30 DAY MATERIALS AND TENTATIVE GENERAL SCHEDULE
NCOIL ANNUAL MEETING
NOVEMBER 15 - 18, 2023

As of November 1, 2023, and Subject to Change

The Renaissance Columbus Downtown Hotel
Columbus, Ohio

NCOIL ANNUAL MEETING
Columbus, Ohio
November 15 - 18, 2023
TENTATIVE SCHEDULE

WEDNESDAY, NOVEMBER 15TH

Tour of Ohio State Capitol	3:00 p.m.		
Welcome Reception Historic Station 67 Firehouse	6:15 p.m.	-	7:15 p.m.

THURSDAY, NOVEMBER 16TH

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Welcome Breakfast	8:15 a.m.	-	9:45 a.m.
Networking Break **Sponsored by Delta Dental of Michigan, Ohio, and Indiana**	9:45 a.m.	-	10:00 a.m.
Health Insurance & Long Term Care Issues Committee	10:00 a.m.	-	11:30 a.m.
General Session Artificial Intelligence: A Major Benefit or Likely Menace for Insurance and Society?	11:30 a.m.	-	1:00 p.m.
The Institutes Griffith Foundation Legislator Luncheon Challenges and Opportunities in the California Property Insurance Market: An Academic Overview ***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 **Sponsored by The Interstate Insurance Product Regulation Commission (IIPRC)**	3:15 p.m.	-	3:30 p.m.
Life Insurance & Financial Planning Committee	3:30 p.m.	-	4:45 p.m.
Articles of Organization & Bylaws Revision Committee	4:45 p.m.	-	5:15 p.m.
IEC Board Meeting	4:45 p.m.	-	5:30 p.m.
Adjournment	5:15 p.m.		
Nominating Committee (Members Only)	5:15 p.m.		
CIP Member & Sponsor Reception	6:00 p.m.	-	7:00 p.m.

FRIDAY, NOVEMBER 17th

Registration *Exhibits Open: 8:00 a.m. – 5:00 p.m.*	8:00 a.m.	-	5:00 p.m.
Financial Services & Multi-Lines Issues Committee	9:00 a.m.	-	10:30 a.m.
Networking Break **Sponsored by Aflac**	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 (Room 22 on the 2nd floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.

General Session NCOIL Special Environmental, Social, and Governance (ESG) Series Part 3: Governance Aspects and Summary of Series	1:30 p.m.	-	3:00 p.m.
Networking Break	3:00 p.m.	-	3:15 p.m.
Property & Casualty Insurance Committee	3:15 p.m.	-	5:00 p.m.

Budget Committee	5:00 p.m.	-	5:20 p.m.
Adjournment	5:20 p.m.		

SATURDAY, NOVEMBER 18TH

Registration *Exhibits Open: 8:00 a.m. – 11:00 a.m.*	8:00 a.m.	-	10:00 a.m.
General Session Whose Claim is This Anyway? Examining a Legislative Framework for Litigation Funding	8:00 a.m.	-	9:40 a.m.
Joint State-Federal Relations & International Insurance Issues Committee	9:40 a.m.	-	11:00 a.m.
Executive Committee	11:00 a.m.	-	11:30 a.m.

******Please note all speakers listed are scheduled to speak as of November 1, 2023. There will be modifications between now and the start of the Meeting.******

******Note: There will be a room (Room 22 on the 2nd floor) available throughout the duration of the conference for informal meetings. Attendees should feel free to meet with legislators there throughout the meeting.******

Wednesday, November 15th, 2023

Tour of Ohio State Capitol
Wednesday, November 15, 2023
3:00 p.m.

Welcome Reception
Historic Station 67 Firehouse
Wednesday, November 15, 2023
6:15 p.m. – 7:15 p.m.

Thursday, November 16th, 2023

Welcome Breakfast
Thursday, November 16, 2023
8:15 a.m. – 9:45 a.m.

1.) Welcome to Columbus
2.) **Hon. Tom Considine**
    -Introductory Comments from NCOIL CEO
3.) **Rep. Deborah Ferguson, DDS (AR)**
    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
Sponsored by Delta Dental of Michigan, Ohio, and Indiana*
Thursday, November 16, 2023
9:45 a.m. – 10:00 a.m.

Health Insurance & Long Term Care Issues Committee
Thursday, November 16, 2023
10:00 a.m. – 11:30 a.m.

Chair: Del. Steve Westfall (WV)
Vice Chair: Rep. Rachel Roberts (KY)

1.) Call to Order/Roll Call/Approval of July 20, 2023 and October 6, 2023 Committee Meeting Minutes
2.) Continued Discussion and Possible Consideration of NCOIL Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act
   Del. Steve Westfall (WV) – Sponsor
   Rep. Rita Mayfield (IL) – Co-sponsor
3.) Discussion and Consideration of Resolution in Support of Embedded Provision in the State Insurance Code to Protect Health Savings Accounts-Qualified Insurance Policies from Certain State Benefit Mandates
   Sen. Jerry Klein (ND) – Sponsor
   Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President; Rep. Rachel Roberts (KY); Sen. Beverly Gossage (KS) – Co-Sponsors
   Kevin McKechnie, Executive Director, HSA Council – American Bankers Association
4.) Amazon's Entry into the U.S. Healthcare Marketplace
   Tanvi Patel, Director & General Manager of Partner Services - Amazon Pharmacy
5.) Drug Shortages and Supply Questions: A Policy and Data Overview
   Andrew Barnhill, Head of Public Policy – IQVIA
6.) Any Other Business
7.) Adjournment

General Session
Artificial Intelligence: A Major Benefit or Likely Menace for Insurance and Society?
Thursday, November 16, 2023
11:30 a.m. – 1:00 p.m.

Moderator: Rep. Forrest Bennett (OK)

Christine Huberty
Lead Benefit Specialist Supervising Attorney
Elder Law & Advocacy Center
Greater Wisconsin Agency on Aging Resources, Inc.

The Honorable Mike Conway
Commissioner
Colorado Department of Insurance

Jaymin Kim
Senior VP, Emerging Technologies
Cyber Practice U.S. & Canada
Marsh

Adam Isles
Principal & Head of Cybersecurity Practice
The Chertoff Group

The Honorable Kathleen Birrane
Commissioner
Maryland Insurance Administration

The Institutes Griffith Foundation Legislator Luncheon
Challenges and Opportunities in the California Property Insurance Market: An Academic Overview
Thursday, November 16, 2023
1:00 p.m. – 2:00 p.m.

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

Martin Grace, Ph.D., J.D.
Harry A. Cochran Professor of Risk, Insurance & Healthcare Management
Fox School of Business
Temple University

Workers' Compensation Insurance Committee
Thursday, November 16, 2023
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 21, 2023 Committee Meeting Minutes
2.) Navigating Workers' Compensation and Medical Marijuana
Derek Jones, MAAA, FCAS – American Academy of Actuaries
3.) Presentation on Work Comp Trends and The Future of Medicine
Michel Choo, M.D., MBA, FACEP, FAAEM, CMRO, Chief Medical Officer and Senior Vice President – Paradigm
4.) Update on Federal Workers' Compensation Insurance Issues
Doug Holmes, President – Strategic Services on Unemployment & Workers' Compensation

5.) Any Other Business
6.) Adjournment

Networking Break
Sponsored by The Interstate Insurance Product Regulation Commission (IIPRC)*
Thursday, November 16, 2023
3:15 p.m. – 3:30 p.m.

Life Insurance & Financial Planning Committee
Thursday, November 16, 2023
3:30 p.m. – 4:45 p.m.

Chair: Rep. Carl Anderson (SC)
Vice Chair: Sen. Mary Felzkowski (WI)

1.) Call to Order/Roll Call/Approval of July 21, 2023 Committee Meeting Minutes
2.) Update on NCOIL Life Insurance is a Promise for Life Model Act
Sen. Travis Holdman (IN), NCOIL Immediate Past President – Sponsor
The Hon. Nat Shapo, Life Insurance Settlement Association (LISA); former Illinois Insurance Director
Leah Walters, Senior Vice President, State Relations – American Council of Life Insurers (ACLI)
3.) Discussion on the Return of the U.S. DOL Fiduciary Rule
Allison Itami, Principal - Groom Law Group
Leah Walters – ACLI
4.) Hold that Rating: Discussion on Activities of NAIC's Securities Valuation Office (SVO)
The Hon. Beth Dwyer, Director – Rhode Island Dep't of Business Regulation
Caitlin Colvin, Senior Managing Director, Business Development – Kroll Bond Rating Agency (KBRA)
Leah Walters – ACLI
5.) Any Other Business
6.) Adjournment

Articles of Organization & Bylaws Revision Committee
Thursday, November 16, 2023
4:45 p.m. – 5:15 p.m.

Chair: Sen. Walter Michel (MS)
Vice Chair: Rep. Kevin Coleman (MI)

1.) Call to Order/Roll Call/Approval of July 21, 2023 Committee Meeting Minutes
2.) Consideration of Proposed Amendments to NCOIL Articles of Organization & Bylaws

3.) Any Other Business
4.) Adjournment

IEC Board Meeting
Thursday, November 16, 2023
4:45 p.m. - 5:30 p.m.

Nominating Committee (Members Only)
Thursday, November 16, 2023
5:15 p.m.

CIP Member & Sponsor Reception
Thursday, November 16, 2023
6:00 p.m. – 7:00 p.m.

Friday, November 17, 2023

Financial Services & Multi-Lines Issues Committee
Friday, November 17, 2023
9:00 a.m. – 10:30 a.m.

Chair: Rep. Forrest Bennett (OK)
Vice Chair: Rep. Tammy Nuccio (CT)

1.) Call to Order/Roll Call/Approval of July 20, 2023 and September 29, 2023 Committee Meeting Minutes
2.) Consideration of Proposed Amendments to NCOIL Insurance E-Commerce Model Act
Rep. Edmond Jordan (LA) – Sponsor
3.) Earned Wage Access: Early Payday or Payday Loan?
Ben LaRocco, Senior Director, Gov't Relations – EarnIn
Andrew Kushner, Policy Counsel – Center for Responsible Lending
4.) Continued Discussion and Consideration of Resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes Due as a Result of Direct Procurement
5.) Presentation on Inflation's Impact on the Insurance Marketplace
Douglas Karel Ruml, DBA, CFM, Assistant Professor, Finance Program Director - Ohio Dominican University, Division of Business

6.) Any Other Business
7.) Adjournment

Networking Break
Sponsored by Aflac*
Friday, November 17, 2023
10:30 a.m. – 10:45 a.m.

NCOIL – NAIC Dialogue
Friday, November 17, 2023
10:45 a.m. – 12:00 p.m.

Co-Chair: Rep. Deborah Ferguson, DDS (AR) – NCOIL President
Co-Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of July 21, 2023 Committee Meeting Minutes
2.) Recap of NCOIL D.C. Fly-in
3.) Update on Draft NAIC Consumer Privacy Protection Model Law
4.) Update on NAIC's Development of Model Bulletin on Issues Relating to Artificial Intelligence and the Insurance Industry
5.) Follow-up Discussion on Activities of NAIC's Securities Valuation Office (SVO)
6.) Discussion on NAIC's Data Call Relating to Property Insurance Market
7.) Discussion on NAIC's Updated Cannabis Insurance White Paper
8.) Any Other Business
9.) Adjournment

Luncheon
Sponsored by CareSource*
Friday, November 17, 2023
12:00 p.m. – 1:30 p.m.

Keynote Address:
The Honorable Mike DeWine
Governor of Ohio

General Session
NCOIL Special Environmental, Social, and Governance (ESG) Series
Co-Chairs: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President
Asw. Pam Hunter (NY) – NCOIL Treasurer
Part 3: Governance Aspects and Summary of Series
Friday, November 17, 2023
1:30 p.m. – 3:00 p.m.

Moderator: Asw. Pam Hunter (NY) – NCOIL Treasurer

The Hon. George Nichols III
President & CEO
The American College of Financial Services

Roosevelt Mosley, FCAS, MAAA, CSPA
Principal & Consulting Actuary
Pinnacle Actuarial Resources, Inc.

Jim Copland
Senior Fellow & Director, Legal Policy
Manhattan Institute

Hughey Newsome
Chief Financial Officer
Piston Group

Networking Break
Friday, November 17, 2023
3:00 p.m. – 3:15 p.m.

Property & Casualty Insurance Committee
Friday, November 17, 2023
3:15 p.m. – 5:00 p.m.

Chair: Rep. Edmond Jordan (LA)
Vice Chair: Sen. Vickie Sawyer (NC)

1.) Call to Order/Roll Call/Approval of July 22, 2023 and September 22, 2023 Committee Meeting Minutes
2.) Continued Discussion on NCOIL Catalytic Converter Theft Prevention Model Act
Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President; Rep. Edmond Jordan (LA) – Joint Sponsors
Eric DeCampos, Dir. of Gov't Affairs – National Insurance Crime Bureau (NICB)
3.) Continued Discussion on Proposed Amendments to NCOIL Model State Uniform Building Code
Rep. Jim Dunnigan (UT) – Sponsor
Rep. Matthew Gambill (GA) - Co-sponsor
Tom Travis, Deputy Commissioner, Office of Policy, Innovation & Research – Louisiana Dep't of Insurance
4.) Continued Discussion on NCOIL Public Adjuster Professional Standards Reform Model Act
Rep. Michael Meredith (KY) – Sponsor
Rep. Matt Lehman (IN), NCOIL Immediate Past President; Del. Steve Westfall (WV) – Co-sponsors
Jon Schnautz, Assistant VP, State Affairs – National Association of Mutual Insurance Companies (NAMIC)
Cole Kline, President – American Association of Public Insurance Adjusters (AAPIA)
Eric DeCampos – NICB

5.) Consideration of Proposed Amendments to NCOIL Delivery Network Company (DNC) Insurance Model Act

Del. Steve Westfall (WV); Rep. Michael Sarge Pollock (KY) – Joint Sponsors

6.) Any Other Business
7.) Adjournment

Budget Committee
Friday, November 17, 2023
5:00 p.m. – 5:20 p.m.

