and Model Act Regarding Use of Insurance Binders as Evidence of Coverage. Per NCOIL bylaws, all model laws must be readopted every five years or else they sunset. We had these five model laws discussed on our interim meeting agenda last month for the purpose of soliciting feedback before we vote on them today. We did not hear any comments at that time but I believe this morning we do have a comment regarding the Travel Insurance Model Act.

Duke de Hass, Vice President and Deputy General Counsel at Allianz, thanked the Committee for the opportunity to speak and stated that I just want to talk briefly about the travel insurance model act which NCOIL did excellent work on in 2017 actually. The

great state of Louisiana was the first state to adopt a version of the NCOIL travel insurance model act. Subsequently, the NAIC did work using the NCOIL framework as the basis for the NAIC model act which they eventually adopted in 2018. We are now up to 29 states that have adopted the model. It has been extremely successful. It's extremely important to the industry to establish a regulatory framework and some certainty for the industry. We're continuing to work out west primarily now to get the model further adopted.

Hearing no further questions or comments, upon a Motion made by Rep. Lehman and seconded by Del. Westfall, the Committee voted without objection by way of a voice vote to re-adopt the five models.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Ken Cooley (CA), NCOIL President, and seconded by Rep. Carl Anderson (SC), the Committee adjourned at 10:45 a.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Delivery Network Company (DNC) Insurance Model Act

***Sponsored by Rep. Bart Rowland (KY)**
***Co-sponsored by Del. Steve Westfall (WV)**

Draft as of September 26~~June 14,~~ 2022. To be discussed and considered during the Property & Casualty Insurance Committee Meeting on November 18~~September 29July 16,~~ 2022.

Section 1. Definitions

(a) "Delivery Network Company" or "DNC" means a corporation, partnership, sole proprietorship, or other entity that operates in [State] and uses a digital network to connect a Delivery Network Company Customer to a Delivery Network Driver to provide Delivery Services. A DNC shall not be deemed to control, direct, or manage the Personal Vehicles or Delivery Network Drivers that connect to its Digital Network, except where agreed to by written contract.

(b) "Delivery Network Company Customer" or "Customer" means a person who orders the delivery of goods, where the Delivery Network Driver delivers such goods at the direction of the Customer.

(c) "Delivery Network Driver" or "Driver" means an individual who provides Delivery Services through a DNC's Digital Network using a personal vehicle.

(d) "Digital Network" means any online-enabled application, software, website, or system offered or utilized by a Delivery Network Company that enables deliveries with Delivery Network Drivers.

(e) "Personal Vehicle" means a vehicle that is:

(1) used by a Delivery Network Driver to provide delivery services via a Digital Network;

(2) owned, leased, or otherwise authorized for use by the Delivery Network Driver; and

~~(3) not an autocab, taxi, limousine, autobus, jitney, motor bus, or other hire vehicle.~~

(f) "Delivery Available Period" means the period:

(1) when a Driver has logged on to a Digital Network and is available to receive requests to provide Delivery Services from a Delivery Network Company,

(2) is operating a Personal Vehicle, and

(3) is not providing Delivery Services or operating in the Delivery Service Period.

(g) "Delivery Services" means the fulfillment of delivery requests made by a Customer through a Digital Network, including the pickup of any good(s) and the delivery of the good(s) to a Customer by a Delivery Network Driver. Delivery Services may include a series of deliveries to different Customers.

(h) "Delivery Service Period" means the period:

(1) beginning when a Driver starts operating a Personal Vehicle enroute to pick up goods for a delivery or series of deliveries as documented via a Digital Network controlled by a Delivery Network Company,

(2) continuing while the Driver transports the requested deliveries, and

(3) ending upon delivery of the requested good(s) to (i) the Customer or the last Customer in a series of deliveries, or (ii) a location designated by the Delivery Network Company, including for purposes of returning the good(s).

Section 2. Interaction with Other Law

Nothing in this act limits the scope of federal or state law regarding delivery or transport of goods. Deliveries made under this act that are subject to such other law must also comply with the requirements of that law. In the event of a conflict between this act and another law dealing with the delivery or transport of goods, the other law prevails.

Section 3. Insurance Requirements

(a) A Delivery Network Company shall ensure that, during the Delivery Available Period, if it applies, and during the Delivery Service Period, primary automobile liability insurance is in place that recognizes that the driver is a Delivery Network Driver or that does not exclude coverage for use of a personal vehicle to provide deliveries.

(b) During the Delivery Service Period and Delivery Available Period, the Delivery Network Driver, Delivery Network Company, or any combination of the two shall maintain insurance for liability to third parties of not less than $50,000 for damages arising out of bodily injury sustained by any one person in an accident, of not less than $100,000 for damages arising out of bodily injury sustained by all persons injured in an accident, and of not less than $25,000 for all damages arising out of damage to or destruction of property in an accident. ~~insurance coverage that at least meets the higher of either the minimum primary automobile insurance amounts required by (reference to state personal financial responsibility law), or liability coverage of not less than twenty-five thousand dollars ($25,000) for all damages arising out of bodily injury sustained by any one (1) person, and not less than fifty thousand dollars ($50,000) for all damages arising out of bodily injury sustained by all persons injured as a result of any one (1) accident, plus liability coverage of not less than twenty-five thousand dollars ($25,000) for all damage arising out of damage to or destruction of property. Additionally, uninsured/underinsured motorist coverage in the amount of twenty-five thousand dollars ($25,000) for all damages arising out of bodily injury sustained by any one (1) person, and not less than fifty thousand dollars ($50,000) for all damages arising out of bodily injury sustained by all persons injured as a result of any one (1) accident shall also be maintained.~~

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

(c) If the insurance coverage maintained by a Delivery Network Driver pursuant to subsections a. and b. of this section has lapsed or does not provide the required coverage, insurance maintained by the Delivery Network Company shall provide the coverage required by subsections a. and b. of this section beginning with the first dollar of a claim and the insurance maintained by the Delivery Network Company shall have the duty to defend the claim.

(d) Coverage under an automobile insurance policy maintained by the Delivery Network Company shall not be dependent upon another motor vehicle liability insurer first denying a claim, nor shall another motor vehicle liability insurance policy be required to first deny a claim.

(e) Insurance coverage required by this section may be obtained from an insurance company duly licensed to transact business under the insurance laws of this State or by an eligible surplus lines insurer under (cite surplus lines law).

(f) The coverage required pursuant to subsections a. and b. of this section shall be deemed to meet the (cite state financial responsibility law).

~~(g) Additionally, a commercial automobile insurance policy that provides coverage for deliveries may also be used under this Act as long as it and the Driver comply with all provisions of this Act.~~

(g~~h~~) A Delivery Network Driver shall carry proof of insurance required pursuant to subsections a. and b. of this section at all times while using a Personal Vehicle in connection with a Digital Network. In the event of an accident, a Delivery Network Driver shall, upon request, provide insurance coverage information to the directly interested parties, automobile insurers, and investigating law enforcement officers.

The insurance coverage information may be displayed or provided in either paper or electronic form as provided in (cite state law on proof of auto insurance). A Delivery Network Driver shall, upon request, disclose to the directly interested parties, automobile insurers, and investigating law enforcement officers ~~whether during the Delivery Available Period or Delivery Service Period~~ whether the Driver was operating during the Delivery Available Period or the Delivery Service Period ~~providing Delivery Services~~ at the time of the accident.

(h~~i~~) In a claims coverage investigation, a Delivery Network Company or its insurer shall cooperate with all insurers that are involved in the claims coverage investigation to facilitate the exchange of information and shall immediately provide upon request by directly involved parties or any insurer the precise times that a Delivery Network Driver began and ended the Delivery Available Period and/or the Delivery Service~~s~~ Period on the Delivery Network Company's Digital Network in the twelve-hour period immediately preceding the accident and in the twelve-hour period immediately following the accident. ~~A Delivery Network Company shall also provide information regarding the precise times when a Delivery Network Driver was acting within the Delivery Available Period and/or the Delivery Service Period.~~ Insurers potentially providing the coverage required in Section 3 shall disclose upon request by any other such insurer involved in the particular claim, the applicable coverages, exclusions, and limits provided under any automobile insurance maintained in order to satisfy the requirements of Section 3.

(i~~j~~) The insurer or insurers of a Delivery Network Company providing coverage under subsections (a) and (b) shall assume primary liability for a claim when a dispute exists as to when the Delivery Available Period and/or the Delivery Service Period began or ended and the Delivery Network Company does not have

available, did not retain, or fails to provide the information required by subsection ~~g~~h. of this section.

Section 4. Disclosures to Delivery Network Drivers

A Delivery Network Company shall not permit a Delivery Network Driver to engage in Delivery Services on the DNC's Digital Network until the DNC discloses in writing to the Driver:

(a) the insurance coverage, including the types of coverage and the limits for each coverage, that the Delivery Network Company provides while the Driver uses a Personal Vehicle in connection with a Delivery Network Company's Digital Network and

(b) that the Driver's own automobile insurance policy might not provide any coverage during the Delivery Available Period, if it applies, or the Delivery Service Period.

Section 5. Exclusions in Motor Vehicle Liability Insurance Policies

(a) An authorized insurer that writes motor vehicle liability insurance in the State may exclude any and all coverage and the duty to defend or indemnify for any injury or loss that occurs during the Delivery Available Period and the Delivery Service Period, including but not limited to:

(1) liability coverage for bodily injury and property damage,
(2) personal injury protection coverage as defined in [CITE STATUTE],
(3) uninsured and underinsured motorist coverage,
(4) medical payments coverage,
(5) comprehensive physical damage coverage, and
(6) collision physical damage coverage.

(b) Nothing in this Act invalidates or limits an exclusion contained in a motor vehicle liability insurance policy, including any insurance policy in use or approved for use that excludes coverage for motor vehicles used for delivery or for any business use.

(c) Nothing in this Act invalidates, limits or restricts an insurer’s ability under existing law to underwrite any insurance policy. Nothing in this Act invalidates, limits or restricts an insurer’s ability under existing law to cancel and non-renew policies.

(d) A motor vehicle liability insurer that defends or indemnifies a claim against a Delivery Network Driver that is excluded under the terms of its policy shall have the right to seek recovery against the insurer providing coverage under subsections 3(a) and 3(b) if the claim:

(1) occurs during the Delivery Available Period or~~and~~ the Delivery Service Period and

(2) is excluded under the terms of its policy.

Section 6. Effective Date

This act shall take effect on (date at least 12 months from enactment).