Chair: Asw. Pam Hunter (NY) – NCOIL Treasurer
Vice Chair: Sen. Travis Holdman (IN) – NCOIL Immediate Past President

1.) Call to Order/Roll Call/Approval of July 19, 2023 Committee Meeting Minutes
2.) Consideration of 2024 Budget
3.) Any Other Business
4.) Adjournment

Saturday, November 18, 2023

General Session
Whose Claim is This Anyway? Examining a Legislative Framework for Litigation Funding
Saturday, November 18, 2023
8:00 a.m. – 9:40 a.m.

Moderator: Rep. Matt Lehman (IN) – NCOIL Immediate Past President

Prof. Maya Steinitz
Professor of Law
R. Gordon Butler Scholar in International Law
Boston University School of Law

Mark Behrens
Co-Chair
Public Policy Practice Group
Shook, Hardy & Bacon, L.L.P.

Eric Schuller
President
Alliance for Responsible Consumer Legal Funding

Jack Kelly
Managing Director
American Legal Finance Association

Jim Whittle
Vice President & Counsel
American Property Casualty Insurance Association (APCIA)

Joint State-Federal Relations & International Insurance Issues Committee
Saturday, November 18, 2023
9:40 a.m. – 11:00 a.m.

Chair: Rep. Jim Dunnigan (UT)
Vice Chair: Rep. Brenda Carter (MI)

1.) Call to Order/Roll Call/Approval of July 20, 2023 Committee Meeting Minutes
2.) Checking in on the Employee Retirement Income Security Act of 1974 (ERISA) – Where do States Stand in Self-Funded Regulation?
Bill Copley, Partner – Weisbrod, Matteis & Copley, PLLC
3.) Presentation on Recent Federal Emergency Management Agency (FEMA) and National Flood Insurance Program (NFIP) Initiatives
David Maurstad, Ass't Administrator, Federal Insurance Directorate - FEMA/Senior Executive – NFIP
4.) Mental Health Parity and the Affordable Care Act (ACA) – Why is There Still a Gap?
Rep. Rachel Roberts (KY) – Sponsor
Ohio Psychological Association (OPA) Representative
5.) Any Other Business
6.) Adjournment

Executive Committee
Saturday, November 18, 2023
11:00 a.m. – 11:30 a.m.

Chair: Rep. Deborah Ferguson, DDS (AR) – NCOIL President
Vice Chair: Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President

1.) Call to Order/Roll Call/Approval of July 22, 2023 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 Re-adopted Therein
5.) Other Sessions
a.) The Institutes Griffith Foundation Legislator Luncheon
b.) General Sessions
c.) Featured Speakers
6.) Consideration of Re-adoption of Model Act to Support State Regulation of Insurance Through More Informed Policymaking – Adopted 12/8/18
7.) Nominating Committee Report/Election of Officers
8.) Any Other Business
-Consideration of Auditor
9.) Adjournment

HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE MATERIALS

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 20, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Thursday, July 20, 2023 at 2:00 PM.

Delegate Steve Westfall (WV), Chair of the Committee, presided.

Other members of the Committee present:

Rep. Deborah Ferguson, DDS (AR)
Asm. Tim Grayson (CA)
Rep. Dafna Michaelson Jenet (CO)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Linda Chaney (FL)
Rep. Rod Furniss (ID)
Rep. Jonathan Carroll (IL)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Sen. Julie Raque-Adams (KY)
Rep. Rachel Roberts (KY)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Rep. Liz Reyer (MN)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Sen. Pam Helming (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)

Other legislators present were:

Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Brian Lohse (IA)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Sen. Michael Fagg (KS)
Rep. David LeBoeuf (MA)
Sen. Pam Beidle (MD)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Sen. Walter Michel (MS)
Rep. Amy Walen (WA)
Del. John Paul Hott (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Rachel Roberts (KY), Vice Chair of the Committee, 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 Rep. Jonathan Carroll (IL), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 12, 2023 meeting in San Diego, CA, and the Committee's May 19, 2023 interim Zoom meeting.

PRESENTATION ON NEW AT-HOME ADDICTION TREATMENT PROGRAMS

Brian Holzer, M.D., President & CEO of Aware Recovery Care (ARC), thanked the Committee for the opportunity to speak and stated that ARC is the country's only scaled in home addiction treatment company and what that means is sending real people in a people first, in home first care model. We have no facilities. We have no treatment centers. Our treatment center is the home of the client that we're treating and the program is delivered in four phases over a 12 month period of time. So, we're sending care teams into the home over a 12 month period of time and that allows the time and opportunity to peel back the onion and address over a period of time, the source traumas, the environmental conditions in many cases, the families in crisis. And we have dedicated staff working with the family and I use the word family loosely to mean friends, allies, constituents and supporters. And through that period of time, you're able to repair the family relationships, ultimately creating strength around a platform of recovery, dive into source traumas that in many cases are contributing to the addiction and ultimately repair and create a foundation for sustained recovery. If you look at the state map, you'll see that in the darker color those are the states that we're in. It's worth noting that this company was founded in 2011.

In the state of Connecticut, as of 2016, seven years ago, the company had 50 employees and 100 clients in the Connecticut area, all being treated in a fee for service situation. In 2016, Anthem of Connecticut came to the table and we were able to negotiate a bundled payment rate so that we receive a bundled payment on a monthly basis for the totality of our services for the client. For the client, what that means is a single copay rather than individual co-pays for the various fee for services that they would be receiving in order to receive the totality of our care model. So seven years ago, 50 employees, 100 clients, one state. We are now 900 employees, 11 states. We've treated over 7,000 clients in the last three years alone. We have 16 bundle payment contracts with various commercial insurers only to support this and we have about 1,800 clients on census. I'll quickly note because my background is actually traditional home healthcare, certified home health - this is not home healthcare. For those of you familiar with traditional home healthcare that is a nurse therapist model, which essentially you're sending a nurse and a therapist, and it's carefully considered in that the acuity of the patient finds how many visits. And I'm a big fan of home health. But the reality is those models make the most sense financially when visits are rationed. When you look at our model on the right you see a total whole person approach to the care team model and because we're in a bundled payment arrangement, we're able to

deliver the right amount of services customized to the needs of the client for an extended period of time.

There's three parts to the wheel. There's a client focused component to our care teams. We have both peer coaches, family educators and therapists dedicated to the client. In the yellow we have a family focused track to our program in which each family is assigned a family education facilitator. And we broker family systems therapy to begin working on the repair of the family unit. All of this is underpinned in medical oversight, in which we have an addiction psychiatrist that is involved in the care team meetings, a health service systems director, and nurse practitioners that will provide bridge medication and ongoing medication-assisted treatment (MAT) services. You may have seen the proliferation of MAT and e-prescribing going on in this space. That is not our business model. That is a feature of our model. This is an integrated care model that provides continuation between the prescribing of medications brokered and overseen by real people delivering the care which I believe is a much more effective model though e-prescribing is again something I'm very pro and something that's very important in this particular segment. So what you're looking at is a medical, behavioral and psychosocial approach to care. Again, I have not seen this. I've been in healthcare my entire career. I have never seen a model that provides this amount of services over an extended period of time, really breaking down the barriers and providing a sustained approach to addiction recovery.

I also don't think this should be specific to addiction. As a side note, this is my view of the way we should be approaching all chronic diseases. We have a sick care system that ultimately chooses to stabilize. We don't have a system in healthcare that chooses to repair and create a foundation to allow for sustained recovery. On the American Society of Addiction Medicine (ASAM) scoring scale for those of you that are familiar and I'll just sort of take away those fancy terms and say that this is a lower acuity residential model all the way down to an outpatient model. Two thirds of our clients are actually coming from residential treatment. So ultimately because residential treatment programs in our country are really about stabilizing, not necessarily creating sobriety much like post acute, which is my background, we stabilize in hospitals and then we kick them out too early and then we rely on disconnected fee for service entities to try and work together, which they don't, to create a continuous care model post hospitalization. As I shifted to addiction, I saw the same thing. Instead of hospitals, we got residential treatment programs and we have all different levels of care that are not connected and we rely on someone in crisis to navigate those levels and an addiction where there's periods of disengagement and engagement. People go up and down on the acuity scale and there's no one there to hold their hand through the levels of care. ARC was grounded and founded on the concept of creating a 12 month integrated care program to allow someone to flow through those levels of care from lower intensity residential all the way through outpatient.

We actually aim for 150 total visits over a 12 month period of time. The color is essentially mapped to the types of resources that are available and the cadence that they go into the home. Without worrying about all the words essentially what you're looking at is each client will be assigned two peer coaches and one care coordinator and there will be a nurse or social worker on the first home visit. The peer coaches are designed to alternate and be in the home twice a week for all 52 weeks. The nurses provide virtual support every four weeks. Family therapy for the client will start very

early in the phases. Family systems therapy will roll in. And all of this is grounded in the medical oversight from an addiction psychiatrist and nurse practitioner. In the interest of time let me skip to some outcomes. First, our outcomes are a reflection of our payer contracts. We are not in Medicaid at this point in time. We are all commercial. And you can see the logos on the bottom in terms of commercial insurers that support our operations in the 11 states. We essentially contract with an insurance company with those bundled rates before we enter a state. We entered the great state of Kentucky in December and in Georgia and the Atlanta area this past month and we'll be entering the New York area as our 12th state early next year. We aim to get into the Medicaid side of the equation. It's a more complicated segment because the pressures on the actual bundle will be real and we think though that there's an opportunity through shared upside on sort of a total per member per month (PMPM) savings basis given the amount of savings that we deliver, there's an opportunity to make the model work on the Medicaid side as well. From an outcomes basis, you're not going to see anything like this - not only addiction, but anywhere in healthcare. At least I haven't seen anything close to it. The average length of stay is 250 days. You can see the retention rates and this is not just someone answering a phone or a telemedicine app. They continue to welcome us into their home. Two-thirds of the clients are with us at six months and a full almost 50% of the clients complete the full 12 month program. That data is encompassing those that will complete the program early because they reach their treatment goals and so our goal is not to drive length of utilization. Our goal is to drive outcomes and meeting of treatment goals.

In terms of data, this is actually not our data, this is Elevance's health data. The right is an expression of our outcomes on a PMPM basis, which is a merge of both medical and behavioral impacts. The medical impacts are driven by inpatient and emergency department (ED) reductions and the behavioral impacts are measured by partial hospital days and intensive outpatient days (PHPIOP). What you see is during the year that they're on our program those are the reductions in PMPM savings compared to the cohort before they started our program. It takes a look at about 300 clients. What were their costs both medical and behavioral prior to starting, what were their cost reductions during the program? And even the year after they are off our program, what were the cost reductions? There is a tail on this program which I've never seen in healthcare. Usually things work while you're doing something, you remove that something, they tend to regress to the mean. Here, it sustains. And when you convert it to the PMPM's on the right, we have a 50% medical PMPM reduction in the year that they're on a program. They're simply using less inpatient ED care because we're resolving what causes a lot of that which is behavioral condition. When we stop our services and they complete the program you are still seeing a tail of 60% plus reduction in behavioral PMPM spend. Never seen it. Why? Because we're creating an environment for sustained recovery and ultimately if they're seeking care it will be outpatient or not at all. This is just a slide showing our Medicaid experience in a pilot in New Hampshire. If you look at the slide before this one, you'd see that our medical PMPM savings are actually better.

Rep. Roberts stated that I appreciate your presentation. I think this is really exciting and I appreciate the time you and I have had to speak about this. Am I correct in assuming that part of the reason you're here is because you're looking for more insurance partners in this realm? If you could please speak to that a little bit. And then my second question - I was impressed that you are not seeing provider shortages so can you actually also speak to some of the success on the provider profession side of this as well? Dr. Holzer

stated that the challenge with this model is it's new and new things in healthcare take time and again, to be a bit of a naysayer, we talked a lot about the shift of value and I think we're a lot further from that than we like to talk about us being. Because in order to create a value based healthcare model you need participation and partnership between providers and payers. And risk based reimbursement and payment models require data and partnership between providers and payers. Our ability to get towards a bundle type model is one giant step towards a full sort of value based risk based model where you put a percent of the bundle at risk, deliver outcomes and receive further upside based on impacts on PMPM savings. Anthem has been to date the only insurer that sort of has leaned into this on the commercial side in a big way and has recently become an investor.

We have had less success with some of the other large commercial insurers simply because when you look at our costs, which are about $40,000 over the course of a full year, it appears to be sticker shock because most, and I worked for insurance companies, tend to look at sort of the ability to control for cost and time in a finite period of time and don't like necessarily long term utilization expense for which this is. It's a shift in mindset, but it's a shift towards exactly where we all want to go or where we're stated to go in terms of payment models. I would certainly support in the states that we're in and we're not in the ability for members here to facilitate introductions and meetings with representatives from large commercial health insurance companies. This needs to be in more homes in more states. The reality is we're not disrupting, we're adding a new level of care, providing more access in a form which does not exist today. The ability for people to continue working, go to school, not have to worry about childcare responsibilities. We come to the home and schedule our visits around the needs of clients. This has got a great application to labor and trade. They don't get paid unless they work, and the labor employer does not enjoy turnover. This has got a very significant impact to employers from the standpoint of alleviating the need for Family and Medical Leave Act (FMLA) and allowing the workers to continue receiving treatment while working. And so I would certainly appreciate any help and guidance with regards to more connections with more commercial insurance executives so that we can get this into the homes of more clients. From a provider standpoint, we hire locally if your definition of providers is our care team providers – 80% of our 900 employees are in recovery themselves. Our company becomes a place of therapy for our employees as well. They are on their recovery journey and this helps them because they're helping others. We are an employer of difficult to employ or impossible to employ people and we will hire folks with felony convictions, previous incarceration, no bachelors degree. We provide tracks for people to essentially get upskilled and have career pathways. From a provider standpoint we help the communities in terms of growing jobs and ultimately those jobs of being people that are transitioning from not being employed or being difficult to employ.

Rep. David LeBoeuf (MA) stated that I have two questions about your model. One, when you reference visits, do those include telemedicine visits? And then second, when you reference about intensive outpatient program (IOP) and partial hospitalization program (PHP) days, those are typically functions performed in a group setting - does your company have your own provision of that? What is the linkage between other services and the cost associated with that? Dr. Holzer stated that we're transitioning a bit on the in person versus virtual as COVID taught us that virtual does work. Prior to COVID almost 100% of the care was delivered in the home across all the resources.

The shift is going to be our peer coach model is designed to be in the home. That is the tip of our sphere. And you're ultimately sending someone into the home that was previously in addiction and has sort of walked the walk and when you send someone in that was the client, that immediately sort of takes the friction out of a white coat going into a home or a nurse that hasn't been through what they've been through. They know all the tricks. They know that the alcohol in the shampoo bottle is not going to be shamed as they did the same thing. And so the peer coaches in the home will stay in the home. We are relying on more virtual connectivity with our other care team supports, the nurses, the social workers. Because a lot of what they do will be the care coordination work making sure they have their follow-up physician visits and that they have access to whatever they need in terms of their medical care, and so the answer to your question is almost 100% of the peer coach work will be in the home, maybe 75% to 100%, and then a lot of the other work will be virtual. For your second question, I'm not in recovery but I'm surrounded by people that are and so I learn from them every day. What I have been told is that group therapy ends up being an inhibitor for many people to seek treatment particularly under the commercial insured professional side of the equation in that it's very difficult for someone to raise their hand in a group setting of strangers and say I have a problem and so it keeps people actually from seeking treatment. Ultimately, what ends up happening is we work with PHP and IOP. We'll be the tail on a PHP stay. And there is the ability for us to co-treat people that are receiving therapy with IOP and also our in-home healthcare model. What ends up happening is folks resolve from their active addiction towards the later part of our stages, people realize they need help and be surrounded by people who have gone through the same thing. They become a little bit more open to group therapy and we will facilitate the interactions with alcoholics anonymous (AA) and narcotics anonymous (NA) and various therapists if they don't have one. So we sort of work through that initial stage where our program allows them to receive treatment confidentially to when if they want group therapy, we will help facilitate that because our goal is when we wind down, we left them with the connectivity in their communities that will allow for a lifelong sobriety.

Asw. Pam Hunter (NY), NCOIL Treasurer, stated that I wanted to know does your program deal with or work with Veterans with post traumatic stress, and what kind of facilitation do you do with the Dep't of Veterans Affairs (VA)? Dr. Holzer stated that we don't have a contract with the VA – we would love one. We are working to employ more Veterans, particularly those in recovery because again the model is predicated on sending someone in the home that looks and feels like the person we're trying to treat. I'm sure we have Veterans on census. We don't have a dedicated approach to that at this point. We've been more focused on first responders. We've hired quite a few first responders and ultimately I try very hard to sort of gender story match our client to the degree possible and we have dedicated programs and relationships with various police associations, firefighters and such in various states and transition programs from incarceration. One of our first clients in Kentucky was actually referred by the police because we're trying to sort of hardwire in the communities when police goes to call and they ultimately see someone, the worst place that they need to be is incarcerated and the real issue is addiction. We serve as potential for that individual to obviate the need for incarceration and ultimately seek the care they need in their home. And so these relationships with first responders are where we've been very focused on the last couple of years. We would love to get more involved with Veterans.

Rep. Dafna Michaelson Jenet (CO) stated that I'm curious about wages. Are you able to pay competitively for your people? Also, have you tried to work with Medicaid and has it just not worked yet? Dr. Holzer stated that I've been here 15 months and Medicaid was on the road map when I got here. It's now on the road. We don't have a Medicaid provider and no number at this point because we're looking for dance partners before we jump into a bunch of states. We need to negotiate a new rate and have to figure out a care model and so on and so forth. We are very eager to bridge the gap into Medicaid. With our Anthem relationship they're also eager and I think it's probably within the next 18 months we're going to have some pilots up and running inside. We pay more than anyone else in the industry, period. Not even close. And that's by design. Our peer coaches currently are W2. We're likely to move them to hourly with the ability to receive benefits if they work over 30 hours so hourly non exempt. That hourly wage would translate to something 20% higher than anything we've seen in the industry and some. We have a 401K matching. We offer benefits that are first in class and so on and so forth. These peer coaches have been completely neglected, quite honestly, with all of the models that are starting to rely on them - $16 an hour or $14 an hour and we're into the low to mid $20's with regards to an hourly wage. We want those folks, our peer coaches, to be competitively paid above anything else they can get anywhere else. It's the most important part of our program, the standpoint of creating that credibility.

Del. Westfall thanked Dr. Holzer and stated that if you would stay around, I think some other people might have some questions afterwards and I'd like to talk to you also.

CONTINUED DISCUSSION ON NCOIL MEDICAL LOSS RATIOS FOR DENTAL HEALTH CARE SERVICES PLANS MODEL ACT

Del. Westfall stated that next on our agenda is a continued discussion the NCOIL Medical Loss Ratio (MLR) for Dental Health Care Services Plan Model Act (Model), a Model which I'm sponsoring. You can view the Model on the website and also in the binder on page 96. As you may know, I am sponsoring similar legislation in my home state of West Virginia but I decided to wait on moving that to see what NCOIL does. I'm also glad that Rep. Rita Mayfield (IL) has signed on as a co-sponsor of the Model which shows the bipartisan support that this issue has. We had a productive discussion on the Model at our meeting this past March in San Diego and I'm looking forward to continuing to work on the Model and get it across the finish line either in November or in April. I'm certainly open to making changes to the Model. In fact, I know that today we're hearing about a different approach that some states have taken with respect to the issue. There will not be any vote on the Model today. We will hear from our speakers and then determine the best way to proceed.

Michael Adelberg, Executive Director of the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that there's been a lot of time invested on NCOIL on this issue. We do appreciate it. We do want to remind you that dental and medical are of course very different in a number of ways, particularly beginning with one being a high premium product and one being a low premium product. We'd refer you to the National Association of Insurance Commissioners (NAIC's) significant work in that area over the years. As you already know, for medical plans there's been a required MLR since the passage of the Affordable Care Act (ACA). As part of the ACA, there were a lot of provisions impacting health plans. Health plans ultimately supported, by in large, the ACA. One of the

reasons that they did was they received 30 million federally subsidized new lives. So, when we talk about applying an MLR to the dental world it's important to note that there is no great public policy trade off here, we're simply talking about applying a new set of requirements. Del. Westfall, you did note that a number of states had moved toward reporting and remediation requirements in the last couple of years. My colleague here today will discuss that as well. I wanted to level set on where we are with dental benefits and make sure that the Committee is aware of progress being made in dental benefits. First of all, dental premiums are barely rising - less than 1% a year over the last few years and that compares very favorably to premium increases in medical and of course, the inflation rate. Similarly, the question has come up, are there improved consumer protections built into dental plans? The answer to that is yes. We have positive trend lines in that direction. We note that the percentage of enrollees in plans with low deductibles has gone from 22% to 41%. This is among the preferred provider organizations (PPOs) but PPO's are 90% of the market. Similarly, the question of annual max has been discussed at prior meetings and the question is are annual max's rising? Again, the answer is yes. And the percentage in plans with high annual max's has gone up from 5% to 17% since 2017. Also, the dental insurance market generally has robust competition across the states and competition, of course, holds down prices and also increases the leverage of providers determining rates and who they want to do business with.

Owen Urech, Director of Gov't Relations at NADP, thanked the Committee for the opportunity to speak and stated that next we wanted to take a little bit of time to go through some of the activity that we've seen since the March meeting and through 2023 as it relates to dental loss ratio (DLR) bills that have been introduced In the states. So, since we last spoke on this issue at the March meeting, there have been 14 states this year that have introduced legislation related to DLR. Most of these bills originally in their form represent a similarity to the Massachusetts ballot initiative which passed last year. In nine of those 14 states those bills were introduced and either did not move forward at all, were not heard in committee, or they ended up not being signed by the end of their legislative session. So that's nine of the 14. In four states you saw compromise legislation or adjusted legislation passed, the first of which being Arizona, which started out as an 80% loss ratio requirement for every dental plan in the state. That ended up being a bill that included reporting requirements for dental plans in the state. In Colorado, which we'll touch on in just a second as well, there was a structure that included not only reporting but additional requirements that outlier dental plans or plans that are outside of the norms for loss ratios within the state would have to conduct some form of remediation with the department.

New Hampshire also passed a reporting structure for their DLRs. And lastly, Nevada was a state that had a loss ratio included within their rate filing process so it was prospective loss ratio that they re-upped in a piece of legislation after it had been on the books for several decades as part of their rate filing process. And we still have one state left that's potentially thinking about DLR legislation this session at this point, that's Pennsylvania, which introduced a reporting only bill. So all of these bills that have ended up in different places, what we're trying to show is a little bit of a contrast to the loss ratio ballot initiative that passed in Massachusetts. So for those of you who may not have seen this ballot initiative, it set an 83% loss ratio for all dental plans within the state of Massachusetts in order for them to exist in state. So, that's not only in the larger market, that's also plans that are for individuals or in the small group market as well.

They set that number across the board. Before this ballot initiative was passed NADP worked with Milliman to get an analysis of what the impact of that ballot initiative would be on our members. And there were some concerns over what we saw when we got that data back. And most in particular the impact would be strongest in the small group market where there was the potential in some circumstances for there to be an up to 38% increase in premiums. So we're talking about a 38% increase in premiums for plans that are being offered to small groups, small businesses of under 50 size. And that any impact on any potential rebating, which is one of the kind of main structures of MLR under the ACA, most of the rebates that would be given out would be de minimis. They would be below ACA requirements for them to be issued. So there would be a lot of administrative activity that would be done, but at the end of the day, there would not be a significant return to the consumer for meeting that loss ratio. In some cases there would be a concern that the cost to send out the rebate checks would exceed the amount of the rebates.

So since the ballot initiative is passed, we did that analysis and we've continued to monitor the situation. There have been significant difficulties in moving towards implementation of this loss ratio requirement. The Department of Insurance within Massachusetts continues to work on a proposed rule to implement the loss ratio. And we have seen even before seeing that rule that some of our members, these are national multiline carriers that are in these small group space, that at least two of those carriers have decided to leave the market in Massachusetts. And we have not even gotten to the implementation. And one of our primary concerns heading into 2024 in Massachusetts, with this loss ratio requirement is that. We're going to continue to see that reduction in the competition. Particularly within the small group space for dental plans. And as Mike pointed out earlier in his presentation, that is one of the things that keeps the dental benefits market in states robust. That you have a large amount of plants that are vying for these different groups and for the individual and small and large group markets. And if we saw a reduction in that competition, then the premium levels that have been kept well below inflation for the past two decades could potentially increase as well as some of the impacts that we saw in the actual implementation of the loss ratio. So, those are kind of the dueling concerns. The potential increase in premium and then also the potential for the loss of competition within the dental benefits market.

And this is just a map to illustrate some of the activity that you can see on there. I'll point out as well New Mexico also set a loss ratio for their plans at the end of 2022. That was through a regulatory process and not through legislation. They set a 65% loss ratio across the board after having essentially two decades of data from rate filings within that state that they were able to look at that information and say that that number made sense. And this is where we think an alternative to the existing draft of the Model comes in. So Maine in 2022 passed LD1266, which was a structure that allowed not only reporting of DLRs for these plans, but also empowered the Department of Insurance to take remedial action against plans that were designated as statistical outliers. So you would have not only the reporting that's been in place in states like California or Washington for a number of years but you would also have this additional enforcement capacity in those states that would be tailored to the data within those markets. So, you would split out the measurements by the individual, the small group and the large group markets, and then over a three-year measurement period in order to determine validity you would look and say what are the outliers from these plans? And then the

Department would be able to go in and check those plans, conduct financial examinations, or require them to adjust their premiums or do other forms of remediation. And this allows the Department as well as the people who pass the legislation to kind of really get into the details of what is happening with these plans. Why are there loss ratios outside of the normal bounds of the market? And what can we do to make sure that these plans present value to the people who were purchasing them? And we really think that the approach in Maine and LD1266 is something that gives them a direction for them to be able to take those actions while preserving the competitiveness that has kept the dental benefits market healthy.

And we saw an example of this type of legislation being implemented in this past legislative session. Colorado passed SB 23179. This was a bill that started out as an 80% loss ratio requirement but after considerable discussions with the sponsor who is the Majority Leader of the Senate, as well as with provider groups and consumer groups and the plans within the state, there was a consensus reached to adopt a reporting and outlier remediation structure that was signed into law on June 2nd. I will also point out that there were additional reporting requirements that were included in the Colorado bill that are not included within the Maine structure. This includes requirements that plans disclose how many people reach their out of pocket maximum every year and then also what the average out of pocket maximum is for their plans in each market segment. So adding on some additional requirements to plans in order for them to report to the Department, make that public, and then also empower the Department to take those actions against outliers in the state. And, if necessary, if the average loss ratio in each market segment is declining then it also empowers the Department to set a minimum floor based on that information.

Mr. Adelberg stated that we ask you as you consider this important issue to think about unintended consequences. And an arbitrarily applied loss ratio that is not based on practices in that state is going to change dental plans in that state potentially very, very significantly. Dental plans are going to have to look at lowering their administrative costs potentially dramatically. When that happens it's important to remember what is included in a administrative costs. It's call centers for providers and for consumers. It's processing claims. It's maintaining broad networks. It's detecting fraud and abuse and a variety of other things that we consider to be very good expenses. The point here is that when you hear the word administrative cost, there's an assumption that it's just someone at the office somewhere with a stapler. These are vital operations and operations that make plans successful. It's also worth noting that consumer satisfaction with their dental plan according to J.D. Power, which does national surveys, has increased to 18 points higher on a 1,000 point scale than it was last year. Mr. Urech also mentioned unintended consequences in the form of plan pullouts if it's an arbitrarily applied high number and the loss of competition and the consolidation that would result. So where do we go from here? We've asked NCOIL to consider that first of all, there are significant successes in the dental insurance market today. We're holding down premiums. We have significant competition. The margins being generated by dental plans are unremarkable and consistent with other lines of business. Having said that, if NCOIL believes a Model is necessary, we do think that a reporting and remediation model as a number of states have adopted and are considering adopting is a vastly better approach than arbitrarily selecting a number that has no bearing in the existing practices in that state. And lastly we would just ask you again, to remember that because something is done to medical, a high premium product with a $600 a month

premium does not mean that that automatically ports to a dental product with a $40 a month premium and many of the same fixed or quasi fixed administrative costs. The NAIC has long recognized the need to treat low premium and high premium products differently.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), thanked the Committee for the opportunity to speak and thanked the NADP for their presentation. I'm here today to convince you about what a good policy MLR is with some additional ingredients to the ones identified by the NADP. I'd like everybody to think about the fact that there has been an inflection point in dental plans and it was the Massachusetts ballot initiative. I know it's uncomfortable for the dental plans to talk about or maybe even it's uncomfortable to talk about it because it is an inflection point. They know that things have changed. The landscape could potentially change. And they would like things to stay in the status quo. But inertia has not worked in the favor of consumers. And when we talk about competition, which they did extensively, we have to focus on who is benefiting? Keeping the premiums low. Who has it ultimately benefited? Who has value out of their products? I would argue that the patients do not get a value out of it. What we have from years and years of competition, basically, is an upper limit of $1,000 is all that the American should deserve or get. That's what this competition has resulted in. And I know that there was some discussion of maybe the annual limits are going up slightly. But the truth is that there are mechanisms built into dental plans that do not allow you to get benefits, you know, major services for greater than 50%. That's built into the cake. And that's why most people don't reach their annual maximums. So how do we address dental plans in a way that focuses on the future? I liked what Dr. Holzer said about let's look at the trends and how we can impact a product so that it is more valuable to people that matter the most, which are the patients. This is a pro consumer initiative.