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Dog Breed Insurance Underwriting ~~Study & Breed~~ Protection Model Act

***Sponsored by Asm. Kevin Cahill (NY) – NCOIL Vice President**

***Co-sponsor: Rep. Tammy Nuccio (CT)**

Draft as of October 18~~June 14~~, 2022. To be ~~introduced and~~ discussed and considered during the Property & Casualty Insurance Committee meeting on November 18~~July 16~~, 2022.

Section 1. Title

This Act shall be referred and cited to as the [State] Dog Breed Insurance Underwriting ~~Study & Breed~~ Protection Act

Section 2. Restrictions on Dog-Breed Discrimination in Homeowners and Renter's Insurance Policies

(A)With respect to homeowners' insurance policies and renter's insurance policies as defined in section ___ of the insurance law, no insurer shall refuse to issue or renew, cancel, or charge or impose an increased premium or rate for such policy or contract, or exclude, limit, restrict, or reduce coverage under such policy or contract based solely upon harboring or owning any dog of a specific breed or mixture of breeds.

(B) The provisions of this section shall not prohibit an insurer from refusing to issue or renew or from canceling any such contract or policy, nor from imposing a reasonably increased premium or rate for such a policy or contract based upon the designation of a dog of any breed or mixture of breeds as a dangerous dog pursuant to section xxxxxxx, based on sound underwriting and actuarial principles reasonably related to actual or anticipated loss experience subject to the applicable provisions of xxxx.

~~Section 3. Collection and Report of Data by the Department~~

~~(A) An insurance company offering homeowner's insurance coverage or renter's insurance coverage that issues a policy or contract insuring against liability for injury to a person or injury to or destruction of property arising out of the ownership, lease, or rental of residential property shall, to the best of its ability, for any claim involving a dog-related incident, record circumstances relating to the incident, including, but not limited to:~~

~~(1) The breed of dog, and, if the breed was made by visual identification, who made the identification: the adjuster, the owner, or the insured;~~

~~(2) where the owner or insured obtained the dog from: a pet store, a breeder, an animal shelter or rescue, a friend or acquaintance, or found the dog as a stray;~~

~~(3) the sex of the dog and whether the dog was spayed or neutered;~~

~~(4) whether the person injured by the dog was observed engaging in teasing, tormenting, battering, assaulting, injuring, or otherwise provoking the dog;~~

~~(5) the type of injury sustained by the victim, such as a bite or fall;~~

~~(6) whether the incident occurred on the insured's property or another location, and if so where; and~~

~~(7) any obedience training or previous claims or past complaints against the dog.~~

~~(B) This information shall be collected for a 2-year period beginning on xxxxx and shall be reported annually to the Department. The Department shall make the information available on the Department's website by xxxx and shall update the information each xxxxxx. The Department shall report the information, in an aggregated & de-identified manner, to the legislature by xxxx. The information or data collected by the Department as well as that reported to the Legislature shall not be released or published in any way that violates the confidentiality or proprietary status or nature of the data.~~

~~*Drafting Note: 'Department' refers to the chief insurance regulatory agency of [state]*~~

Section 3~~4~~. Rules

The Insurance Commissioner shall have the authority to promulgate rules that are not inconsistent with and necessary to administer and enforce the provisions of this Act

Section 4~~5~~ Effective Date

This act shall take effect six months after passage ~~immediately~~ and shall apply to all policies issued, renewed, modified, altered or amended on or after such date.

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National Council of Insurance Legislators (NCOIL)

Insurance Underwriting Transparency Model Act

Sponsor's substitute as of November 10, 2022
To be discussed and considered by the NCOIL Property & Casualty Insurance Committee on November 18, 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. Purpose

The purpose of this legislation is to provide personal auto and homeowners insurance consumers with clear and useful information explaining a declination to provide coverage, nonrenewal, or company-initiated increase in premiums.

Section 3. Definitions

"Adverse Action" means a declination, non-renewal, cancellation, or an increase of more than 9.99% over the expiring premium for, or a reduction in coverage or other adverse or unfavorable change in the terms of coverage or amount of insurance in connection with the underwriting of a property & casualty personal private passenger

automobile or homeowners insurance policy, excluding any increase in the insurer's statewide base rate and any additional premium due to a policyholder-initiated change in the insured's coverage.

"**Applicant**" means a person who has completed and submitted an application to an insurer for the purpose of obtaining insurance coverage.

"Policyholder-initiated change" includes but is not limited to adding or removing vehicles or drivers, adding an endorsement, adding additional coverages, adding covered premises, or increasing or decreasing coverage limits or deductibles.

Section 4. Transparency Requirements

(a) When an insurer communicates an adverse action to an applicant or insured, the notification shall include either:

(1) A statement describing the applicant's or insured's right to request and obtain a notice explaining the principal factors for the adverse action; or

(2) A notice explaining the principal factors for the adverse action.

(b) If an insurer takes an adverse action, the insurer shall, upon a written request from the applicant or insured, or that person's authorized insurance producer, provide a written notice to the applicant or insured explaining the principal factors for the adverse action. The request or the notice may be provided by postal mail or, if the applicant or insured has provided consent, in electronic form, via e-mail, via electronic document or by providing a link to the personalized statement specific to that applicant or insured posted to a secure location on the insurer's website or mobile device application.

(c) The notices required by this section must be sufficiently clear and use specific language so the applicant or insured is able to identify the basis for the insurer's decision to take an adverse action. Statements that the adverse action was based on the insurer's internal standards, policies, or models or that the applicant or insured failed to achieve a particular score on the insurer's scoring system, has a poor credit history or poor credit rating do not satisfy this requirement. The notices must also include a description of the specific principal factors most heavily weighed by the insurer for the adverse action in no particular order; however, if the insurer uses more than ten (10) such factors, then only the 10 most heavily weighed must be disclosed in no particular order. This section does not require disclosure of factors known to the insurer as a result of the applicant's or insured's participation in a usage based or telematics insurance program that are

otherwise disclosed to the applicant or insured. The notice may also provide a point of contact for the recipient to discuss the reasons for the adverse action.

(d) An insurer shall provide copies of the notices described in this section to the applicant's or insured's authorized insurance producer, if any. The notices may be provided to the producer in electronic form, via e-mail, via electronic document or by providing a link to the personalized statement specific to that applicant or insured posted on the insurer's website.

(e) Nothing in this Act prohibits an insurer from voluntarily providing the disclosures required by this section.

Section 5. Rules and Penalties

The Commissioner shall adopt rules as necessary to effectuate the provisions of this Act. Those rules shall include monetary penalties consistent with those assessed for other similar violations of this State's insurance code. Violations shall be enforced solely by the Commissioner. A violation of this Act shall not create a private cause of action.

Section 6. Effective Date

The required notices shall be provided on applications submitted and policies eligible for renewal on or after [date 12 months following enactment of this law].

Drafting Notes:

1) This Model is intended to apply to property & casualty personal lines insurance policies such as personal auto insurance and personal homeowners' insurance. This may also include farm and farm auto policies. Other lines of insurance, such as life insurance and commercial property & casualty insurance, are not intended to be brought within the scope of this Model.

2) Some states have existing laws governing notices for cancellations, non-renewals, and/or significant premium increases. Where in place, this model should be modified to be consistent with the percentages in these existing laws.

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

4) "Commissioner" may be replaced with the title of the state's chief insurance regulatory officer.

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National Council of Insurance Legislators (NCOIL)

Insurance Underwriting Transparency Model Act

***Draft as of October 18~~September 26~~~~June 14~~, 2022**
***To be discussed and considered by the NCOIL Property & Casualty Insurance Committee on November 18~~September 29~~~~July 16,~~ 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 declination, non-renewal~~nialbased on data or information that is not inherently part of the risk,~~ ~~or~~ cancellation ~~of~~, or an increase of more than 9~~7~~.9% ~~or more increase~~ in a rate~~charge~~ for, or a reduction in coverage or other adverse or unfavorable change in the terms of coverage or amount of insurance in connection with the underwriting of a property & casualty personal insurance policy based on external consumer data, excluding any increase in the insurer's statewide rate and any additional premium due to a policyholder-initiated change in the insured's coverage.

~~*Drafting Note: The intent of including the phrase "inherently part of the risk" is to distinguish between* **factors that fall into this classification and those that do not***when the transparency requirements set forth in Section 3 of the Model apply to denials. It is*~~

~~*the intent for the transparency requirements to apply to* **adverse actions***denials based on data or information that is not "inherently part of the risk.",* **Those not "inherently part of the risk" would include, but not be limited to,** *such as a consumer's social media footprint, purchasing habits, internet activities, etc.,* **Data or information that are "inherently part of the risk"** *and not to denials that are based on traditional underwriting data or information such as physical condition of the risk, motor vehicle records (MVR), or a Comprehensive Loss Underwriting Exchange (CLUE) report.*~~

Drafting Note: This Model is intended to apply to property & casualty personal lines insurance policies such as personal auto insurance and personal homeowners' insurance. This may also include farm and farm auto policies. Other lines of insurance, such as life insurance and commercial property & casualty insurance, are not intended to be brought within the scope of this Model.

Drafting note: Some states have existing laws governing notices for cancellations, non-renewals, and/or significant premium increases. Where in place, this model should be modified to be consistent with the percentages in these existing laws.

"**Applicant**" means a person who has completed and submitted an application to an insurer for the purpose of obtaining insurance coverage.

"External Consumer Data" means data or information that is obtained from an external source and used by an insurer to supplement traditional underwriting or rating. The term does not include:

(1) Traditional rating and underwriting tools, including physical condition of the risk, motor vehicle records, or an insurance claim loss history report; or

(2) Driving data or information the policyholder provides to the insurer or agent, including through participation in usage-based programs and/or telematics programs when those programs are limited to driving based information only.

Drafting Note: The intent of this Model is to require transparency of factors based on external consumer data that are not inherently part of the risk. The exclusions set forth in this definition distinguish between factors that fall into this classification and those that do not. It is the intent for the transparency requirements to apply to adverse actions based on data or information that is not inherently part of the risk. Those not inherently part of the risk would include, but not be limited to, a consumer's social media footprint, purchasing habits, internet activities, etc.

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 an applicant who received a declination for insurance coverage from that insurer ~~consumer~~, must disclose to that~~e~~ applicant~~consumer all primary~~ those factors, in no particular order, based on external consumer data, ~~up to a maximum of ten (10), of those~~ most heavily weighed~~,~~ by ~~that~~ the insurer ~~uses~~ in issuing the declination~~calculating a premium~~; however, if the insurer uses more than ten (10) such factors, then only the 10 most heavily weighed must be disclosed.

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

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

(2) ~~all~~ those factors, in no particular order, based on external consumer data most heavily weighed by the insurer in determining the adverse action; however, if the insurer uses more than ~~up to a maximum of~~ ten (10) such factors, then only the 10 most heavily weighed must be disclosed~~that were the primary influences on the adverse action~~.

(c) With the written consent of a policyholder, an insurer shall provide the disclosure required under subsections (a) or (b) to a designated agent or producer.

(d) Nothing in this Act prohibits an insurer from voluntarily providing the disclosures required by this section.

Drafting Note: The use of generalized terms such as "poor credit history," "poor credit rating," or "poor insurance score" do not meet the explanation requirements of Section 3(b).

Section 4. Penalties

A violation concerning external consumer data shall constitute a violation of [*insert citation to state unfair trade practices statute*] to be enforced solely by the Commissioner. A violation of this Act shall not create a private cause of action.

Drafting Note: If states have existing laws where their unfair trade practices statute is enforced by another state official, then that existing statute should govern.

Section 5. Rules

[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.

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 twelve~~six~~ (12~~6~~) months for all actions governed by this Act~~applications, renewals, and declinations thereafter~~.

BUDGET COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 13, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Budget Committee met at The Hyatt Regency in Jersey City, New Jersey on Wednesday, July 13, 2022 at 5:00 p.m.

California Assemblyman Ken Cooley, NCOIL President, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Matt Lehman (IN)
Sen. Jerry Klein (ND)

Also in attendance were:

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

QUORUM

Upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Ferguson, and seconded by Sen. Klein, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 17, 2021 meeting.

2023 BUDGET PLANNING DISCUSSION

Asm. Cooley stated that the Committee is here today to discuss and plan for NCOIL's 2023 budget. Before going through the budget and opening it up for questions and comments, Asm. Cooley noted some procedural matters: today's meeting is only for the Committee to discuss the document distributed and determine if any changes should be made – no votes will be taken. The Committee will then meet at the NCOIL Annual Meeting in New Orleans in November to formally adopt the 2023 Budget and send it to the Executive Committee for final consideration at the conclusion of the Annual Meeting.

Asm. Cooley noted that NCOIL is in the midst of having another strong year and the numbers in the proposed 2023 budget represent an expectation that things will remain positive for the organization. Starting with Dues - 30 states paid last year for a total of $645,000 which represented an all-time high for NCOIL in terms of the amount of dues collected. The reason why the total amount collected does not read $600,000 ($20,000 times 30) is because some state dues payments for 2020 were received during the 2021 calendar year. This reflects NCOIL's modified accrual accounting method for dues

payments. As of now, NCOIL is on track to have 30 states pay again this year and we're optimistic that we'll get at least one new state to join. Accordingly, $620,000 represents a reasonable number for 2023. As of July 11, 12 states have paid their 2022 dues, but most states operate on a July 1 fiscal year, so the majority of dues payments typically arrive after this meeting. Sen. Klein noted that for the past two years his home state of North Dakota has paid the prior amount of dues ($10,000) as that amount was earmarked into future budgets but he has raised the issue with the ND Insurance Commissioner to get it resolved.

Next, for Corporate & Institutional Partners (CIP) revenue, the proposed amount is $475,000 which does represent a significant increase in last year's budgeted amount, but also represents the reality of a thriving CIP program. As of June 30, we have received $459,000 in CIP dues and while we have closed CIP membership for the remainder of this year, there are still some outstanding membership dues. Also, we have already secured a few new CIP members for next year. Thus, the $475,000 proposed amount for next year seems in line with the growth of the CIP program. Asm. Cooley stated that the Committee has in the past strove for a 2:1 ratio of state dues to CIP dues, but he is comfortable with adjusting that ratio to meet economic and organizational realities. As long as nothing changes in terms of the way the CIP program has been operating, and does not become the primary source of revenue for NCOIL, then we're in a great place to see the CIP program continue to grow, subject to periodic closures like the one we have now to balance the necessary financial balance. Rep. Ferguson asked why the CIP has been closed for this year. Cmsr. Considine explained that it was closed in an abundance of caution to ensure that the CIP's revenue didn't surpass state dues revenue. Rep. Lehman stated that nothing like the 2:1 ratio should be carved in stone as it should be able to be adjusted on an as-needed basis, but of course the goal is always to get more states involved in NCOIL as it's a state driven organization.

Asm. Cooley then noted that for meeting support & revenue, the 2023 numbers are similar to those from last year but with some adjustments based on the location of the conferences. While the cities of Minneapolis and Columbus are wonderful American cities, we may take a slight hit in attendance for those meetings. Contrast that with the Spring Meeting in San Diego where we'll likely see an increase in attendance. Rep. Ferguson suggested sending out photos promoting the site of the conference because she and others had a perception of Jersey City that was completely wrong and that may have hurt participation for this conference. Rep. Lehman agreed.

Asm. Cooley then discussed the Industry Education Council (IEC) NCOIL grant. As note 2 in the document states, that projected number is based on IEC negative growth. The IEC has a formula based on as their membership shrinks, their grant to NCOIL shrinks – this has been the case for several years. Hearing no questions or comments, Asm. Cooley proceeded.

Next: interim calls. We expect the trend of more interim Zoom meetings to continue. The number of $5,000 in the document is near what we already have received this year in interim call revenue. Rep. Ferguson asked for the interest portion of the budget to be explained in terms of how it is calculated. Cmsr. Considine stated that it's just simple interest. If the Committee desires, we could look into depositing a certain amount of money in a Certificate of Deposit for interest purposes.

Asm. Cooley stated that overall, the total support & revenue number comes in at $1,660,450 which reflects consistency as well as continued growth.

Asm. Cooley then moved to the expense side and stated that CIP expenses are up essentially because we expect more members which increases the cost of the CIP meetings and receptions. Additionally, as some of you know, last month we had the annual CIP Planning Meeting in Napa, CA and it was unanimously agreed by everyone there that the Planning Meeting going forward should be in locations that are outside the typical NCOIL conference cycle. We're looking into next year's meeting being in Coeur d'Alene, Idaho. That will also result in an increase in CIP expenses. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to the stipend program – the legislator stipend program assumes a complete consumption of $9,000 for all fully contributing states. This number represents an increase of $3,000 over the prior amount of $6,000. Asm. Cooley asked Cmsr. Considine to explain the proposed increase. Cmsr. Considine stated that this is for the twofold purpose of equalizing the stipend amount with the scholarship amount, and accounting for these inflationary times. Rep. Ferguson said there should be attendance required at conference meetings/session in order to receive a stipend or scholarship. Cmsr. Considine agreed. Rep. Lehman stated that issue will need to be addressed for purposes of any legislators that will be playing in the NCOIL Open Golf Outing in November. Cmsr. Considine suggested that a letter should be sent to any legislator who receives a stipend or scholarship explaining the guidelines and requirements. Rep. Lehman agreed and stated that a legislator receiving that wouldn't want legislative leadership to then hear from NCOIL that she or he didn't meet the guidelines and requirements.

Moving to the retainer and incentive payment. For the retainer, as note 4 in the document shows, the increased number reflects 100% of the retainer being paid from NCOIL, not the Insurance Legislators Foundation (ILF). Additionally, the annual contractual increase of 3%, which NCOIL Support Services waived in 2021, continues on in 2023. For the incentive payment, that number is based on a contractual formula involving a change in NCOIL net assets over a contractual base amount. As overall NCOIL performance results increase, so does the incentive payment to staff. Asm. Cooley noted that if there are any questions on that, please direct them to Cmsr. Considine as he is very transparent with everything related to the retainer and incentive payment. Asm. Cooley noted that he believes the incentive payment structure is proper and serves a good purpose. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to conference expenses, the numbers are similar to years past and generally correspond with which locations we expect to have more attendance which means more expenses. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to future location deposits – that number is based on how future contracts read and they all largely mirror past contracts. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to IEC Discount Givebacks – that involves discounts IEC members receive on NCOIL conference registrations so we track that lost revenue as an expense. As IEC membership is expected to decrease, the number in the distributed document

accordingly is less than last year. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to travel – we generally budget for $20,000 and that has never been exceeded but this year we have experienced a slight bump in travel expenses so out of an abundance of caution we have budgeted for a slightly increased amount for next year. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to Professional Fees. Prior budgets had two lines, one labeled "Audit Fees" and the other labeled "Accounting Fees." In consultation with staff, we agree that the lines should be merged and titled as "Professional Fees." The amount of $22,000 reflects: NCOIL bearing a greater portion of the audit expenses and the ILF a lesser share; standard accounting fees; and the anticipated fees for the new research/writer 1099 position. Hearing no questions or comments, Asm. Cooley proceeded.

Moving to Miscellaneous – that number remains the same. Hearing no questions or comments, Asm. Cooley proceeded.

Lastly, the D&O insurance amount has increased, mainly due to inflation. Hearing no questions or comments, Asm. Cooley proceeded.

Asm. Cooley stated that overall, the proposed budget has support and revenue at $1,660,450 and expenses at $1,526,588.30 for an excess of $133,861.70 which reflects consistency and continued growth.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Ferguson, the Committee adjourned at 5:30 p.m.

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
JERSEY CITY, NEW JERSEY
JULY 14, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Hyatt Regency in Jersey City, New Jersey on Thursday, July 14, 2022 at 11:30 a.m.

Representative Brenda Carter of Michigan, Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Jason Rapert (AR)
Asm. Ken Cooley (CA)
Rep. Matt Lehman (IN)
Rep. Joe Fischer (KY)
Rep. Hank Zuber (MS)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Roy Takumi (HI)
Rep. Rod Furniss (ID)
Sen. Beverly Gossage (KS)
Rep. Derek Lewis (KY)
Rep. Kevin Coleman (MI)
Sen. Mike McLendon (MS)
Sen. Walter Michel (MS)
Asm. Roy Freiman (NJ)
Asw. Elaine Marzola (NV)
Asw. Pam Hunter (NY)
Rep. Brian Lampton (OH)
Rep. Forrest Bennett (OK)
Rep. Wendi Thomas (PA)
Rep. Dennis Paul (TX)
Rep. Jim Dunnigan (UT)
Sen. Mary Felzkowski (WI)

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 Immediate Past President, and seconded by Sen. Bob Hackett (OH) the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL Secretary, and seconded by Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 4, 2022 meeting in Las Vegas, NV.

CONTINUED DISCUSSION ON 340B DRUG PRICING PROGRAM

Rep. Carter stated that we'll start today with a continued discussion on the 340B drug pricing program. This topic was previously being discussed in the NCOIL Health Insurance & Long Term Care Issues Committee but at the NCOIL Spring Meeting in March it was announced that it would be transferred to this Committee. Since the 340B drug pricing program is a Federal program, it made sense to transfer the topic to this committee. Today is really about information gathering and further education on the program and after today, we will evaluate what, if any, next steps would be involved with this topic. Let's start with hearing from Asw. Pam Hunter (NY).