Okay, what is MLR? I'm not sure if that was explained earlier. Just to be clear, it is setting a ratio that this is the amount of money that has to be spent on care and the rest can be collected by the insurance company, the dental benefit plan and administrative salaries, etc. This was highly successful in Massachusetts. Nearly 72% voted in favor of this. Because I think it is shocking to most people to find out that the healthcare product has the ability to collect, say, 50% in premium and then, you know, keep 50% of that. That's shocking to most people. And when they found out about it, they voted in a big way. So how does this benefit it? It adds transparency, which I heard from my colleagues at the NADP that they support. But establishing that minimum percentage holds the carrier's feet to the fire and requires carriers that do not meet the threshold to refund the difference. I'm going to talk about rebates in a little bit in the presentation and I'm glad that NADP brought it up. So how does this help patients? It improves the value for employers and patients that they get out of their premium dollars. It makes dental insurance more reliable. It ensures patients get the care they need when they need it and incentivizes dental insurers to cover needed care. I talked about this last time but just to bring it up again, the current incentive structure for dental plans is out of whack. It is that if you de-incentivize patients from getting care, the insurers make more money. That doesn't exist on the health plan side. And there's a reason for that because a health product is a little bit different. It should be focused on helping these people get the care they need. Incentivizing the dental plan to change the cost structure where they say the patient is responsible for 50% and even adjusting that up to 60% would mean a

great deal to somebody that has to get an extraction. It would mean they could afford it that year. That's what we want out of a dental plan.

So I'm going to go through some responses to the opposition for MLR. Number one, the claim is that the insured patients currently have excellent access to dental care. We want dental plans to not check the box and say we've done enough. Even if you have insurance, it is still too costly. It still costs people too much and they delay care. How can we change these products so they're focused on the patients and focused on getting the access to the care they need today? The claim is that a large portion of the dental premiums go to administrative costs, which is good for patients. Our argument is when too large a portion of the dental premiums go to administrative costs it takes away from the patient care. And Mr. Adelberg stated that it's more than a person stapling in the backroom and we know there's more to administrative costs. We're for administrative costs that makes sense. We're just for more of those costs and in incentivizing dental plans to become more efficient. That's what the ACA has done and we're asking for that same thing when it comes to the dental plans. I'm going to talk you through some California data because we have it available and I wanted to walk you through that because I want to address a couple of things. One is it would be impossible for the dental plans to meet this - that's not what's borne out by the data. And also I want you to see that without something like the rebate system that exists, during COVID dental plants collected premium and did not have to pay out in care. How do we alleviate something like that? So let's take a look real quick. This is the large group market and you can see there's a little grid down at the bottom where if a plan is over 80%. You can see that a number of large employers are able to meet that. I will say to the members of this Committee, if you'd like to see the entire scan of all the plans that were available in California I can certainly provide that to you just let me know. But this is just reflective of the fact that this is possible for the dental plans to meet and it will not kill competition automatically. And shouldn't we incentivize these plans to be better? I frequently use this analogy, I'll do it again, this should be like fuel economy standards. Where we're nudging dental plans in the correct direction. This is what this type of policy would do. Mr. Adelberg also mentioned that the small group is a little lower and difficult to do. Again, there are those that can meet it, and I would be very interested in talking with NADP about a tiered system where there was a different percentage maybe set for the small group market. Here's the averages of the California DLR. You can see that dipped down during COVID. Again, if there were policy in place that was set up, that money would go back to the patients or whoever was paying the premium. That's why this is good policy.

The other thing I will let you know is there are a number of plans in California that have very low MLRs really could you even call them a true dental benefit plan? That's something this policy would also address. Finally, the claim that rebates are self defeating and cost too much to generate. I think that there are options for a state that's addressing this. They mentioned that the checks would have to be cut, the juice is not worth the squeeze but what if it's a reduction in the premium that the patient has to pay the next year. You know that makes the dental benefit more affordable. There are technical options that can make this amenable to all the parties involved. NADP would like us to stop at the definitions in transparency here but these, we feel, are the four essential components of an MLR bill. Good definitions - making sure this fits in with statute that you're working with. Good transparency - and that's where NADP would like us to stop. A refund/rebate - everybody knows about incentives here. If there's nothing

that's going to hold you to the fire, you're going to get the California data again which basically stayed the same in 10 years that it's been there. Finally - rate review and approval requirements. There was mentioned that the Milliman report said that there would be an increase of 38% for the small group market. Remember in that same report they said because of the rate review that's inherent in the ballot initiative, because of that rate review requirement that says that the dental plans rate increases are automatically disapproved if they go over dental services consumer price index, they admitted that they didn't take that into account when they put out that 38% increase. So that's another essential component that we see.

Michael Flynn, DDS, a practicing Minnesota dentist, thanked the Committee for the opportunity to speak and stated that I'm going to be talking about your insurance. There's about 40 of you just sitting around the table here and if you're the average citizen in Minnesota I know 30 of you have dental insurance. So I'm going to talk about your dental insurance. Now the first thing it's been mentioned is the unusually low maximum annual payment. I think Mr. Olson mentioned $1,000 but $1,500 is common. I want you to think of what yours is. I have dental insurance. I'm lucky my wife's working too, and she's the one that pays for it along with her employer. And mine is one of the highest there is, it's $2.500 which is pretty good. But you think about your dental insurance and you can tell I've been in this business for several decades. Back in the 1980s the maximum payments were about the same. I had $1,500 back in 1983. It's 2023 and we still have $1,500. Back in 1983 your preventative services in my office for the year, if you came twice a year would have been less than $100. Today they're $500. So you're losing on that maximum benefit if you need any care you're going to go over the maximum benefit and it doesn't take much to do that. Now, the other thing I want to incorporate into this is the new technology you've had the last 40 years, it's nice. Now last year I cracked a tooth and I lost a tooth because when you split the root you cannot salvage it. So I had two options. I could do a bridge or I can do an implant. I chose to do an implant and with my $2,500 maximum after my preventative services, it covered about 20% of my expenses. My point is, we're behind the times on what we should be. If you go back to 1982 at $1,500 to now, that would be $500 back then. Our inflation has gone up at least three times if not more. Even though our industry of dentistry has been one of the lower medical fields that has held the line on costs. We actually are very efficient at holding the line on costs. And again, if you're in 2023, if you want an implant or if you will need a root canal or maybe you need partials or dentures or think about your care and what you need. Isn't it kind of embarrassing that whatever you pick out of those major areas it's only partially covered because you've reached your max? So my position here is this has to change, we need to make the max higher and I've heard that there's a lot of difference between medicine and dentistry. Well there is in how we deliver. But we all know if you don't have a healthy mouth you don't have a healthy body, right? Dentistry is not optional if you want to live a wholesome life and a good quality of life. We do know that of our nursing home patients when I graduated, 40% had complete dentures and today it's less than 20%. Isn't that great? It means we have to maintain those teeth they have for quality of life.

So in conclusion I'd just say without a doubt dental insurance will change to meet the current needs of our insured. And from what I've heard and what I watched on the slides, I don't see it's meeting the current needs. Outdated policies need to become current. I think having a standard like an MLR will help meet this need. I really do. Now, whether you're a dentist like me, basically retired from this larger practice for five

years, or if you're middle-aged teacher, block layer, cement worker, truck driver, pick your occupation, they want quality dental care. They want adequate care and not just a minor supplemental benefit and that's where we are right now. So my position is to change the way we're marketing our insurance and I appreciate them trying to keep the cost down but below inflation hasn't helped because inflation kept going. And now we have an opportunity to alternatives. Now think about when you go to the dentist and what it costs you out of your pocket. You want real dental insurance, right? So that's what I'm promoting and I want to thank you for your time.

Sen. Bob Hackett (OH) stated that I have a number of dental clients and when you ask dentists what is the most important coverage that they have they'll say preventive. And they pay 100% of preventive. 80% of basic and 50% of major. And you ask them why is that the most important? Because it gets the people to go to the dentist twice a year. And then they find out and they save on cavities as they don't have as much cavities and they make sure things are done and they get the cleanings and things are done. So when you talk to dentists, I would say many times they're worried about driving people away from not seeing them. I agree with you that it's basically a preventive care basic plan. It's not even 50% by the time you get to it and you don't have that much left. So my question is don't you think the number of people that go to a dentist and get under the plans will decrease if you offer much higher benefits at a much higher cost, etc.? The key is you want to get people to the dentist. So when you ask dentists, what's the reason why you haven't had the big increase in the benefits - it's because they don't want to drive people away from going under the plans and having those two visits a year.

Mr. Olson stated that my response to that is dental tourism is happening and there's a reason it's happening. They're going to places like Mexico to seek care because it's too expensive. And I think that there is a real potential with a policy like that to change the paradigm without the severe reduction like you're saying. I don't think dentists are satisfied with the current crop of plans. They would like to see more and I don't know if Dr. Flynn would like to comment on that but that's what I hear at the ADA – products should be out there that support more than just the bare minimum. It is good that people come to the dentist because of these products and that's not what we saw in MLR on the major med side so I don't anticipate a real big drop in coverage. I'll also point out and NADP can be specific about the numbers, but the number of covered lives by dental has only shot up exponentially in the last 10 to 15 years. So if there is some sort of tailing off because the plans are not adequate and then everybody adjusts because this policy takes root and then these are great products nationwide, I think that's an overall good for Americans.

Sen. Hackett stated that my district is not a super affluent district. If you're a dentist in a high affluent district of course the people want better coverage. But if you're an average district, you're going to drive people away from going to the dentist if you don't give 100% of preventative. You don't give them the incentive. Dr. Flynn stated that I hope I never implied that we didn't want to get preventive. My position was in 1982 the cost of preventative care, meaning your cleanings and X-rays, was approximately $100. In 2023 we do want preventative care, but it now costs about $500 so if you need something more than preventative care, you are really short. And they want better services. I do a lot of pain management when it comes to that and they might do their routinely, but you're going to have people like myself who are chewing on something you

probably shouldn't have been chewing on split a tooth in the middle of the root and I needed extended care. When we got to that care, I have one of the best plans in the state of Minnesota, and it still only covered about 20% of it. And I'm saying that people today want better dental health. They demand it. The dental IQ now is way different than it was 40 years ago. They don't consider their teeth optional. They consider their teeth necessary. And they're going to do whatever they can to preserve their dental health and sometimes that's more than preventative care. And I never saw a plan that came in my office that was "just for preventative care." I mean, that's great. We want to get them in. But I practice in a small town of 1,400 people. I knew every one of them and I knew who couldn't afford care and I knew who could. And I never kicked anybody out of my office that couldn't afford care. And I don't need to tell you I was the only dentist in town and you treat the community. From what you said I have a feeling your community is that same way.

Mr. Urech stated that I can briefly respond to this from the plan perspective as well. I think you're absolutely right that preventive care is what keeps people going to the dentist and we absolutely share the value that Dr. Flynn pointed out - that is one of the most important parts of people's continuing oral health that they have access to a dental home. I will say from our plan's perspective is that when they were designing the products that they are offering to a small business or to an individual that they want that emphasis on the preventive coverage. But also these groups or these individuals are coming with a budget of what is the type of plan that I am able to offer to my employees so that they have dental coverage? And in those conversations particularly in the small group market, they are looking for a low premium that they can keep so that they can offer and people can maintain thar coverage and they can get that preventive treatment. And that is first and foremost one of the most important things that the dental plan can provide for them. So we absolutely agree and our major concern is that if you see an increase in premium I mean the economics data is clear on this that for dental plans in particular, people are extremely price sensitive on the premiums. When they're shopping for benefits they are looking for that premium in particular and that's one of the key decisions that they make and so our plans work very hard to work with those groups to say what is your budget, what can we accommodate, what types of plans can we build for you? And that focus on prevention is always critical to those designs.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that I have some feedback. I've sat here and listened to this now for a couple of different sessions and I have family in the dental world and they're saying it is causing some service issues because I may refer you to a completely different dentist because the reimbursement from the dental plan is less than my cost. So I'm not going to provide that service. And that's troubling. But if we talk about an MLR as the solution, I'm going to go back to the ACA. The MLR is what everybody wanted in the ACA. I had 16 health insurance carriers in 2009. Now I have two. So if you push this pendulum too far in the other direction, you're going to limit the amount of carriers that can be out there. So, I think moving forward as we continue this discussion, I've heard about Maine and other places. Are there ways that we can find this so we can help providers but also not injure the industry or put them out of business because we've seen what that's done via the ACA.

Mr. Urech stated that one thing I would add on to that is to elaborate a little bit more on the structure that Maine and Colorado have passed. As Mr. Olson mentioned earlier discussing the California reporting data which has been utilized since 2014, it does show

a spread of loss ratios in all of the different markets. But what we think is effective about utilizing the Maine or Colorado language is that it empowers the Department to look at those plans and to say what benefit is this showing? What benefit is this providing to the people who have enrolled in it? And utilizing that data and making sure that it's specific to its state so that you can develop regulations that are going to be tailored to your state and to the needs of the plans and the individuals in your state and we think that's going to be the most portable approach.

Mr. Olson stated that I think one thing I would focus in on is that you said something about more money going to the providers and I admit that it would but I think the more important thing to focus on is the buying power of the patient. The ability to buy the services that he or she needs. That's the real focus and why this is such an important consumer issue. And then addressing your comments on competition. I think there is some wiggle room and this is something that I had talked a little bit with Del. Westfall about, where you could have a covered lives limit where if you had under that certain number of covered lives in the state, the MLR would not apply and that would increase the competition and the ability of new entrants to come in. But once you've gone over that threshold, then you would have to abide by that MLR and again, this is nudging payers in the right direction where they're incented to get the care out.

Rep. Stephen Meskers (CT) stated that I think the MLR and DLR are complicated issues. The biggest problem I have with the MLR or DLR is it incentivizes the insurance carriers to increase prices. Because I don't care whether the limit is 15% or 12% or 20%. On every dollar of premiums I'm making twelve cents, fifteen cents, twenty cents. So the only way I make money is in an increase in premiums, which is driving the increase in costs. So I worry that the unintended consequence is going to increase the cost of service. It's also going to drive out the number of the insurance carriers because they're going to have to have that regulated framework. I'm not convinced that we get to the right level of practice and I'm not sure we're in the crisis I'm hearing other than the question is whether the policies and the demands of the public are to have larger premiums so you can cover more expensive procedures. But I'm with my colleague that the first thing is preventive medicine. And I'm not sure that this is going to do anything to reduce costs. In fact, everything I see in the medical profession tells me it's been an abject failure in the MLR's. Because we have no control over costs in the medical profession. Our insurance rates are going through the roof. It's becoming unaffordable. So it's not addressing my constituents problems in the medical profession, and now I'm importing it into the dental profession where I'm not hearing the problem. I'm very worried about it. I don't know if there's a question there or a statement but I don't understand how I keep control of costs under a DLR. And if I can't regulate it at the medical side, what makes it unique that I'm going to be able to do it on the dental side? Maybe you can explain what the differences are on MLR versus DLR and how you envision it?

Mr. Olson stated that I would point you to that fourth bullet that I had in the essential parts where the state had the authority to disapprove rates, and that's what happened in the Massachusetts ballot initiative. The state has the ability to disapprove rates. I understand certain members of the Committees have concerns about competition and want to maintain that but I think that there's the ability of insurance companies that are staffed by a bunch of smart people to adjust and continue to offer products I think it's remarkable. And to see even the broad swath of carriers that offer products in places

like California - they will be able to adjust. And I will also say as NADP indicated there is some reduction in the number of carriers that may be offering in Massachusetts, I think we're going to have to see. That is a very rich market and they will continue to offer coverage there. If it is applied to all then all will adjust.

Mr. Adelberg stated that it's been discussed that establishing an arbitrarily determined MLR is a nudge. It's kind of pushing the market off a cliff as opposed to a nudge. What a nudge would be is more along the lines of what Colorado is doing. Where there will be transparency, but on top of transparency there will be remediation powers given to the regulator. And if there are outliers, the regulator can nudge the outliers. That's a nudge. Taking a number that has no history in the state and assigning it to the state is spinning a roulette wheel. There have also been comments made about the basic benefit structure and where annual maximums get set. Just note that dental plans talk to their customers and dental plans are quite happy to sell more expensive products when there's a customer that wants to buy a more expensive product. There are plenty of no annual max group plans out there. They're not predominant in the market because most employers won't pay for them. But employers who want the no annual max product can get one. Employers who want the product where unused benefit gets rolled over in the following year to compound the annual max next year - employers who want to pay for that get that. There are also dental plans that further incent preventative care by adding to the annual max the following year for people who are getting their preventive care appropriately. So, a number of the comments being made about common or historically common benefits structures are in fact there - there's a good deal of innovation in the market currently.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, stated that it would certainly be my hope that if you have an MLR that instead of necessarily giving rebates as you pointed out it might be expensive to send out for the small carriers so you could instead increase the dental benefit. In response to Sen. Hackett, preventative is very important. Don't get me wrong, but I'm a dentist, and I would see people all the time in my practice and they would come in and have preventive care and you say, "well you need a crown on this tooth." Then they used up all their benefit for other things. It was going to pay very minimally. And you would offer all kinds of incentives to go on and get it done and in payments, but then they would drag their feet because they would find other things more important than having dental care. And then they come back six months later instead of a crown they now need a root canal and a crown. So, it's not just preventative it's about being able to afford the care. And hopefully the difference in the MLR you would make up in expanding the annual maximum or those kind of things.

Mr. Urech stated that we absolutely sympathize and agree that making sure that people are in the chair and getting the care that they need is incredibly important. I think really the difficulty of this and where we see a mandated MLR coming in and becoming an issue for these people that may not be able to afford their care generally is that even if in circumstances that Mr. Olson discussed where there may be a cap or an ability for the state to deny rates, we're already seeing in Massachusetts that that means that those plans are potentially going to leave the market if they think that it doesn't make sense for them or they're not even able to offer the plans that they originally have had in the state. And we know that that means a perpetuation of issues for those people to be able to find coverage. And I think that our underlying concern is that in kind of setting a higher loss ratio that's not based on the data or the market within the state is that you're going to

see more of those plans leave and that you're going to then have the cascade effect on people's oral health that they're not going to be able to get the coverage they need. And I think that our members and the ADA as well know that there's a broader conversation about oral health in the U.S., and we know that dental coverage plays a critical role to that but we just don't think that as currently drafted the proposal would make sense to meet those needs. Rep. Ferguson stated that I hate when people leave the market, but with any insurance, it's only as good as it is when you need it and maybe if those plans are worthless to start with it's better they leave the market.

Mr. Olson stated that I think the reason this policy is such a good one to look at and again, we urge your adoption with those four parameters that I outlined, is because this is about getting people to good oral health. And preventative only plans as Sen. Hackett put out that would get people's butts in the chairs but it does not get them to good oral health. And I think that is why this is a worthy policy for everybody to examine. Let's look at the value of these dental benefit plans and how to incentivize them to pay out the patient care that is needed. That's the opportunity here today and I encourage you to endorse.

Sen. Beverly Gossage (KS) stated that I've been a health insurance agent for 20 years. I help write dental plans. But I often talk more people out of dental plans than buy them. And that's partially because they don't necessarily understand them, particularly employers who just ask how much is the premium and say ok we'll have our employees pay whatever portion that may be. But yes, they have options. You can have the $5,000 total out of pocket. You can have the $25. You can put endodontics and periodontics into basic and pay 80% of that. But the premiums are going to be a lot more. They just would have to be. And so most of the employers and most of the individuals don't choose that option, even though it's offered. I'm concerned that oftentimes government becomes the problem rather than the solution. And if we were to try to do what happened with MLR we could see problems like what happened in my state. We went from 17 carriers to three when they implemented the ACA and what I see right now is a vibrant dental insurance market. We have lots of wonderful dentists. I personally for 30 years have never had dental insurance. I just have a relationship with my dentist. He doesn't have to file insurance. He doesn't even take it. And then we can just work directly together. Do I think dental insurance is wicked? Not at all. I think this is an option that people can have and we need to have these options. We need to have a vibrant market where they have a lot of different competitors. And we have that now. So I would not be in favor of model legislation that would do MLR in my state.

Del. Westfall thanked everyone for speaking and stated that we'll probably have an interim meeting of this Committee sometime before our November meeting. If anybody has any ideas or comments or suggestions please reach out to me or NCOIL staff. Hopefully we'll vote on this in November or April.

CONSIDERATION OF NCOIL HOSPITAL PRICE TRANSPARENCY MODEL ACT

Del. Westfall stated that next on our agenda is the consideration of the NCOIL Hospital Price Transparency Model Act sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, and co-sponsored by Rep. Roberts. You can view the Model on page 99 in your binder and on the website and on the app. We will be voting on this Model today. The American Hospital Association (AHA) has been involved in discussion with this

Model for the past several months, but they have declined to send a representative to this meeting.

Rep. Oliverson stated that I'm very proud to sponsor this Model alongside my colleague Rep. Roberts and I also have to give a shout out to my colleague, Rep. Meskers, who gave me the idea to introduce this in the first place by speaking up a couple of meetings ago so I appreciate you both for your support in this. As you know, this is something that the federal government has taken on, the idea that a consumer should be able to know in advance for a shoppable service what their insurance company is going to pay the hospital or service that's elective that's shoppable that's going to be provided and they ought to be able to shop around. We can do this in pretty much every single segment of our economy, except for healthcare. And so federal regulations have been enacted on hospital price transparency and what we saw in my state and what I think Colorado simultaneously saw was a desire to ignore the rule and so what this Model does and what I think it will solve is it actually increases the financial penalties on non-compliance to the point where hospital systems can no longer ignore what is already required by federal rule. And it also simultaneously requires that at the state level and it does that through a series of escalating what I call tiered penalties, where every day of non-compliance is compounded by an additional violation. And so essentially there's logarithmic growth in the size and scope of the administrative penalty that's assessed. And we felt like that's the best way to bring some of these extremely large tax-exempt, some would call not for profit healthcare systems, into compliance because they were the bad actors by and large on this while at the same time respecting that there are may be small healthcare entities out there that don't have an extensive IT department and compliance may be more difficult.

So our Model actually takes that into account and it creates a different tiered penalty structure for non compliance based on total revenue of a facility. We added to that some excellent language from our colleagues in Colorado which actually would prohibit a hospital that is in non-compliance with this Model from being able to send a patient to collections for the non-payment of medical services that have been received. If you're not willing to show your prices upfront, is it really reasonable to be able to send someone to collections and take them to court after the fact on something that you weren't even able to give them advanced warning of what they're out of pocket would be? So I think this is just a common sense thing. We've talked a lot about the cost of healthcare. To my way of thinking, transparency and pricing upfront is literally the best antidote we have to the ever increasing cost of healthcare. And I do strongly believe that the average American citizen is smart enough that given information about price in the areas of places where they could go for services that they will begin to shop with their feet. They will select services based on what they can afford based on what seems good to them. And studies have also shown that when patients are able to ask questions about price and they start seeing price and they want to compare those prices they also began to ask questions about quality. And so that's something else that is sort of a hidden benefit by adopting this Model is that we actually arm consumers with pricing information, which stimulates their interest in quality as well. Which those are sort of, in my mind, the two legs of the two legged value stool.

JP Wieske, VP of State Affairs at the Council for Affordable Health Coverage (Council), thanked the Committee for the opportunity to speak and stated that the Council is a broad-based advocacy alliance with a singular focus on bringing down the cost of

healthcare for all Americans. We've been fighting for hospital transparency since our founding in the early 2000s. And I just want to heartily endorse the Model. The work here to extend the federal actions and to ensure that there's compliance is going to bear fruit over time and we want to thank you for introducing this and we give it a strong endorsement.

Rep. Tim Barhorst (OH) stated that in Ohio we just passed a hospital transparency bill off the floor about five weeks ago. It was bipartisan with 90 yes votes and five no votes. So, we're going to get that over to the Senate this Fall. But we did the simple codification of the federal rule like you did and we had three provisions of non-compliance saying that there's no third-party debt collection allowed for 12 months, no credit score hit, and no private right of action to sue you for your assets to collect that debt. So, the consumer and a patient does owe these bills, but we're just trying to get the time out so they have time. If you won't give them the price, you got to give them the time to get through it. So I commend you on that. And our bill is based on the Colorado law more than yours. What I do like about yours is the total revenue and the penalty structure. Can you tell us how you're enforcing it over there? We have a Department of Health and an oversight of the state auditor as well in there and some of the challenges we'll have in the next step is to make sure everything is being followed.

Rep. Oliverson stated that we did spend a fair amount of time with our Health and Human Services Commission in Texas making sure that they understood exactly what we were trying to do. It is simply written but it's one of those word problems in math that really requires you to break out a pencil and a piece of paper in order to really understand kind of how it works because of its stacking structure where every separate day of a violation triggers a brand new penalty which compounds daily. So it really does increase over time like a pyramid. The reason we did it that way, quite frankly, is that the number one reason why the federal rule was ignored for so long is just simply because the penalties were a fraction of even the daily revenue that the facility is able to get. And by sort of hiding behind this cloak of non disclosure, it was a simple business decision. It's cheaper to pay the penalty than it is to be compliant and actually post your prices. And so we fixed that. So our mechanism for the largest tier you're talking about a multi million dollar administrative penalty that's assessed annually. And so we felt like that's really the size that was needed. Now the way that our Department decided to implement that in a way that was crystal clear to everybody, which I thought was rather ingenious, is they just gave examples literally like algebra problems. They literally just said so hospital A is in violation and here's how many days and they just calculated it out in plain math so that there's zero ambiguity and everybody could see here's the situation. Now you'll notice in the Model that there are considerations and in our statute as well that good faith efforts as far as compliance and trying to get their previous history of violations of this same chapter, these are all things that should be taken into consideration. One of the things that we ran across early in implementation with this law is that our law also is pretty aggressive in terms of looking at websites, making sure that you can get to it within one click from the home page and if you can't do that then you're in violation. We didn't want this buried on some back page that nobody could navigate to. Our Department was sending out letters of non compliance based on the fact that they went to the website and they couldn't find it, not receiving a response from the hospital to their certified letter, and then just saying, "well see this just proves that they're not compliant because they never responded." So there are some implementation challenges that go along with this but so far it's actually worked well. In Texas now we're

over 80% compliant with the federal rule after less than a full calendar year of the implementation of this law.

Rep. Barhorst stated that some of the surprises I had in this bill in Ohio is a lot of the smaller rural systems were scared because the federal rule and the penalties with that were significant to them. So I've got some of them fully compliant that I've met with and sat down with. And several of them are just a couple steps away. So let's say they're 80% or 90% compliant and it's just the big ones that have literally done nothing and just laugh at you and say we're not going to. So that's the impetus of trying to do this. And then the one thing that we ran into is they create complete confusion of what price transparency is versus what estimators are. Estimators are not price transparency, they have no binding and that's all full of small print. And don't let estimators get stuck in your argument as fulfilling compliance and that's the part we had to push back at the most.