Asw. Hunter stated that I appreciate you letting me make a few brief remarks since we did move this topic from the Health Committee at our last session. It's been a very important conversation in New York as we've had long standing discussions about 340B and the savings. We want to make sure that any savings continue to go towards those programs and services, especially federally qualified health centers. So, I'm definitely interested in hearing how we can have a robust discussion on this, especially at the Federal level, about who is taking the savings who don't need them and are therefore putting other programs in peril.

Wayne Winegarden, Ph.D., Senior Fellow, Business & Economics at the Pacific Research Institute (PRI), thanked the committee for the opportunity to speak and stated that I think what the Assemblywoman said in terms of ensuring the program exists for those institutions, those hospitals, that it's made for is the most compelling reason why we need to reform the program. So, let me start with a very quick elevator pitch in terms of why 340B needs reform and then kind of spend the rest of my ten minutes here just trying to back this up to convince you that it's an important program. What we're trying to do is very important but we're doing it very poorly and that puts the entire program in jeopardy because right now it is completely unsustainable. The reason it's unsustainable is because when you look at the growth whether you measure the growth of dollar value of drugs going through, the number of hospitals, or "covered entities" as those that participate in the program are referred to as, or whether you're talking about the number of contract pharmacies, that growth has been out of control.

Now, if it was actually achieving its purpose, that would make sense. But it's not. So, we have out of control growth, combined with a program that's not actually doing what it's supposed to do and then it has ancillary impacts which includes incentivizing more expensive medicines to be used. You're actually raising costs for other users of drugs and you're actually incentivizing a consolidation in the medical practices which when you do it for 340B is actually inefficient as it raises costs and hurts quality of care. I think you're familiar with 340B but let me just go through it very quickly just in case some of us aren't. The purpose of 340B is to help ensure patients have the needed medicines by supporting hospitals or clinics that are serving what they call disproportionate share but basically, lower income people, particularly people without insurance. If you look at the history of it, it's actually interesting because it's a little bit of the old woman who swallowed the fly where it was once you had pharmaceutical companies provided low-cost medicines, sometimes for free, to these same types of hospitals or entities but then when Medicaid came along when they had their reform in 1990 and you had "best price". Well, "best price", if I'm giving the medicine away for free, that's your best price. That's

something you can do for a small share of hospitals but you can't do that for the entire Medicaid program so you actually, from one reform trying to do something over here, you squeeze the balloon and you caused a problem over here. So, now we'll squeeze the balloon again and we created 340B and the idea for 340B is we're going to allow these covered entities to purchase the drug at a lower price. That lower price they get reimbursed at the higher rate which is in subsidy which they're then supposed to use to expand to care. Talking about discounts, it could be 50% more and actually on average they're right now significantly more.

Here is a very simple kind of example to how this works and it's simple because I'm not including margins, markups, and all these other kind of fun things or when you talk about prices in the drug industry, we can have a whole conversation about that. But if we assume a drug with a price of $1,000, if you have 340B discount of 50%, then that hospital when they're purchasing the drug, assume it's an infusion drug for cancer, you're actually going to pay $500. Even though you paid $500, the insurer, or Medicare, is going to reimburse at the full value. For Medicare it would to be Average Sale Price (ASP) plus 6%, but we'll just call it $1,000 and that means what we've now done is given that hospital $500. Now, what's really important to remember though is that that $500 came from the pharmaceutical manufacturer. Which when you're talking about the program when it's contained and it's part of kind of a charitable operation, it's doable but when the program grows beyond something that they can afford, you end up with restrictions, which is what we're actually seeing in the program now. Entities that deserve these types of discounts are actually finding it very hard to maintain them.

Starting with the growth very quickly, and this chart came from Drug Channels, which if you're not familiar with it, it's is a fantastic source in all things drugs. And there's two bars in this which is why this one's interesting. The light blue bar is what they guesstimate the price of the drugs are at the 340B discounted price. In this case it's the purple bar that's at the list price, or what they call wholesale acquisition cost (WAC). And what you see is you focus on the blue bar, that's a 27% average annual growth a year. So, you have the revenues in this program are growing at kind of what they're paying, 27% a year. Now, to see how excessive that is, manufacturer revenues are going up 5% a year. So, you see a huge increase in the dollar value going through this program and you can see a large part of that, that's kind of at the end of 2020 there, is through contract pharmacies which we'll come back to as that's one of the big problems in terms of why this program is having more fraud issues and is growing out of control. If you look at this graph, and this is from IQVIA, they take the WAC price data, so that bar all the way to 2021, you can see it's now going to $94 billion, or 14% of all drug spending valued at this price. That's just an incredible growth. It's become the second largest kind of program discount in the system. So, it's supposed to be something that's kind of tailored to specific hospital's serving low-income people. Now, it's at 14% and the second largest discount program.

And why that's happened, and to me what really amazes me about this chart, and this is from IQVIA again, the light blue bar is what they call covered entities - hospitals, things of that nature. And it looks like it's not growing. But that grew 50% between 2010 to 2020. Now, why is 2010 important? Because that's when we had some changes that allowed entities to have as many contract pharmacies as they want. It's interesting about contract pharmacies as they were put in there because some of these entities, the ones that are deserving of the discount, they didn't have pharmacies internal. So, you have huge hospital systems that have their own pharmacy, then many of these entities

didn't. So, you're allowed to have one contract pharmacy. In 2010, it was decided you can have as many as you want. Some institutions now have 150 contract pharmacies and so you can see in that green bar how much that's grown. It's so excessive that you can't even see the growth in the number of entities which is huge in and of itself. And then the bar in between which is also very important is entity sites because you have that incentive to consolidate, to bring independent practices into your hospital system. And this is evidence that that incentive is actually working, that we're actually buying up practices and bringing them to the hospital system. And basically the reason is for the 340B discount. So, with the relaxation of Medicaid, and with the relaxation of research and contract pharmacies all around 2010, we've seen a huge growth in this program.

In terms of contract pharmacies and why that's very important, if we're talking about almost 30,000 contract pharmacies, 70% of those, the Walgreens, the CVS', they're actually getting about 25% of the revenues from 340B because when you fill a prescription and you're a contract pharmacy, you get a higher rate than you would on a normal prescription. Seventy percent of it is going through huge big name companies. So, here's one kind of problem with the program. Contract pharmacies have exploded. They're getting a big chunk of the money and they're not the intended institutions we're trying to support. So, we have this off chute of all of the revenues going to these contract pharmacies. That's a huge problem. If we're looking at the hospitals themselves and this is now reciting some of the research I've done where we looked at a sample of hospitals in this case, this is looking at a sample of 340B hospitals and we went through 990's to see if we could get a sense of how much their revenues are growing compared to the average hospital and you can see average annual revenue growth is significantly higher in a 340B. However you measure that average doesn't matter - we have a higher revenue growth compared to your average hospital.

Not only do we have higher revenue growth, but profit growth also compared to some basic benchmarks is excessive. So, what we're seeing is growth in revenues in the hospital systems, growth in profits in the hospital systems but when you look at also the profitability, and we're able to not just do a sample, we can look at all 340B hospitals - this is for 2017 and they are actually more profitable. They're excess revenues engaged in a non-profit institution relative to revenues at 340B hospitals are significantly higher – 25% higher. So, we have incredibly profitable institutions with strong growth in revenues, strong growth in profits. The big problem is they're not spending more on charity care. If you look at how much they're spending on charity care, it's about average of 1.66% compared to a bit over 2% for your average hospital. So, we have subsidization of the program, it's expanded to the point where it's not achieving its purpose and that purpose is important but we need to reform 340B to bring it back to that issue. And why is the program having these results? Part of the problem is you're incentivizing high cost medicines and that just gets to how the markup works. Fifty percent of a higher number is a larger amount. What we actually see, and this is from a Government Accountability Office (GAO) study that they are actually prescribing more drugs and they're prescribing more expensive drugs. So, 340B is incentivizing all these hospitals that are growing to spend a lot more to use higher cost drugs. Because of that and because of the growth of the program, what we're seeing is evidence of cost shifting. And the GAO and New England Journal of Medicine stated that in fact there is cost shifting. So, non 340B patients are paying more for their drugs because of the huge discounts that are coming through the 340B program.

And we're also seeing consolidation of medical practices. When we looked at those entities cited, what you're seeing is if you were an independent cancer center, the drugs that you're using are very expensive. So, that 340B discount is worth a lot and so what you've seen is oncology practices are no longer independent; they're now part of big hospital systems. Higher costs are associated with hospital systems plus quality of care. Patients who prefer to be independent can't do it. And that leads us to why we need to reform. Some of the reforms we're talking about is most importantly transparency and restrictions on contract pharmacies as you shouldn't have 150 contract pharmacies, as it's not necessary. Boston General has a contract pharmacy in Florida - that's a bit excessive. We need to roll those back. We also need to make sure that the patients benefit and this something I hit upon but when you talk about a patient's co-insurance cost, that's typically not based in the 340B price. So, in the example I gave earlier it would be based on $1,000. So, even though the cost to the hospital is based on $500, a patient's paying their co-insurance on $1,000. So, patients directly benefiting isn't part of the program but it should be. Also, restricting expansions to medically underserved areas is important. Right now, a profitable strategy is to pick up an oncology center in the very rich neighborhood with people with lots of good insurance, and you're going to get a lot of money. But again, the purpose of the program is to serve medically underserved areas.

Miranda Motter, Senior VP, State Affairs and Policy at America's Health Insurance Plans (AHIP), thanked the Committee for the opportunity to speak and stated that she would like to spend a couple of minutes talking about 340B with particular emphasis on the parties and the disputes that I know many of you have read about in the press. I'm not going to try to duplicate any of the information that Dr. Winegarden has shared because I think some of the information that he has shared you will see here in my slides but where I talk about it there is an emphasis that I think is really important as we think about the program and we think about the disputes and the problems Dr. Winegarden talked about. And certainly we should think about if there are solutions that should be considered. So, I'm going to spend a couple minutes talking about the purpose and the participants and then really spend most of my time providing again some granularity around the disputes and where they lie and why. The purpose of the program as it was created by Congress in 1992, was to stretch scarce Federal resources to reach more eligible patients and to provide more comprehensive services to low income patients and to uninsured patients.