Rep. Linda Chaney (FL) stated that we took a swing at this legislation last session and it didn't get through, but conversations are continuing. Part of the conversation were we also included in this requiring hospitals to identify themselves as hospitals. Which seems crazy. But there's a lot of small hospitals popping up that look like these walk-in clinics and so patients were going in thinking they were going to one of these walk-in clinics and would get billing that way and instead they would be receiving hospital billing. So that's something to consider. Rep. Oliverson stated that it is interesting that Colorado and Texas also share a distinction that I think we're the only two states that have a free standing emergency room (ER), as well. And so that was another issue for us as to separate it out and work through because a lot of these charges could concern services provided in an ER so the free standing ER's how are they going to be participating in this. That's sort of a constant frustration in Texas. It's sort of a friction between the acute care hospitals and free standing ER's and the insurers, and unfortunately, the patients get ground up in the gears there. So, I hope that you give it another shot and I'm happy to come help you.

Hearing no further questions or comments, upon a Motion made by Rep. Roberts and seconded by Rep. Jonathan Carroll (IL), the Committee voted without objection by way of a voice vote to adopt the Model. Del. Westfall thanked everyone and stated that the Model will be brought up Saturday in the Executive committee for final adoption.

CONSIDERATION OF NCOIL BIOMARKER TESTING INSURANCE COVERAGE MODEL ACT

Del. Westfall stated that next on the agenda is the consideration of the NCOIL Biomarker Testing Insurance Coverage Model Act, sponsored by Asw. Hunter and co-sponsored by Sen. Paul Utke (MN), NCOIL Secretary. We will be voting on the Model today.

Asw. Hunter stated that I will be brief as we've been discussing the Model for many meetings. I just wanted to add a few points and note a few changes to the Model that have been made since we met last and since the conversation we had at our interim meeting. The Model is in your binders on page 92 and is on the website and app. As many of you know, I did pass a bill last month that I sponsored in my home state of New York that is based on the Model and it passed with near unanimous support in both chambers and is now awaiting the Governor's signature. The bill passed unanimously in the Senate and passed the Assembly by a vote of 143 to two and we have 150

assembly members in New York. Also, after many collaborative discussions with the New York Health Plan Association, they did not actively oppose the bill due to some amendments being made, many of which I have now included in this Model. And I really thank them because they were really hand and hand with me in making amendments to get them passed in the state of New York. With this bill passing in New York that marks 10 states, both blue and red, that have adopted similar legislation, and another 10 states have introduced similar legislation. So with this issue, we're certainly talking about a national trend that I think is important for NCOIL to be a part of. As you can see in the latest version of the Model I have made some changes most of which aim to reinforce that the Model is only meant to apply post diagnosis. I know many see the word "diagnosis" in the Model and it causes some agita, but the language that follows "of a covered person's disease or condition" means that the testing is being conducted on someone with an existing disease or condition, not someone just walking off the street and ordering a test. In furtherance of the Model only applying post diagnosis I have added language saying that "nothing in the model should be construed to require coverage of biomarker testing for screening purposes" and testing is only meant to be covered when it guides treatment decisions and clinical utility. Taken together, both of these amendments aim to make it crystal clear that the Model is only meant to apply post diagnosis to people with already existing diseases or conditions. And I'm going to stop there. I really appreciate everyone's work and everyone's been really supportive. We know that this has been a hot topic issue and I'm asking for all of your support in pushing this forward.

Hilary Gee Goeckner, Director of State & Local Campaigns, Access to Care at the American Cancer Society Cancer Action Network, thanked the Committee for the opportunity to speak and thanked Asw. Hunter and Sen. Utke for their support and leadership on this issue as well. I will be very brief. We've discussed this at length at previous meetings. This will allow more patients to access proven tests that are necessary to guide their treatment, improve outcomes and often avoid unnecessary or ineffective treatments. We appreciate the amendments that have been made to address questions raised at earlier discussions. As Asw. Hunter noted, this is not a partisan issue. Many of you have supported similar legislation in your states already. This is now passed in 13 states, including many of those that you represent and we urge your support.

Rep. Lehman thanked Asw. Hunter for the amendments and stated that my only concern is do we have a clean version of that? I'm still looking at the Model that's in the binder and I'm seeing biomarker testing "for the purposes of diagnosis" and I think you use the term post diagnosis. I want to make sure we're very clear that we're not talking about an initial diagnosis but we're talking about after that. For example, if I think I have cancer, I don't want someone saying, you know what, let's just do a biomarker test on you, not a biopsy. I think the whole thing of biomarker testing is once I'm diagnosed, there's different paths of treatment I can get and I'm very supportive of that. I just want to make sure I'm very clear my understanding is that this language will be in its final format, showing it as post diagnosis. I'm referencing the language in Section 3(a).

Ms. Goeckner stated that diagnostic testing is a broad category that includes a lot of biomarker testing that's used to guide the treatment of cancer and other conditions and so I believe from your comments it sounds like the concern is about screening or looking for disease in an otherwise healthy person. And so that's covered by the language that

was added about not being construed to require coverage of screening testing. One of the very common uses of biomarker testing is to subtype their cancer and determine which mutations are responsible for that. That would be considered diagnostic testing typically and so we wouldn't want to exclude that and miss out on a lot of opportunities to get people on the right treatment early or avoid treatments that will be ineffective and have better, more efficient care delivery. Rep. Lehman stated that I think you answered my question but I want to make sure I'm very clear. I don't know how this was worded in New York, but if I would use biomarker testing for an initial diagnosis then I could make the argument this would require them to pay that. Ms. Goeckner stated that there are the purposes for when testing is appropriate that "diagnosis, treatment, ongoing monitoring of a disease or condition" and those are all included in the 13 states that have passed this to date. But there are also sources of evidence that must be met in order for a test to qualify. So, being supported by nationally recognized clinical practice guidelines or a Food and Drug Administration (FDA) approved or cleared test. So, this is something that's being done for a patient who's already in a provider's care for a disease or condition as Asw. Hunter noted and this is maybe refining the diagnosis. There might be a suspected lung cancer and biopsy tissue is sent for biomarker testing which confirms an ROS1 positive mutation that's driving that lung cancer.

Rep. Lehman stated that again, I believe you've answered my question but I'm still not hearing maybe clearly that there is no benefit for a first time initial diagnosis. Ms. Goeckner stated that I think it depends on the specifics of a patient and what testing is being done. Rep. Lehman asked if an example could be provided where biomarker testing would be used as the initial test to see whether or not I have cancer. Ms. Goeckner stated that I think the question would be, is this is a screening that someone is going for? So, are you going to have a screening mammogram? Or genetic testing to see if you're at risk for later developing a certain cancer? There are early detection tests for cancers that are being developed. Those would be screening tests that might find a cancer diagnosis. But if you have a biopsy done for lung tumors and that tissue from the biopsy is sent for testing. That testing may include biomarker testing that would confirm the suspected case of lung cancer because you have tumors in your lungs. Rep. Lehman stated that I have no problem with. I'm going back to in lieu of a biopsy I'm going to put you through some biomarker testing because yeah normally we do a biopsy but I'm going to bypass that and just use a biomarker test. Ms. Goeckner stated that many biomarker tests are actually done with tissue from a biopsy and some are done with a blood draw so there isn't a single way to do a biomarker test. But often it's actually done with that tissue from a biopsy sample to look for particular markers in cancer cells. Rep. Lehman stated that I'll leave it at that and I'm going to defer back to Asw. Hunter and I trust her greatly with her post diagnosis assurance.

Sen. George Lang (OH) stated that I appreciate the opportunity to speak in opposition to this Model. I share Rep. Lehman's concerns about the language is confusing and I do appreciate the clean-up language but it still says "for the purposes of diagnosis" - it doesn't get very much clearer than that. And if the goal of this is to get early diagnosis I can appreciate that. In 2017 I was diagnosed with Stage IV colon cancer. It ended up being stage II but it was a three-year battle for me. Had I discovered it in stage I, my guess is it would have been an inconvenience for me rather than a battle. So, I appreciate the intent of doing that but the reality of this is I still would not have gotten tested earlier. That's not who I am. I waited until it was late in the process and 27% of people that have health insurance never use it. That's how health insurance works.

There's a lot of people paying into the system that don't use it to benefit those 5% of participants that typically are 60% of the claims. So this is not going to change behavior. But what it will do is it will add cost to the system because it's an unfunded mandate. I trust free markets and free people to get it right. I wish the health insurers would offer this. Some of those will. Some of those do. Oh, and by the way, in my situation I have the coverage available because I'm under that state of Ohio's plan which is governed by the Employee Retirement Income Security Act of 1974 (ERISA) but for those health insurers that want to offer this to small employers, they can price it into their plan and those employers can then use that as an incentive when they're recruiting employees. We're going to give you better healthcare coverage if you come to work with us. So, I trust free markets and free people to get it right. Another problem I have on this is that it's only going to affect our small employers. Our pass-through entities. If you're a large, self-funded employer you come under ERISA, we cannot regulate you under ERISA, so we're going to pass this burden on to the small guys. The heart and soul of each one of our communities. The guys that are there for your charities and for your little league. This is not going to affect the big guys. It's going to affect the little guys who are all struggling now with high inflation and with workforce development issues and with supply chain issues. These are the ones that are going to suffer. I trust the health plans to get it right. They will enjoy the benefits of good decisions or suffer consequences of bad decisions. And I cannot support an unfunded mandate on the private sector. And I believe over time the private sector will handle this and they'll handle this in a way that the sponsor of this bill who I commend for bringing it forward would like to see happen. I just trust the private sector to do it far better than the public sector and I urge my colleagues to join me in voting no.

Rep. Carroll stated that I'm going to slightly disagree with Sen. Lang. We actually did this in Illinois and we were the first state to do this and I will tell you right now that we saw some real benefits from doing this. The standpoint is that we're screening people early and finding out certain things that they're dealing with. And it really offers technology to where patients can be matched with the right precision treatment without taking the shotgun approach. So I appreciate what Sen. Lang is saying but I disagree because I think the ability of us to know what we're dealing with can't just be one size fits all. We have to have specific things that come into place and this is certainly one of those. So I'm very supportive of this legislation. And this will bring costs down. The cost of these tests are not astronomical. I do understand the unfunded mandate part of this but I don't think this is an unfunded mandate that's not tolerable because the cost of this is not as high. So, I'm very supportive of this and I hate disagreeing with my colleagues but we'll get along on other things but I think this is very important to the future of healthcare and I stand in strong support of it.

Sen. Hackett stated that I am going to echo some of Rep. Lehman's remarks. So, you have a situation where let's say you have one incident, your grandmother had breast cancer. And so you decide as a woman to get tested and even though the test comes back negative you decide at that time to have a mastectomy because you say it's cheaper and I'll go through less and I won't have the problems, etc. I don't totally agree with that costs will always go down and the problem is that we pass this to everybody. So we were told that this testing in the Model would only apply to a person with an existing disease or condition. But how do you answer the breast cancer scenario I just described? A person doesn't have a condition. Someone in the family had it. So how would you respond? Because the way I read this, it's not clear. Ms. Goeckner stated

that in that scenario, that would not be biomarker testing as defined in this legislation. That would be genetic screening that someone may go through and that, depending on their family history, may already be covered to have that screen test to determine if they are later at risk. Sen. Hackett asked why doesn't it say that it doesn't apply to genetic screening? Ms. Goeckner stated that's one of the amendments that Asw. Hunter added after the May interim meeting – "nothing in this legislation should be construed to require coverage of testing for screening purposes." So that excludes anything for early diagnosis or risk. We love early diagnosis and detection, but that's not what this is about. This is about getting people connected with the right treatment for a condition or disease that they have. And so often in cancer that means allowing people to avoid aggressive treatments or treatments that will be dangerous to them or ineffective. And avoiding trial and error with different chemotherapies that many of you may have experienced or known people who go through treatment after treatment trying to find something that works. And this provides more information to patients and their healthcare providers to match them with the right treatment. This is not 23andMe. This is sophisticated testing that's being ordered by a treating professional only when it is supported by these sources of evidence and for the purposes spelled out in the Model.

Sen. Lana Theis (MI) stated that one of the things I wanted to mention was that on page 94 in the binder, Section 3(d) and Section 4(d) both have that language that "nothing in this section shall be construed to require coverage biomarker testing for screening purposes." Sen. Hackett acknowledged that language. Sen. Theis stated that what this would do is help to define what it is that they found in the screening and then better aim the arrows at the issues that are there particularly with respect to anything that is cancer related. But I have questions with respect to the statistics. In the states where this is passed already, do you have any statistical evidence that speaks to the number of people that this change actually affected and what that cost could look like? Ms. Goeckner stated that unfortunately there is quite a lag when the legislation is passed. It's then usually at least six to 18 months before that takes effect and then another year or more before there's sufficient claims data to analyze. However, there is ample evidence of the benefits of biomarker testing when it's used for these purposes and supported by the evidence and the guidelines. Allowing people to live longer and improving quality of life and often significantly reducing costs by avoiding ineffective treatments or treatments that are completely unnecessary. So, we have a volunteer in California who received a biomarker test to predict the risk of metastasis and recurrence with her breast cancer. Her insurance would not cover that but she was able to pay $1,000 out of pocket to cover that and that showed she would not benefit from further chemotherapy and she was able to avoid significantly more expensive treatments by having that information and having the means to put that out of pocket or take the risk that insurance would not cover it.

Rep. Chaney stated that I and the State of Florida are not real keen on unfunded mandates but having said that my husband and I ran a mobile mammography business for five years and definitely have seen the benefit of early detection and the best technology that you can have for that which I believe biomarker testing is. But to address costs I was given some information by the American Cancer Society on tests on studies that were done by CVS Health and Millman, and their projection is an increase in premiums of between 14 and 51 cents per member per month and a savings of as much as $8,500 per member per month in total cost of care. Now this is somebody who's obviously been diagnosed with the disease and as a result of more optimal treatment

and that does not account for any potential cost savings from avoiding ineffective treatments, which was just addressed. So I just wanted to throw those data points out.

Sen. Arthur Ellis (MD) stated that I was the Senate sponsor of a similar bill in Maryland and I just want to say it passed in the Senate 46 to zero and was very bipartisan and there was a lot of support and it passed in the House 132 to three. And we worked with all the interest groups and with the Cancer Society and with our insurers and the drug companies and it was a lot of work but the Model here is very similar to what we ended up with in Maryland which is very successful. We worked with the Department of Health to fund it so basically, this was not an unfunded mandate for us. We worked it out where everything fit perfectly into budget and our insurance carriers were very supportive of that.