Here, I think it's really important to focus on who the participants of the program are and there are four main categories of participants. The Health Resource and Services Administration, referred to as HRSA. The Office of Pharmacy within HRSA is actually the administrator of the program and that's really important particularly as we talk later on about the disputes. Drug manufacturers who are participating in the Medicaid drug rebate program are participants and it's really important again to note that drug manufacturers must participate in the 340B program in order to have their drugs covered under the Medicaid program. So, that is again another really important distinction that there is essentially an exchange they receive. They provide their drugs at a discount in the 340B program and as a result their drugs then are available in the Medicaid program. We talked a little bit about covered entity and contracted pharmacies. Contracted pharmacies essentially the way I think about it is stand in the shoes of the covered entity and as Dr. Winegarden said, under Health and Human Services (HHS) guidance and HRSA guidance hospitals are utilizing contracted pharmacies in ways that are permitted under the Affordable Care Act (ACA) due to the expansion of the program.

It's also important to again focus on the eligible patients. So, the regulations at HRSA are very clear about the types of patients that should be receiving the discounts and the rebates and they're essentially those that receive care from a covered entity. So, let's talk just a quick minute again about how the program works. As I said, drug manufacturers essentially provide a discount and Dr. Winegarden talked about it being 50% or more but I think generally what we hear is the average is anywhere between 20% and 50% on outpatient drugs that are purchased by covered entities. Again, the drug discount is given in exchange for coverage of their drugs in Medicaid. The covered entities on contracted pharmacies must comply with all the 340B program requirements including making sure that the drugs are distributed and given to eligible patients. You'll hear sometimes what's referred to as a prohibition about a duplicate discount and this is really in the Medicaid context where there are duplicate discounts so discounts that result from 340B and discounts that result from the Federal rebate program are impermissible under Medicaid. That's not the case necessarily in the commercial market but you may hear references to duplicate discounts. And then lastly here and you'll see throughout my presentation there are number of links because I do think again it is very important as you are considering this issue to really go to and look at the resources that are out there whether it's the HRSA's FAQ's where it talks very specifically about covered entity requirements, contracted entity requirements, and drug manufacturer requirements. This is a slide very similar to what you saw Dr. Winegarden present. It is simple math where you see the discounted drug, the discount being given by the drug manufacturer to the hospital or the covered entity and then what the reimbursement for that drug is. And then certainly, the difference or the delta of that goes back to the covered entity.

One of the things that I think is really important as we look at the disputes here is that this is not a health plan issue. The disputes that I'll talk about here in a minute are disputes between drug manufacturers who are essentially in some instances resisting the 340B program requirements to provide those 340B discounts. That is one situation. And then the other instance is where a drug manufacturer may be imposing certain conditions or restrictions to make sure that they get the information they need or to ensure that that drug is going to an eligible patient. And then the other sort of group of disputes that you'll see here in a minute is really by the covered entity. So, those who are seeking to protect those scarce resources to protect those funds that they are receiving under the 340B program to use for a variety of purposes. This is a high level review of where the disputes lie on the drug manufacturer side. Here, I included the materials around the 340B advocacy that you'll see PhRMA has put out and put forward and I think it's really important to see those things and their rationale of the dispute as it relates to providing the rebate to covered entities. You'll see here that initially; I think the major dispute started when notices by a small number of drug manufacturers were sent to HHS that they were going to limit and not provide the discount. Quickly thereafter, you had a number of other drug manufacturers follow suit.

This next slide really provides the backup or the additional detail of the bubbles on the prior side. So, as I said, other drug manufacturers quickly followed suit after a couple of drug manufacturers indicated that they were not going to provide the rebate. Seventeen drug manufacturers I believe to date have indicated that they will not be providing that discount. And then as I said, about 10 of those companies have indicated that they will impose certain restrictions to make sure that they get the information back that they need from a covered entity. In December of 2020 as I mentioned HHS issued an

advisory opinion that concluded that drug manufacturers are required to provide that discount under the program on covered outpatient drugs when a contract pharmacy is an agent for that covered entity. Additionally, in December of 2022, HHS issued a final rule as it related to their administrative dispute resolution (ADR) process. Drug manufacturers quickly and along with PhRMA have filed suit that challenged HRSA's advisory opinion as it related to the ADR process. And some manufacturers had, or are in, disputes as it relates to both of those things. You'll see there between 2021 and 2022 HRSA sent letters to drug manufacturers. You can see the letters there on HRSA's website to those drug manufacturers that announced they would not provide the rebate indicating that they needed to do that per HRSA guidance. And then in September of 2021 HRSA has referred a number of those cases to the Office of Inspector General within HHS.

So, again a quick high-level overview of where the disputes lie and really the perspective of the drug manufacturers as it relates to the 340B program. Let me quickly move to the disputes on the covered entity side. Again, I wanted to provide sort of the high level overview of all of the different categories of disputes that we see on the covered entity side. Again, I wanted to show and provide to you information that's publicly available on America's Hospital Association (AHA) website of what they believe the challenges are which again are really focused on the drug manufacturers. And then some resources are shown there by 340B Health which is essentially a member association of hospitals that are working on 340B advocacy and reform issues. So, let's go to the detail slide and let's start with the hospital association and the 340B providers. Quickly after those drug manufacturers announced that they were not going to provide that rebate they sent letters to those drugs companies asking them to reinstate the discounts on those products. Thereafter, those 340B providers filed suit to really ask and to enforce HHS's obligation as it relates to drug manufacturers and enforcing the program and the drug manufacturers requirements.

Related to 340B disputes but different than the drug manufacturer issues, I did think it was also important to highlight that the Centers for Medicare & Medicaid Services (CMS) during all of this also issued a rule that would have essentially cut Medicare payments for drugs that were acquired under the 340B program. And so, as you can imagine, there were suits and litigation that followed as a result and most recently just a couple of weeks ago, the U.S. Supreme Court issued a decision in that case and you may have seen some of the press coverage as it related to that decision. In short, as you can see here there are a variety of disputes that really at its core are about the discounts that manufacturers are required to provide. And on the other side it's the covered entities and the contracted pharmacies and their role and the funding that they receive and the important resources that they receive under the 340B program. I think it is really important to note that this is not a health plan issue for all of the reasons that I just walked through and in closing I would say it is really important to be cautious against any type of legislation and policy proposals that would essentially leave the ultimate purchaser of healthcare, which is the employer and the individual patient from being left holding the bag. And when I say that I mean making sure that proposals don't relieve drug manufacturers from paying that rebate when they are required to pay that rebate under the Federal program and then also likewise making sure that any proposals don't relieve covered entities from having to comply with the program's requirements as well.

Greg Doggett, VP, Legal and Policy Counsel with 340B Health, stated that I just wanted to thank NCOIL for its continued interest in 340B. A lot of interesting information has

been shared. I would like to highlight that a lot of the issues raised today are primarily Federal in nature. Going back to the NCOIL Health Committee discussions at the last two NCOIL meetings about 340B, one area that is ripe for State regulation, or I should say State legislation, is regulation of pharmacy benefit managers (PBMs). Specifically, legislation that would address discriminatory payor practices such as low reimbursement. States have already shown a tremendous interest in this issue. We have now two dozen states that have already enacted such laws. So, I would encourage the organization to continue to consider the model legislation that was discussed at those last two meetings. Also, in light of some of the information shared today, I just wanted to briefly mention a couple of research points that I think demonstrate that 340B continues to target the proper hospitals that serve a lot of low income patients, or patients in rural areas. 340B hospitals make up only 40% of the hospitals in the U.S. but they provide 60% of all uncompensated and unreimbursed care. They also provide 75% of total hospital care to Medicaid beneficiaries. And then just one last point - critical access hospitals, hospitals where healthcare access is a major issue, consistently report that 340B is one of the lifelines that just simply allows them to stay open. Especially at a time with COVID and especially when so many hospitals are facing closure in rural areas.

Asw. Hunter stated that Ms. Motter had repeated a couple different times that this is not a health plan issue - it's a drug manufacturer and covered entity issue. So, it would have been nice to actually have PhRMA here to speak on this issue. Also, we really wouldn't be needing to have this discussion if the drug prices weren't so expensive in the first place which I feel like we don't have many conversations about and that is what got us into this position in the first place. But my two question or points which I don't know if they can be addressed today or not relate to identifying the need population and what that looks like relative to safety net hospitals and their need. Because if you are talking about a situation like where I live, where I have a FQHC and a safety net hospital, this hospital has hundreds of millions of dollars for their programs and services and the savings that they're getting benefits programs and services but the millions of dollars that come to the FQHC cannot be replaced. I think that needs to be addressed and I'd like to know how we're going to go about doing that and what is the Federal government's plan to supplant this removed money? New York is talking about, "We want our savings back" and all of a sudden it seems like a money grab from the state trying to take this savings money back but who is going to give an FQHC that money that they were using directly for programs and services that they're not going to have otherwise? So, I don't know if you all have the answers to these questions. I think that this definitely warrants more discussion than unfortunately the limited amount of time that it allows today but this is a very serious problem that I think we need to have some more people at the table to address.

Sen. Hackett stated that I agree a lot with what Asw. Hunter said. I've been involved a long time with 340B and if you look at 340B, initially you had the veterans, you had the FQHCs, and you had the disproportionate share hospitals and then President Obama allowed a lot more hospitals to get involved. So, the biggest issue is not the FQHCs and the veterans. I think if you talk to people in Washington D.C., it would destroy them and it would really be bad. And in Ohio we had some drug companies that basically said they weren't going to pay the discount and you have to realize a lot of our FQHCs are working in deserts as it is and if you cut out a Walgreens or a CVS, they have to have them if they don't have an in place pharmacy. So, the question I have is, when they set the law ten years ago or whenever they did it that the additional dollars had to be used

under specific rules that the Feds dictated - has that been changed? Is that at a point where that's been strengthened? Are there any negotiations going on at the Federal level? I agree that this is a Federal issue and it's not a State issue - it's a Federal issue. And so, is there anything going on at the federal level? Because we cannot let PhRMA just dictate to us to cut this out. I understand the issue with the one set of hospitals. I'm not in the middle of that, and they can fight that how they want but is there anything being done at the Federal level to get this thing resolved so that we don't keep fighting this over and over and over?

Ms. Motter stated that from what I understand there have been attempts whether it's at the Congressional level or through HHS to try to adjust and reform the program. But it remains as it is today by the ACA and by additional laws and regulations so I am not certain it has not been changed but I would just continue to reiterate that this is a Federal program and these challenges lie at the Federal level because of the way it is currently situated. Sen. Hackett stated that if the law hadn't changed we wouldn't have this problem. If Congress would have left it alone we would have helped the ones we were helping and so adding that layer of hospitals into the system is what has created this problem from day one. And I'm not making a value judgment whether they should be in or not but the issue is we had additional hospitals that qualified for the dollars. If they hadn't had done that we wouldn't have this problem.