Rep. Liz Reyer (MN) stated that I am the sponsor of a similar bill that just passed in the Minnesota House and in Minnesota we are required to have an assessment done if we are possibly going to have a mandate added to our insurance package. So, looking at the material that we received from the actuaries and from the team that did this analysis, the monthly expenditures, if you assumed 1.2 tests per 1,000 individuals, would increase monthly premiums by one cent per member. So, clearly the risk of an unfunded mandate would be offset. The other thing I want to add that we haven't touched on is the impact of providing this coverage to address the disparities in healthcare outcomes. We know that black and brown people in our society have much poorer access to healthcare. Much less and much, much worse outcomes. So, this is a valuable tool that we really have a responsibility in my opinion to be furthering and promoting.

Rep. Michaelson Jenet stated that first I wanted to disabuse anybody of the notion that any woman is quickly making the decision to get mastectomies. As a survivor of breast cancer and having had a bilateral masticate it's not pleasant and it is very distressing to a woman. So I'm not worried that people are going to quickly make the decision to get mastectomies. That being said, maybe prostates are more your speed. My husband was recently diagnosed with prostate cancer and through biomarker testing we found the right exact treatment for him, which meant that he missed no work that he is already had his first prostate-specific antigen (PSA) test that has shown a reduction in his cancer levels. And we know this because of biomarker testing. It's 2023 and we have this amazing tool at our fingertips. Why should we not do everything in our power to make sure that our constituents get access to it as well?

Asw. Hunter stated that I just want to thank all of my colleagues. This has been very thorough and well thought out and the conversation about healthcare disparity is very real as are the conversations relative to quality of life when someone has been diagnosed with cancer or some other disorder, knowing that we want to be able to give them the best type of treatment possible. I understand the concern about business and we're talking about finances and we never want to be in a position to put any company out of business. We're talking about quality of lives for our constituents, our family members, our friends. My husband had cancer. My mother died of cancer. Both my sisters have had cancer. I'm not using this as a tool for them but for someone in the future. This could be used on someone to have the best quality of life possible without having to go through some unnecessary treatments. I appreciate all my colleagues on both sides of the aisle for being very diligent and thoughtful about supporting this legislation.

Hearing no further questions or comments, upon a Motion made by Rep. Carroll and seconded by Rep. Roberts, the Model passed via a voice vote with Del. Westfall determining that the yes votes clearly outnumbered the no votes. Del. Westfall thanked everyone and stated that this will be on the Executive Committee agenda for final ratification on Saturday.

INTRODUCTION OF RESOLUTION IN SUPPORT OF EMBEDDED PROVISION IN THE STATE INSURANCE CODE TO PROTECT HEALTH SAVINGS ACCOUNTS-QUALIFIED HEALTH INSURANCE POLICIES FROM CERTAIN STATE BENEFIT MANDATES

Del. Westfall stated that last on the agenda is the introduction of a Resolution dealing with health saving accounts (HSAs). We will not be voting on this today. We will briefly introduce it and further discuss it during our next meeting. I'll recognize Sen. Jerry Klein (ND), sponsor of the Resolution, for brief remarks. Sen. Klein stated that the Resolution is an encouragement for an amendment to state law that's going to help ensure that when we adopt certain types of laws in our states that they don't inadvertently cause people to lose access to their HSAs. Several states have already made such an amendment to their code with my state of North Dakota being one of them.

Kevin McKechnie, Executive Director of the HSA Council at the American Bankers Association thanked the Committee for the opportunity to speak and thanked Sen. Klein for his support. We look forward to this being discussed and debated over the course of the next couple of months. The NCOIL Accumulator Adjustment Program Model Act was amended to make it HSA friendly. Sen. Klien's proposal does the same thing to all the other state health benefit mandates and we look forward to discussing it with you.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Lehman and seconded by Rep. Ferguson, the Committee adjourned at 3:45 PM.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
HEALTH INSURANCE & LONG TERM CARE ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – OCTOBER 6, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Health Insurance & Long Term Care Issues Committee held an interim meeting via Zoom on Friday, October 6, 2023 at 12:00 P.M. (EST)

Delegate Steve Westfall of West Virginia, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Asm. Tim Grayson (CA)
Rep. Camille Lilly (IL)
Rep. Rachel Roberts (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Lezzah Sun (AZ)
Rep. Jim Gooch (KY)
Rep. Poppy Arford (ME)
Sen. Walter Michel (MS)
Rep. Forrest Bennett (OK)
Rep. Carl Perry (SD)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

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

INTRODUCTORY REMARKS: CHAIR WESTFALL

Del. Westfall thanked everyone for joining the meeting and stated that while there are only two items on our agenda, I anticipate that each will generate a lot of discussion. We'll begin with a continued discussion on what I refer to as the NCOIL Dental Loss Ration (DLR) Model Act, a Model which I am sponsoring and Rep. Rita Mayfield (IL) is co-sponsoring. There won't be any votes on the Model today. Rather, we'll be discussing some alternative language that has been circulated and we'll be hearing from some new perspectives on this issue today. We'll then discuss a proposed federal rule that deals with certain issues such as short-term limit duration insurance and excepted benefits coverage.

CONTINUED DISCUSSION ON NCOIL DLR MODEL ACT

First, we'll continue discussion on the NCOIL DLR Model. I know Rep. Deborah Ferguson, DDS (AR), NCOIL President, has been working with some interested parties and staff trying to develop a compromise for all sides to accept - or at least something that leaves everyone sullen but not rebellious. I hope we can see the language within the next week. Rep. Ferguson stated that I look forward to working towards a compromise with something that's not just the Colorado law but somewhat of a "Colorado plus" with additional provisions.

Del. Westfall stated that as you can see in the meeting materials, there's a revised version of the Model that has been posted and it generally follows the approach Colorado took when dealing with this issue. Instead of requiring a DLR and setting forth specific percentages, Colorado took the approach of requiring carriers to submit DLR information to the Commissioner. And after two years, the Commissioner is required to issue rules to calculate an average DLR, verify any carriers that significantly deviate from the average DLR, and investigate the cause of the deviation. I'm not necessarily committed to replacing the current version of the Model with this version, but I'd like to at least hear what the speakers today have to say as well as my fellow committee members. After today's discussion I will discuss with staff how I'd like to proceed with our next meeting in November.

Mary Watanabe, Director of the California Department of Managed Health Care, thanked the Committee for the opportunity to speak and stated that her colleague, Pritika Dutt, Deputy Director for our Office of Financial Review which reviews our DLR filings, is also present. It's an honor to be with you today to provide an overview of our requirements here in California for DLR reporting and to share a summary of the data that was submitted in 2021. We just received and are reviewing our 2022 data so that will be available publicly early next year. So, just a quick overview of who we are in California. We actually have two regulators: myself at the Department of Managed Healthcare and then we also have the Department of Insurance. We license 143 health plans, including full service and specialized plans. We have nearly 30 million of California's 39 to 40 million consumers under our jurisdiction. That's about 96% of state regulated commercial and public health plan enrollment in the state. So it's a big responsibility that I have.

So, our Department has been collecting DLR information since 2015. AB 1962 was signed by the Governor in 2014 and it required commercial dental plans to file their DLR information with us by September 30th, starting in 2015. To develop the template for reporting, we worked with our dental plans, associations, the Department of Insurance, and other stakeholders. The legislation was really intended to bring transparency. Prior to this bill, we really didn't know how much of premiums were being spent on dental services. And so it didn't establish a DLR requirement but was really around transparency. It was intended to be considered by the legislature in adopting a DLR standard that would take effect no later than January 1st, 2018. However, to date, the legislature has not adopted a DLR. We do produce an annual report that we organize by product type. So, you'll hear me talk a little bit about dental health maintenance organization (HMO's) and dental preferred provider organizations (PPO's) and we also look at the information by market type in the individual market small group and the large group market. We post this information on our website and we present it to our Financial Solvency Standards Board which meets quarterly to advise me on financial matters.

The next bill that impacted dental reporting was Senate Bill 1008 that was signed in 2018 and it requires plans that cover dental services to use a uniform benefits and coverage disclosure matrix starting in January of 2021. This was really intended to bring transparency to consumers to compare plans and see what benefits were covered to see what they're getting for sometimes a very low premium or more costly premium. Again, we worked with our Department of Insurance and other stakeholders to develop this matrix. We promulgated regulations. The bill did also require plans to continue reporting the DLR information but it moved the deadline from September 30th to July 31st of each year to align with the federal medical loss ratio (MLR) reporting requirements.

Okay, so now I'm going to go over the results from 2021 and again, we'll start with the dental HMO products. So, you can see here that in the individual market the DLR ranged from a really low 5% to 81%. The weighted average was 61%. We had 14 plans in the individual market, 18 overall that offered dental HMO products. In the small group market it ranged from 37% to 88% with an average of 50%. And then in our large group market you see there are 38% to 75% with an average of 63%. This next slide just shows kind of our trends since we started collecting the information in 2014. There hasn't been a whole lot of movement. You can see some slight changes, particularly on the small group market but overall, it's remained pretty consistent. And then this is the slide I think that's always the most interesting. It shows the weighted average premium in our dental HMO market. In 2021 in the individual market the average is around $11 and small group was $14. And then the large group was about $14.50. So, these are fairly low premiums in the dental HMO market.

So, next we'll go to our dental PPO plans. You can see here we have a smaller number of plans. So, three plans that offered dental PPO products. The two plans in the individual market had DLR's of 62% and 69% for an average of 64%. In the small group market it ranged from 55% to 65% with an average of 57%. And then in the large group market, DLR ranged from 57% to 88% with an average of 88%. There was very little change. I think on the next slide we'll show you the trends we did. I will just note we had some outliers when we first started to collect this information. I think the transparency helped to kind of move everybody to a little more consistency. So, we didn't have as many outliers, which you can kind of see here on this chart, but overall, pretty consistent year over year.

And then here, of course, the premiums in our PPO. The individual market was a $48 average. Small group was an average premium of $50. Large group was $42. So, quite a bit difference from the smaller $14 to about $18 that we see in the HMO market. So that concludes our presentation. I hope it was helpful to kind of see some of the data. I will just note we don't have a position on setting a DLR. I think the transparency has been really helpful to us. I think overall we can all agree on the importance of oral health in overall health and we want to make sure consumers understand what they're getting even for those lowest premiums. The transparency has been very helpful. I'm sure you'll hear from plans and providers of kind of the pros and cons of setting a DLR. As we've had these conversations with our board and in public forums I think one of the fundamental questions that comes up is just what is the value of these very low cost dental plans? And is there value to having some dental coverage versus employers, particularly small group employers or individuals, just not offering coverage. What does that mean for potential consolidation in the market? As you're well aware, unlike on the

medical benefits side we don't have a standard benefit design or mandated benefits so it's different and it's complicated. I think we've had a lot of conversations with our board of just where to set a DLR. Is DLR the right measurement? So again, I think the transparency has been very helpful because prior to this reporting we just didn't know how much of the premium dollar was spent on dental services.

Chad Olson, Director of State Gov't Affairs at the American Dental Association (ADA), thanked the Committee for the opportunity to speak and thanked the speakers from California for bringing that information to us. It reflects some of the previous comments I've made about things staying very similarly in terms of the DLR's that are reported. And that's I think the question before the committee as we keep considering the Model is do we look at this as an opportunity to change the value structure of the plans which is something that DLR has the opportunity to do. We are also pleased to be working with several legislators and interested persons on concepts beyond just the Colorado language.

Brianna Pittman-Spencer, Senior Director of Gov't Affairs at the California Dental Association (CDA), thanked the Committee for the opportunity to speak and stated we have been looking at and thinking about and talking about MLR since 2014 when we worked on AB1962 and put that in place. And then sort of watching the MLR and trying to understand what it all meant. And I really agree that the MLR data has been really helpful from sort of a policy perspective in understanding the market and it has given us a lot of insight. A lot of times we look at things like those weighted averages and they seem fairly reasonable 65% but that really does hide that sort of huge spread. I think what you saw in the slides is that some of the trends seem to be that sort of the larger the plan or the larger the group the higher the number. So larger large group products tend to have a higher MLR than small groups which tend to have a higher MLR than individual. But when you look at them individually they are products and plans that have similar size that have very different MLRs, and there are high MLRs. So, it is very clear that you can provide that value at a smaller scale.

And I think we have some of the same concerns and CDA would really like to see a high threshold. We know that the medical MLR threshold is set at 80%/85% and we sort of remain unconvinced that dental plans can't meet that. And we think that would be a good thing for patients but those really low MLR plans are really concerning. What is that? Is that actually a benefit? Is that of value? If five cents of every dollar is going to patient care, is that a good use of somebody's dollars? When you get more into what's the right threshold – is it 50%? Is it 60%? Again, CDA would like to see it higher but I think even an MLR below 50%, that seems pretty low. How do we rationalize allowing consumers to spend money when they're only getting less than 50 cents of every dollar back in value? And I think that there's a wide range just really shows sort of the Wild West of dental plans. There isn't a standardized benefit. As much as I think we all should know how to use our dental plan, there really is this wide range. There's no standardized benefits. There's no cap on out of pocket expenses. There's a very low annual max and not really meeting people's needs. There's been a lot of studies to show out of pocket expenses are rising. We know that people skip dental visits because dental care is really expensive, even when they have dental insurance. So for us, the MLR reporting has been really helpful in understanding and thinking through what our dental plans offer and what value do we think they should provide to consumers. It hasn't really at least in California, moved the needle. We haven't seen sort of this rise in

MLR over time. Because of the way it's reported, it's not something consumers can use to make decisions about their healthcare dollars.
So it's not driving competition. That's not to say it's not good, but I think for us it's useful and in California I think it was the very start of the conversation around MLR. So, I guess my message would just be don't make that the end. I think it's really helpful to look at and understand and think about dental plans but I really believe that we need to be raising the floor on dental products and that includes an MLR but probably some other conversations around what the value is? Is there a standardized benefit? What do we think people should be getting to make sure they can take care of their dental health? And I would really encourage MLR to be part of that conversation. I don't think reporting alone is going to get anybody where they want and it's definitely not going to be pushing greater value.