Dr. Winegarden stated that some of that wasn't intentional. When we created the ACA, we expanded Medicaid. When you expanded the Medicaid population you brought hospitals that weren't part of the program into the program. So, there's a lot of unintended consequences. When you're looking at the issue with 340B, nobody intended for some of these things to happen they just have happened. But to directly answer your question, there's no legislation moving right now at the Federal level that would address any of these issues.

Mr. Doggett stated that regarding the point mentioned about the contract pharmacy restrictions, in the waning days of the Trump administration they put out an opinion to say what manufacturers were doing with limiting 340B pricing for contract pharmacy was illegal and it violated the statute. The Biden administration has maintained that position. Numerous pharmaceutical manufacturers are suing the administration and there's multiple cases tied up in courts. One thing I would mention was that the ACA did expand the number of hospitals that were in 340B but these were mostly just small rural hospitals and cancer hospitals and children's hospitals. Disproportionate share hospitals already qualified for 340B and have since the inception. Sen. Hackett stated that I'm going to argue with you on that because if you look at Ohio, the rural hospitals are all owned by the big city hospitals. So, you may say that, but that is not true in Ohio. Mr. Doggett stated that I hear what you're saying. I'm just saying if you look at the total count of hospitals, the bulk are small critical access hospitals. I'm not disagreeing with you that some of them are part of health systems and some of them are a bit larger.

DISCUSSION ON INTERNATIONAL INSURANCE ISSUES OF LEGISLATIVE AND REGULATORY CONCERN

The Hon. Dean Cameron, Idaho Insurance Director and National Association of Insurance Commissioners (NAIC) President, thanked the Committee for the opportunity to speak and stated that it's a pleasure to be here with you and we're grateful for the opportunity to provide you with an NAIC update on key international issues. Some of

you may be considering why is it important for the NAIC and for you to be aware of these issues and be involved as heavily as we are? We all guard our consumers and want to protect our consumers so that they aren't hurt and with that comes the responsibility of protecting carriers who are both selling here in the United States as well as selling in other areas. We also want to be able to help those countries who have less of a robust regulatory system, or are trying to figure out their regulatory system, or what's appropriate and we can talk about some of that. And then thirdly, we know that it's important for us to build relationships as we battle some of the issues that come forward. I'm going to turn things over now to The Hon. Gary Anderson, Massachusetts Insurance Commissioner and Chair of the NAIC International Insurance Relations (G) Committee.

Cmsr. Anderson thanked the Committee for the opportunity to speak and stated that I started my career in the insurance world for a regional carrier in the Northwestern United States and then I had the opportunity to be a counsel in the Massachusetts legislature working on insurance and banking issues at the intersection of law and politics and policy. And now I have the opportunity to serve as the insurance commissioner. So, I feel very fortunate to have seen the market from a few different perspectives. As Dir. Cameron noted, this has been a critical issue for a number of years and maybe I'll just set the stage a little bit and I can do it quickly just to go back a little bit to set some context. If you go back to 2013, so this not long after the crisis and the financial stability board charged the International Association of Insurance (IAI) supervisors with creating global capital standards. And as part of that, if you recall, at that time there were nine firms that were designated as potentially systemically important insurers. Of those nine, three were from the United States. So, we have long held here in the United States that it's not just the size of these entities that may or may not pose a risk but it's what kind of activities are they engaged in? And so, when you're developing capital standards, I think it's also a challenge to think about creating one capital standard for the globe when all of our jurisdictions, particularly here in the United States, are so different from another. For example, another country in Europe, it's been the belief of Team USA that the capital standards have to account for the differing legal frameworks of the jurisdictions across the globe. I think it's fair to say that's going back to 2013 with that charge. Since then, a lot of work has been done. In 2019, we were faced with a little bit of a challenge at that time. I think there was some momentum on the side of some of our colleagues from overseas with regard to developing this single global capital standard and we had said for years that this would not be fit for purpose here in the United States. The United States had been developing our own group capital standard, which is known as the GCC, the group capital calculation.

And that leverages the structure of the United States which is, it takes the legal entities within a company and it aggregates that capital to develop a calculation at the group level. We had pushed for that. I think in 2019 we were challenged because there was no mechanism in place for us to be recognized for the work that we were doing and I would say for Team USA I think we helped to reshape the power dynamics if you will in 2019 in our favor. And what we did was, through the IAI there was being developed the international capital standard, the insurance capital standard, the ICS. We needed a framework to compare what we were developing here in the United States - the group capital calculation which is known as an aggregated method because it aggregates the capital. It's also, we've argued for years, jurisdictionally agnostic. So, if you're a jurisdiction that is a developing nation and you're looking for a capital calculation this will work for you too.

So, we were fortunate through a lot of hard work able to develop a framework to compare these two standards. That's known as the comparability assessment. So, for the past several years, since 2019 we were able to put that in place. We've then been developing areas that we needed to focus on for this comparability assessment between those two standards. We then took those areas of focus and we built them into what are known as high level principles. And throughout this process we are engaging with stakeholders, and we go through consultations. We get input from the industry and other stakeholders and we took those high level principles and now we're at a point where we're developing the last stage of what's known as criteria. That is now out for consultation so our carriers will be commenting on this last set of criteria that helped build the framework to compare these two standards.

We had an international forum in D.C. a couple of months ago. There were a few things that we needed from our international colleagues to move forward in this process. We were able to achieve those things. Those are making sure that stakeholder input is not only heard but is taken on and used in the development of this criteria and we were able to get that. We had some concerns about the comparability comparison, that it will be made at the end of 2024. We had some concerns about the makeup of the team of assessors. We got that fixed. So, I think we're on a really good path at the moment. I think that's a lot of effort that's been done over the number of years by Team USA that includes the NAIC colleagues - the Federal Reserve and Treasury that work with us as partners in our effort. So, at this point we're in a good place but we've now developed over the years, kind of a common framework, if you will, to discuss these issues with supervisors across the globe. We hold supervisory colleges. So, let's say for example, Liberty Mutual, which I am the group wide supervisor for in Massachusetts, will hold a supervisory college. Regulators from across the globe will come in and we'll discuss issues relevant to Liberty Mutual. So, we have done a lot of work to develop these common framework and common language. We assess risk across the activities that is within insurers, but also within the market. So, I'll turn it back to Dir. Cameron as I think he had a few things to say on bilateral engagements but I think we're in a very good place as far as the efforts we made over the last several years.

Dir. Cameron stated that we've also been engaging in a number of bilateral communications with other countries such as Singapore, Taiwan, and Hong Kong and Japan we met with here recently. We also met representatives from Australia, Canada, South America, South Africa, Argentina, and Brazil. And we signed a memorandum of understanding with the Conférence Interafricaine des Marchés d'Assurances (CIMA) which is the organization in Africa that most represents the majority of countries there.

Rep. Stephen Meskers (CT) stated that I want to thank you for the work you're doing for the oversight. Obviously, the regulatory framework on an international basis, on a local basis for insurance companies is super important. In relation to your work in the NAIC, I've been reviewing and we just finished a conversation on 340B and now we're moving on. So, when we look at the regulatory framework, there's a second part of the equation which is looking at the insurance industry and its future health and sanity which is related to the cost structure and the payment structure at the insurance company. So, we're having the conversation about 340B and PBMs, etc. When I go into U.S. Government research there's a Ways and Means Committee report in 2019 mentioning that the U.S. pays about four times what the Organization for Economic Cooperation and Development (OECD) countries pay for its drug prices for the pharmaceuticals and I think for the sanity of the NAIC and our regulatory framework we have to address that

elephant in the room which is what are we going to do about pharmaceutical prices and what's the potential at some point for a cap in the U.S. so we're not paying four times what OECD countries are, and what's the regulatory premium we want to see in the U.S. to keep research and development in the U.S. and at the same time give our constituents affordable healthcare? I can't explain to people why drugs are four times more expensive than in Canada and if I tell people to go up to Canada, the pharmaceuticals say they can't ship to Canada because it ends up in the U.S. and they're going to limit supplies. So, we're going to have to figure out a pricing mechanism where we guarantee a profitability, keep an industry that saves lives, and does a great job for the U.S. but I don't know where we stand on that and how important is that in terms of your regulatory oversight.

Cmsr. Anderson stated that it's not necessarily what I was prepared to talk about but I can share I think as regulators across the states we share the concern about pricing. In Massachusetts, we go through a healthcare rate review every single quarter which is a challenge and you see that the drug prices take up a little bit more each time of the chunk of overall cost relative to a premium that's paid by each of our policyholders, our consumers. There have been some efforts, I can speak only you know for Massachusetts, to address that through legislation that Governor Baker had filed and whether the legislature has the desire to take that up and the time are questions as we finish our legislative session here at the end of July for this two year session. But it's certainly on top of mind, and to your point about the value, a good friend of mine, the former Superintendent of Maine, used to say if you're not at the table you're on the table as the meal and I think that goes for these discussions but also at the international level. If we're not engaged there then things will happen to us, which happen to our carriers, which happen to our policyholders. So, it's really important that we're engaged to push our policy and particularly on this one, I wish I had a silver bullet on this one as it's been a challenge since I've been the Commissioner and before so.

Rep. Meskers stated that if I could suggest to the NAIC, I think the message to D.C. has to be the credible management of our pharmaceutical pricing. We want the industry and research here but we all need to think about where we're going with the price structure we're seeing. In Connecticut we're talking and I think it's on the order of a 20% price increase this year and that's not sustainable over time.

PRESENTATION ON DEVELOPMENTS SURROUNDING NEW TREATMENTS FOR ALZHEIMER'S DISEASE

Carter Harrison, Director of State Regulatory and Legislative Affairs at the Alzheimer's Association thanked the Committee for the opportunity to speak and stated that today I'd like to speak briefly about the new advancements that are occurring around Alzheimer's treatments and the potential impact that these treatments may have on state policy work moving forward. I'm going to start with a bit of review of the drug that has sort of kicked off this process and I'm sure you all have seen this in the news around Aduhelm which is part of a class of drugs that seeks to remove amyloid buildup in the brain which is one of the markers for Alzheimer's type dementia. This drug has been approved to treat the early stages of dementia, so that's mild cognitive impairment or early Alzheimer's disease and this is currently the only FDA approved treatment that treats the pathology of Alzheimer's disease and it was approved under the accelerated pathway. Again, something that was noted quite a bit in the news. Also, things that were not noted but are important for policy considerations in the future is that this drug is administered by

IV. It is not an oral drug and there are some very important parts of the label that deal with safety related to Amyloid Related Imaging Abnormalities (ARIA) which is very dangerous if it's not monitored and will have some future state policy impacts additionally.

So, I'd like to start with the Medicare CMS determination for the national coverage decision and I'm going to essentially break this down into a couple of different sentences although there's quite a bit more detail up here. But basically, in order to have this covered under Medicare, you'll have to be in some type of clinical trial. So, there are various options for those clinical trials which you will see up here whether they be National Institutes of Health (NIH) studies, or CMS approved studies. But in all cases, you will have to be a part of a study in order for Medicare to cover the cost of this drug. As you can see, on the last point on the slide, outside of this criteria the drug is considered not covered by Medicare. Now, this has a number of implications. Obviously, the first one I'd like to start with is on the Medicaid front. So, for those of you that are not as familiar with the Medicare program, if a manufacturer participates in the Medicaid drug rebate program, the drug has to be covered. And this was touched upon in some of the earlier presentations and of course the manufacturer for Aduhelm does participate, so therefore, the drug has to be covered under Medicaid.

Of course, states can and have restricted the use of this drug through utilization management techniques in order to make sure that the population is targeted to what exists in the label for the drug. And additionally, one of the issues that has come up as a part of this decision is that the drug when covered by Medicare is considered a Part B drug. And when not covered by Medicare is considered a Part D drug. And the reason that that's important is because Medicaid cannot pay for Part D drugs for full dual eligibles.

So, you have a circumstance where dual eligibles cannot receive this drug but other recipients in the Medicaid program, at least theoretically could if they meet the prior authorization criteria. So, as you can imagine this was pretty devastating for any person that is currently living with Alzheimer's disease but I did want to sort of highlight some of the responses to CMS's decision where there may be at least a bit of hope for the future. So, first of all while this did apply to the entire class of drugs of which there are several in the research pipeline currently, it does not mean that Medicare and CMS will not evaluate each one individually and if the data is convincing or more convincing then they may change this current national coverage determination (NCD).

In addition, they did talk about how this was promising but not quite meeting the statutory requirement for it to be covered. Again, I'm sort of taking the glass half full versus the glass half empty approach to that piece as well. And also, there are going to be future drugs that come forth and I think there's a lot of things that you as policymakers in the states will have a lot of opportunity to help impact this. And I'd like to use this chart to sort of demonstrate how I think that will happen. Now, this chart is again for demonstration purposes only but it shows how a person normally ages and gets diagnosed. And in this point, the star here represents age 65 diagnosis . And then you can see sort of a rapid cognitive decline. Also, you'll note in the chart again that the individual has been declining prior to the diagnosis that they received. This chart shows something that I hope we get to in the near future which is a place where an individual has only a mild bit of cognitive decline and is then diagnosed at an earlier age and here for this chart's demonstration purposes, we are looking at age 45 and then they begin to

receive a treatment that slows their cognitive decline. Now, when you put these two charts next to one another, you may not think there's a lot of difference between the rate of cognitive decline. However, what I'd like to point out is that there are a lot of cost savings to the healthcare system by avoiding as much healthcare needs, especially on the long-term care side, especially for Medicaid spending where you reduce the amount of time or you lengthen the runway for that individual's cognitive decline.

Not to mention the fact that the person with the disease will have more time to spend with their families, more time to plan, more time to be a part of normal society. So in the end there's a number of questions that I think states will be addressing as these treatments move forward and are starting to service the dementia population. One of those areas will deal with genetic testing and diagnosis protections. If you have individuals that are going to receive a diagnosis when they are younger perhaps when they are still working it's going to be very important that that individual that might be undergoing treatment receive the protections that are necessary in order to continue to work or be participatory in society especially if there's a genetic test. There are several forms of dementia that genetic testing does indicate that the individual may, or is more likely to develop dementia and those types of protections are going to be needed.

Additionally, testing is very important. It has also been shown in the NCD but right now these drugs, the labels want you to confirm that there are amyloid buildups in the brain and that is currently done by either spinal fluid or PET scans. Both of these, the PET scans particularly, are very expensive and they may have a certificate of public need issues related to them. There is a possibility that in the near future there will be testing that is not as expensive or does not require these types of machines which actually makes this even more complicated because providers may not be willing to invest in this equipment that would be necessary to do the treatment and to monitor it safely.

So, earlier I referenced the scans for ARIA, the label for Aduhelm currently requires constant monitoring through MRIs. It is certainly possible that future drugs will have similar requirements. So, there will be additional costs and additional needs there. The next item deals with drug delivery. You heard me state earlier that the Aduhelm was an IV drug and would be administered in a doctor's office or perhaps some other type of clinical setting and most of the drugs that are currently in the pipeline also are administered within a clinical setting and so it's going to be important to make sure that those settings are available and able to handle it.

Lastly, there's a couple of coverage implications. The reason that I went through the chart was to point out that those policymakers think about Alzheimer's as a Medicare problem, and possibly a Medicaid problem. But as these treatments come to market, the line will start earlier before an individual is likely eligible for Medicare or Medicaid. And so that will push the treatment options closer to the private insurance sector and will start to have impacts on private insurance as these treatments continue to be developed and then of course lastly, I have state employee health plans listed. I think many of you can think about other types of treatments that have come out and the policies that have gone into those whether they be cancer and the impacts they've had on the state employee health insurance plans.

Rep. Ferguson asked how many clinical trials are running right now. Mr. Harrison stated that I don't have an exact number but I'd be happy to check with our colleagues and get you the number. Rep. Ferguson asked if there is a trial in most states. Mr. Harrison

replied no, not necessarily but in Arkansas, we have identified an interesting problem there and that is a lack of PET machines. So, they don't have the PET scanners available to the population there and so they would have to go outside of state in order to participate in those types of trials so that is an issue for your state.

ADJOURNMENT

Hearing no further business, upon a motion made by Asm. Ken Cooley (CA), NCOIL President, and seconded by Rep. Tom Oliverson, M.D. (TX), NCOIL Treasurer, the Committee adjourned at 12:45 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Exhaustion of Administrative Remedies Model Legislation

Adopted by the NCOIL State-Federal Relations and Executive Committees on November 22, 2002; readopted on March 4, 2005, and November 21, 2010.
Re-adopted by the NCOIL State-Federal Relations Committee on November 17, 2017 and the NCOIL Executive Committee on November 19, 2017.

To be considered for re-adoption during the Joint State-Federal Relations & International Insurance Issues Committee on November 19, 2022.

I. DISMISSAL OR ABATEMENT IF STATE INSURANCE DEPARTMENT JURISDICTION INVOLVED:

(a) A court shall abate or dismiss an action filed against an insurance entity unless the court determines that:

(1) the interpretation, application, or violation of an insurance-related statute or rule involves only questions of law; and
(2) the insurance department may not make any findings of fact or conclusions of law or issue any orders that would aid the court in resolving the action.

(b) A court may abate or dismiss an action filed against an insurance entity if the court determines that the insurance department may order in a contested case all or part of the relief the claimant seeks. The court shall specify in its order of abatement or dismissal the portion of the statute on which the court bases its order.

(c) A court that abates an action under this section:

(1) shall refer specific issues or claims within the insurance department's jurisdiction to the insurance department for action; and
(2) may direct the insurance department to report to the court periodically concerning the disposition of the matters referred to the agency.

(d) The statute of limitations for an action dismissed or abated under this section is tolled for the period during which the claimant seeks an administrative remedy.

II. PERIOD OF ABATEMENT: The court shall provide that the period of abatement is at least six months from the date the court enters the order of abatement, or such other reasonable time as the court may determine.

III. ADEQUATE RELIEF: Relief awarded to a claimant may be adequate even if the relief does not include exemplary damages, multiple damages, attorneys' fees, or costs of court.

IV. APPLICABILITY: This section applies only to a civil action filed against an insurance entity in which:

(1) a claimant seeks recovery of damages on behalf of a class of claimants and
(2) the interpretation, application, or violation of an insurance-related statute or rule is involved for at least one defendant.

V. DEFINITION: For purposes of this act, an insurance entity is any entity required to be licensed under the insurance laws of this state.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Producer Compensation Disclosure Model
Amendment to the Producer Licensing Model Act

Adopted by the NCOIL State-Federal Relations and Executive Committees on March 5, 2005; readopted on November 21, 2010.
A revised version of the December 29 NAIC broker disclosure amendment proposed to the Producer Licensing Model Act.
Readopted by the NCOIL State-Federal Relations Committee on November 17, 2017 and the NCOIL Executive Committee on November 19, 2017.

To be considered for re-adoption during the Joint State-Federal Relations & International Insurance Issues Committee on November 19, 2022.

Section __. Compensation Disclosure

A. Where any insurance producer or any affiliate of such producer receives any compensation from the customer for the initial placement of insurance, neither that producer nor the affiliate shall accept or receive any compensation from an insurer or other third party for that placement of insurance unless the producer has, prior to the customer's purchase of insurance:

(1) Obtained the customer's documented acknowledgment that such compensation will be received by the producer or affiliate; and

(2) Provided a description of the method and factors utilized for calculating the compensation to be received from the insurer or other third party for that placement.

B. This section shall not apply to:

(1) A person licensed as an insurance producer who acts only as an intermediary between an insurer and the customer's producer, for example a managing general agent, a sales manager, or wholesale broker;

(2) The placement of insurance in secondary or residual markets; or

(3) A producer whose sole compensation for the placement is derived from commissions, salaries, and other remuneration from the insurer.

C. For purposes of this section:

(1) “Affiliate” means a person that controls, is controlled by, or is under common control with the producer.

(2) ”Compensation from an insurer or other third party” means payments, commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options, gifts, prizes or any other form of valuable consideration, whether or not payable pursuant to a written agreement.

(3) “Compensation from the customer” shall not include any fee or similar expense as provided in [insert reference to statutory provision(s) or regulation(s)] or any fee or amount collected by or paid to the producer that does not exceed an amount established by the commissioner.

(4) “Customer” means the person signing the application or submission for insurance or the authorized representative of the insured actually negotiating the placement of insurance with the producer. A person shall not be considered a “customer” for purposes of this section if the person is:

(a) A participant or beneficiary of an employee benefit plan; or
(b) Covered by a group or blanket insurance policy or group annuity contract sold, solicited or negotiated by the insurance producer or affiliate.

(5) “Documented acknowledgement” means the customer’s acknowledgement obtained prior to the customer’s purchase of insurance

D. An insurance producer may satisfy any requirements imposed by this Section directly or through an affiliate.

E This Section shall take effect six (6) months after the date of enactment or [insert date], whichever is later.

Drafting Note: In many transactions, a broker will owe a fiduciary or other legal duty to the client. However, the duty may vary depending upon contractual obligations or transaction specific facts. Therefore, the States should review the precedent set forth in their common law to determine if any statutory standards are necessary.

EXECUTIVE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2022 NCOIL SUMMER MEETING – JERSEY CITY, NJ
JULY 16, 2022
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Hyatt Regency in Jersey City, New Jersey on Saturday July 16, 2022 at 12:00 PM (EST).

NCOIL President, Assemblyman Ken Cooley (CA), Chair of the Committee, presided.

Other members of the committee present

Rep. Deborah Ferguson, DDS (AR)
Sen. Jason Rapert (AR)
Rep. Matt Lehman (IN)
Rep. Brenda Carter (MI)
Sen. Michael McLendon (MS)
Sen. Bob Hackett (OH)
Rep. Carl Anderson (SC)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Forrest Bennett (OK)
Sen. Mary Felzkowski (WI)

Also in attendance were:

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

QUORUM

Upon a motion made by Rep. Brenda Carter (MI) and seconded by Sen. Michael McLendon (MS), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a motion made by Rep. Carl Anderson (SC) and seconded by Sen. Jason Rapert (AR), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's March 6, 2022 meeting in Las Vegas, NV.

DISCUSSION AND CONSIDERATION OF RESOULTION IN HONOR OF VERMONT REPRESENTATIVE WARREN KITZMILLER

Asm. Cooley stated that the first order of business relates to the passing of longtime NCOIL member and Vermont Representative Warren Kitzmiller. A Resolution has been

presented honoring Rep. Kitzmiller, sponsored by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and Asm. Kevin Cahill (NY), NCOIL Vice President.

Rep. Lehman stated that Rep. Kitzmiller was a genuine man who loved his family, Montpelier, and Vermont. Rep. Lehman also stated that it was some time before he learned that Rep. Kitzmiller was a Democrat which speaks to the heart of what NCOIL stands for and Rep. Kitzmiller was the epitome of that bipartisanship. Rep. Kitzmiller was a true gentleman and a selfless person who had a high standard when it came to being a proper person. Rep. Lehman stated that Rep. Kitzmiller will be missed and NCOIL sends its condolences to Rep. Kitzmiller's family. Rep. Lehman stated that he is honored to offer this Resolution to honor our friend.

Sen. Rapert stated that he agrees with everything that Rep. Lehman said and added that the other Vermont State legislators he knew also thought of Rep. Kitzmiller in a similar way. Sen. Rapert stated that he appreciated NCOIL for considering this resolution.

Asm. Cooley stated that the quality of an organization depends on the quality of the people who participate. Rep. Kitzmiller's work in his own state and his devotion to the public well-being was great to have at NCOIL.

Upon a motion made by Rep. Anderson and seconded by Rep. Deborah Ferguson DDS (AR), NCOIL Secretary, the Committee voted unanimously by way of a voice vote to adopt the resolution.

FUTURE MEETING LOCATIONS

Asm. Cooley noted that the 2022 Annual Meeting in New Orleans will take place from November 16th-19th. He also noted that preceding the Annual Meeting on November 16th will be the first annual NCOIL Open Golf Outing to benefit the Insurance Legislators Foundation (ILF) scholarship fund. Additional upcoming meetings include the 2023 Spring Meeting in San Diego, CA from March 9th to 12th, the 2023 Summer Meeting in Minneapolis, MN from July 19th-23rd and the 2023 Annual Meeting in Columbus, OH from November 15th-18th.

Will Melofchik, NCOIL General Counsel, stated that the 2024 Spring Meeting will be in April in Nashville, TN and noted that this will be the start of all NCOIL Spring Meetings being held in April instead of early March. The 2024 Summer Meeting will be in mid-July in Costa Mesa, CA and the 2024 Annual Meeting will be held in San Antonio, TX in November. The only meeting NCOIL has gone to contract with for 2025 is the Annual Meeting in Atlanta, GA. NCOIL is still in discussions with Maryland for the 2025 Spring Meeting contingent on Maryland rejoining NCOIL as a Contributing Member State. The same goes for the 2025 Summer Meeting, with NCOIL looking at Chicago contingent on Illinois rejoining as a Contributing Member State.

Asm. Cooley noted that moving the Spring Meetings from March to April allows for more lawmakers to be able to attend because five additional legislatures are out of session in April as compared to March.

Rep. Anderson stated that South Carolina is open for hosting an NCOIL Meeting in Charleston in 2025 if other location negotiations fall through.

ADMINISTRATION

Mr. Melofchik stated that there were 325 total registrants consisting of 48 legislators from 26 states including seven first time legislators from six states. Additionally, 12 insurance commissioners had registered but a couple ended up not being able to make it. Regardless, that is still an NCOIL record in terms of Commissioner participation. In total, 16 Insurance Departments were represented.

Mr. Melofchik gave the 2022 unaudited financials through June 30th of this year showing revenue of $873,627.56 and expenses of $548,933.45 leading to a surplus of $324,694.11 heading into this meeting.

AUDIT COMMITTEE REPORT

Asm. Cooley stated that the Audit Committee met on Wednesday of this week in Jersey City and received the audits for both NCOIL and the ILF from Jim Cunningham of Collins & Company who has served as the NCOIL auditor for 5 years which gives him knowledge of the organization, its operations, and what has gone on in recent years. That is relevant because he reported in reviewing NCOIL and ILF financials that in each case he rendered an unqualified opinion meaning that the financials looked proper and up to industry standard practices. There was a positive change in net assets for NCOIL in excess of $300,000.

Hearing no questions, upon a Motion made by Rep. Jim Dunnigan (UT), and seconded by Rep. Carter, the Committee voted without objection by way of a voice vote to accept the audits.

CONSENT CALENDAR

Asm. Cooley 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 Workers' Compensation Insurance Committee adopted amendments to the NCOIL Model State Structured Settlement Protection Act and readopted said Model.
- The Life Insurance & Financial Planning Committee adopted: a Resolution Identifying Certain Enhanced Cash Surrender Value Endorsements as Violating The Standard Nonforfeiture Law; a Resolution in Support of Position Statement Recognizing Congressional Consent to the Interstate Insurance Product Regulation Compact (IIPRC); and a Resolution Regarding Recruitment, Retention, and Diversity within the Life Insurance Agent Profession.
- The Property & Casualty Insurance Committee readopted: the Auto Insurance Fraud Model Act; Asbestos Bankruptcy Trust Claims Transparency Model; Certificates of Insurance Model Act; Travel Insurance Model; and Model Act Regarding Use of Insurance Binders as Evidence of Coverage.

- Ratification of decisions made and actions taken by the NCOIL Officers in the time between Executive Committee Meetings

Asm. Cooley asked if any Committee member wanted anything removed from the consent calendar. Hearing no such requests, upon a motion made by Rep. Ferguson and seconded by Rep. Anderson, the Committee voted to adopt the consent calendar without objection by way of a voice vote.

OTHER SESSIONS

Asm. Cooley stated that The Institutes Griffith Foundation held a legislator luncheon and breakfast., The luncheon focused on the very important topic of legislative oversight and the breakfast focused on how the insurance marketplace is deliberately structured to be resilient during uncertain economic times.

There were also three great general sessions, the first focusing on private equity's involvement in the insurance marketplace. Asm. Cooley noted that it was the highest attended general session in a very long time. Other general sessions were focused on biomarker testing and precision medicine, and the debate over the term "social inflation." There were also featured speakers during the luncheon including NJ Attorney General Matthew J. Platkin as well as National Association of Insurance Commissioners (NAIC) President and Idaho Insurance Director Dean Cameron.

ORDER AND DECORUM RULES AT NCOIL COMMITTEE MEETINGS AND GENERAL SESSIONS AND IN MATERIALS

Asm. Cooley stated that draft decorum rules were distributed at the Spring Meeting in March which were in response to an unfortunate event that occurred at the 2021 Annual Meeting in Scottsdale. Asm. Cooley noted that there has been discussion about these rules for a considerable amount of time, and therefore asked for a motion to adopt the order and decorum rules.

Upon a motion by Sen. Bob Hackett (OH) and seconded by Rep. Carter, the Committee voted to adopt the order and decorum rules without objection by way of a voice vote.

ANY OTHER BUSINESS

Pursuant to NCOIL bylaws, the chair of the committee responsible for insurance legislation in each legislative house of each Contributing State shall automatically, by nature of his or her office be a member of the Executive Committee at his or her first meeting. Upon a motion made by Rep. Carter and seconded by Rep. Ferguson, the Committee voted without objection by way of a voice vote to add Sen. Mary Felzkowski (WI), chair of the WI Senate Committee on Insurance, Licensing, and Forestry to the Executive Committee.

Frank O'Brien, Vice President of State Government Relations at the American Property Casualty Insurance Association (APCIA) stated that the Industry Education Council (IEC) has proposed a topic relating to surplus and excess line insurance, a growing and

interesting field that is sometimes subject to a great deal of confusion. The IEC thinks it is a worthy topic for a general session educating legislators on what it is, what it does, and the what the state's role is in overseeing it.

Rep. Dunnigan stated that there were concerns in Utah about getting fire insurance due to all of the wildfires that have been occurring. He asked that the proposed IEC topic include discussion as to whether or not there is an adequate marketplace for that type of insurance.

Asm. Cooley thanked everyone for attending the meeting and noted that he is very much looking forward to the next meeting in New Orleans in November but there is a bittersweet aspect to it because Asm. Kevin Cahill (NY), NCOIL Vice President, who has devoted a great deal of time and service to NCOIL did not prevail in his re-election and is nearing the end of his public service. Asm. Cooley stated that New Orleans will give everyone an opportunity to thank Asm. Cahill for his public service.

" Commissioner Tom Considine, NCOIL CEO, thanked everyone for attending the meeting in the Garden State. He also noted that when he first started at NCOIL, some states wouldn't join because legislators and others there somehow believed NCOIL was a Republican, industry-dominated organization. Cmsr. Considine stated that when looking around during this meeting, he noticed that there was an equal representation of Democrats and Republicans showing that NCOIL is the epitome of bipartisanship. He also noted that at various times the diversity of the legislators represented at the table really did look like a cross section of America."

Mr. Melofchik thanked everyone for attending the Meeting and mentioned to Rep. Dunnigan that he would reach out regarding his inquiry about the IEC topic in order to get materials lined up so that the topic is on the agenda for the next meeting in New Orleans.

ADJOURNMENT

There being no further business, upon a motion made by Rep. Lehman and seconded by Rep. Anderson, the Committee adjourned at 12:45 PM.