Mike Adelberg, Executive Director of the National Association of Dental Plans (NADP), thanked the Committee for the opportunity to speak and stated that in considering this issue I want to note that NADP is prepared to support a Colorado type approach. And we view Colorado as a significant concession but there aren't very many industries that step forward and say please regulate me more. We also note that while the Colorado approach is characterized as transparency or reporting, it's also reporting plus remediation. And so to Ms. Pittman's comments, they're appreciated, but if there are 5% plans and the regulator wishes to remediate them this is a lever to do that. With respect to the Massachusetts approach and whether there should be an MLR imposed on a much lower premium product, I just note that the news coming out of Massachusetts I think is concerning. The Department is late in finalizing its regulation. It was released a couple of days ago and we think the Department is struggling and doing its best to ameliorate a difficult situation. But nonetheless, we think there are going to be some bad outcomes on January 1st and today I do want to announce and inform NCOIL that there are now three dental plans that will be leaving the small group market in Massachusetts. Guardian had previously made this announcement. Today I can inform you that both Ameritas and Principal will also be leaving the Massachusetts market and other exits are quite possible as dental plans look at the regulation and run the numbers and see whether they can in fact do business with a medical level MLR - a loss ratio devised for a high premium product and applying that to a low premium product like dental. Regrettably, I think things are going to be tough in Massachusetts next year. We just wanted to make sure that NCOIL is aware of that. And we continue to be happy to engage in constructive dialogue but do want NCOIL to understand that we think the Colorado approach is already a significant concession on our part.

Jeff Album, VP of Public & Gov't Affairs at Delta Dental of California thanked the Committee for the opportunity to speak and stated that as one of the dental plans that is heavily weighted in those figures that were spoken about earlier I simply wanted to explain that the reason you do not see over time the loss ratio changing very much is because the market pushes us to reduce our administration as low as we possibly can and reduce the premium as low as we possibly can to reach the marketplace, especially in the small group and individual market. So on these individual products specifically what we have is that a loss ratio not actually measuring the savings that has generated to a customer because they are paying lower premium. In fact, you are penalized. The MLR penalizes your plan for lowering the premium to the customer because as you lower the premium the administration has to take a higher percentage of that premium.

So, if you really want to measure savings, and I did make this point last Spring, a higher MLR dental plan can actually deliver higher savings to a customer than a lower MLR plan. The MLR is perverse when you apply it to a low premium product like dental. If you're only spending less than $200 a year on your dental plan, if you show up and get two dental services cleanings and X-rays all at 100% coverage and a 50% MLR dental plan, you're going to get $400 worth of services. You've already got your premium back plus some. And then if you actually need a filling or something else the savings are more. So again, the MLR threshold is a perverse measurement that has nothing to do with the value of the product and I would strongly encourage you to go with transparency. As you heard earlier, the transparency provides some value and the remediation element of the Colorado model gives the regulator room to act when these outliers occur and there is some other aspect to the story.

Mr. Olson thanked everyone for their comments and stated that he wanted to point out a couple of things. One is that what Mr. Album has just said is an admission that the value of dental plans is almost fully based on the discounts they demand through providers. It is not about paying for care. The true customers of these plans in many cases are employers, and not the patients themselves. Just to remind everyone that Massachusetts passed with 72% of the vote because when patients heard the true value of the plan and how much is being paid for their care, they voted overwhelmingly for this policy. But keeping costs low for employers as the only gauge on whether plans are providing value is not proper and so I would push back on the idea that Mr. Album presented that this is a perverse policy. It is working on the major medical side and it can definitely work on the dental side.

Rep. Camille Lilly (IL) asked if information could be shared on the rollout in states that passed dental MLR policy and what was learned there. Ms. Watanabe stated that probably the biggest challenge to the rollout was just developing the templates and the guidance for the reporting. So again, it wasn't a DLR requirement, it was just a reporting requirement. So we had a robust stakeholder process to make sure all of our dental plans and provider associations work with the us and the Department of Insurance just so we could make sure we captured the information that would be helpful to just provide that transparency. So, I think robust stakeholder engagement to make sure everybody has a voice at the table is really important. Publicly sharing the information is important too. Anytime you start something new, sometimes you need to tweak things and so sharing that in public settings and allowing for that dialogue I think it's been really helpful. Again, we haven't set a DLR in California but I think just having that stakeholder engagement and transparency has been helpful.

Ms. Pittman-Spencer stated that I agree with everything that Ms. Watanabe said and really appreciated the engagement in California. I think because we were the first state that did this we didn't quite know what we were doing and one of the things I think looking back there's probably ways that we could have made the data more accessible. I know Ms. Watanabe's department does a really great job of putting together the slide deck and the charts that you have just seen that they share at their regular quarterly meeting. But when you actually get down into what does this particular plan or this particular product ratio have - it's really hard to access. The CDA spends a lot of time and energy every year so we have sort of historical information on that but I don't know that anybody else outside of us and the departments and maybe some of the plans is doing that. So, I do think if you're looking at either a reporting, reporting plus or setting

an MLR threshold I really do think that thinking through how do you want to present the information and what do you want it to do is important. Again, it's not something that your average consumer is going to be able to access and really do anything with. So, that might be something to think through - are you just doing reporting? Are you trying to have it be something that pushes consumer dollars? How do you want to display that information? Those are things definitely worth thinking about. And I think if we knew then what we know now, we might have moved a little bit differently.

Owen Urech, Director of State Gov't Affairs at NADP thanked the Committee for the opportunity to speak and stated that the California experience has been very informative in other states. In Colorado we're currently going through the rule making process. There was a listening session yesterday on the implementation of the law that passed last year. And Maine recently wrapped up that process and is finalizing those requirements and that built on a lot of the work that was done in California from 2014 and after about making that information accessible but then also knowing that the regulators had kind of a robust framework to jump off on when they're implementing those outlier requirements.

Del. Westfall thanked everyone for speaking and stated that if anyone has any thoughts or comments, please contact me or the NCOIL staff. I look forward to continuing discussion in November and depending on how things go between now and then, we could vote on the Model.

DISCUSSION ON NOTICE OF PROPOSED RULEMAKING "SHORT TERM LIMITED DURATION INSURANCE; INDEPENDENT NON-COORDINATED EXCEPTED BENEFITS COVERAGE; LEVEL-FUNDED PLAN ARRANGEMENTS; AND TAX TREATMENT OF CERTAIN ACCIDENT AND HEALTH INSURANCE

Del. Westfall stated that next up is a discussion on the proposed federal rule issued by the federal tri-agencies (Labor, Health & Human Services, and Treasury). Included in the meeting materials is a comment letter that NCOIL submitted on the proposed rule. NCOIL CEO, Cmsr. Tom Considine, will speak briefly about the letter.

Cmsr. Considine thanked Del. Westfall and stated that without regard to anyone's substantive position on the underlying proposals, the rule is essentially an attempt at a second bite at the apple by the Biden Administration to try and do something that the Obama-Biden Administration was not able to do some years ago back in 2016. And so it would be a significant encroachment into state jurisdiction of insurance and that was the basis for our objection. I understand that reasonable minds can differ on issues such as short term limited duration insurance and other things covered in the rule, but some of the items covered in the rule were considered during the Affordable Care Act (ACA), and Congress expressly decided to exempt them. The McCarran-Ferguson Act did give Congress the ability to regulate the business of insurance in certain instances but it didn't give any agencies to the federal government the ability to regulate the business of insurance. So, without going into the underlying issues, NCOIL really protects the turf of state regulation of insurance and that was the basis for our letter.

JoAnn Volk, Research Professor at the Georgetown University Center on Health Insurance Reforms, thanked the Committee for the opportunity to speak and to share some of our research on short term plans. We've long done research on these plans

and the risks they pose for consumers and I'm pleased that I can share some of that research with you today. Just a little bit about the Center before I jump into the plans. We are part of the McCourt School of Public Policy at Georgetown University and we're a team of about 15 people who study the legal and policy framework for private health insurance that is regulated by the states as well as federally regulated plans. We track market trends, also and publish reports, studies, blog posts, and provide technical assistance to consumer and patient groups and to state officials on private insurance. I'm going to talk about the short term plans and the research on them and the benefit limits that they have and the risks for the enrollees. And then I want to share some recent research looking at the sales of one of the benefit plans during the public health emergency unwinding. We conducted a secret shopper study earlier this year.
So as I'm sure you know, the limited benefit products universe out there is a multitude of products that don't have to comply with the ACA marketplace rules. They include short term limited duration plans, which I'll call short term plans, fixed indemnity plans, but also healthcare sharing ministries which I know you all looked at before. Importantly, they don't have to comply with key ACA protections including coverage of the ten essential health benefits such as: prohibition on dollar limits on benefits, requirement to cover pre-existing conditions, requirement to cover people and renew that coverage when it ends, and to meet a minimum loss ratio which is a measure of how much of an enrollee's premium goes towards healthcare versus overhead costs.

So short term plans is one of those limited benefit plans. When the 2018 rule came out there were predictions that sellers of the policies would make coverage more robust to make it seem more comprehensive than it had previously been. But that didn't happen. Instead, it just erased the line between short term plans and comprehensive coverage so that it was nearly impossible to distinguish between a plan that stopped just short of 12 months and another that could go for a full year. And it often appears cheaper for enrollees who are considering these products. But the gaps and exclusions leave patients with very high out of pocket costs. And of course, they're medically underwritten, meaning that applicants with health conditions can be turned down, charged more or have benefits excluded for their pre-existing conditions. Typically, for all enrollees these plans exclude key services such as maternity, mental health and substance abuse disorder treatments and prescription drugs. Some of these can be added with a costly rider but they are not in the benefit plan. They can impose dollar limits on benefits. They don't have to be renewed at the plans end. And they can in fact be rescinded during the policy if a claim is submitted and the insurer can use the substantial documentation of health conditions that was part of the application process to show that there was some basis for knowing that there was a condition there even if the enrollee didn't recognize it as such. There are five states that have banned recissions and I show that here. In a number of areas, here are states that have gone beyond the federal floor.

So, I want to talk particularly about the end of the continuous Medicaid coverage. As you all know, Congress established a continuous Medicaid coverage policy during the COVID public health emergency in which states were not allowed to do Medicaid redeterminations and Medicaid enrollment reached a record high. That policy ended in March and states have now resumed their redeterminations and by one estimate more than 15 million people are expected to lose Medicaid coverage before the end of this year. The ACA marketplace is a source of comprehensive affordable coverage for those coming off of Medicaid but former Medicaid enrollees may not know about this option.

There's been a number of studies of deceptive and aggressive marketing tactics used to sell limited benefit products including short term plans and we've done some at Georgetown. The Government Accountability Office did a secret shopper study and others have too. I include links to a lot of this research at the end of my presentation. So, we wondered earlier this year with 15 million people coming off Medicaid, the marketplace open with a special enrollment period, and enhanced premium tax credits making coverage more affordable for individuals at $10 dollars or less for four out of five people - we wondered whether or not people that went online to shop for coverage would be directed to the marketplaces and subsidies for which they are eligible.

This actually adopts the same process we used in previous Georgetown secret shopper studies. We created two profiles for hypothetical consumers losing Medicaid in Texas. They had one who had no pre-existing conditions and the other who was older and had a pre-existing condition. So, when asked they indicated that they took a prescription drug for high cholesterol. But otherwise they were the same. Both were females about to lose Medicaid in their state and had the same annual income and the household size of two. So, with that income for their household size, we knew that they were eligible for $0 silver plans, including plans with no deductibles, and they were also eligible for marketplace special enrollment period. So, with those profiles, we went online to search with Google for terms that people might use when looking for coverage including health, Obamacare plans, and affordable health insurance, and healthcare.gov. After entering the information for the consumer profiles on websites that came up with that search, we spoke to 20 sales representatives, 10 for each profile. The results are as follows - in no case was a federal marketplace healthcare.gov the top result. It was sites promoting limited benefit products with usually paid advertisements and promoted well above other results. And the first results were often lead generating sites in which you enter your information and calls are generated and outreach from brokers from those sites. One of our consumers received over 100 voicemails in one week in response to entering her information into one website.

Out of the 20 sales representatives, 11 tried to sell a limited benefit product. At least two are fixed indemnity products. In one case there was information shared that we could use to actually determine what the plan was. So, it might have been short term, could have been fixed indemnity. In two cases information was shared sufficient to identify them as fixed indemnity plans. But the premiums ranged from $109 to $271. Even though they were eligible for a $0 premium plan in the marketplace with a $0 deductible. In no case did a representative direct the shoppers to that plan. For one thing, they misrepresented the products and I think this is important with short term plans. I know there's an argument that they are a gap filler and as long as people understand the limits they should be entitled to buy what they want to buy. And I think the substantial challenge here is they do not have enough information to understand what they are buying and often don't find out until too late the benefits limits that there are.

So just to describe this process, the brokers or people who reached out to the consumers gave false or deceptive information about the level of coverage these products offered. They made misleading comparisons to major medical plans and then refused to provide written plan information when asked. That was a part of the protocol, was in all cases to ask for information before making a decision. And it was only shared in one case. And in another case it was a screen shared to look at some quick three pages of planned documents. They also misrepresented the marketplace plan, saying

that the marketplace was closed and not open to enrollment and that subsidies are only available during open enrollment and hat they were more costly and had higher deductibles than what could be had with the plans the brokers were selling. And there was substantial pressure on the shoppers to buy immediately, urging them to commit to the plan over the phone without information about the underlying plan and discouraging them from taking time to look at options or even consider their budget with a premium amount and telling them that if they came back later the plans would fill up or be unavailable. And these high-pressure sales tactics were more common among representatives selling limited benefit plans.

In terms of the policy implications, despite some enforcement efforts deceptive marketing on limited benefit products persists putting millions of people at risk. We of course have this proposed rule that you all commented on that would limit the short-term plans to three months. And states can of course go above whatever federal floor is set. And many have. And I think it's important to raise awareness about marketplace plans and investing in enrollment assistance so people can really take their time and understand their plan options. Again, one of the big risks for short term plans is you do not get the information about the risks and find out too late what was excluded. Or, that coverage can be canceled. And I think while there's a hope and expectation that providing disclosures can help consumers know what they're buying, importantly from the Secret Shopper study that moment never happened in that sales transaction that they could understand exactly what they would have been buying. And there was substantial pressure to buy on the spot. So, I've concluded links to the Secret Shopper study here along with previous Secret Shopper studies and the research that has been done at Georgetown and other centers or researchers about the limits and risks of short-term plans.

JP Wieske, Executive Director of the Health Benefits Institute (HBI), thanked the Committee for the opportunity to speak and thanked NCOIL for protecting the state's ability to be able to regulate these plans. First it is frustrating to conflate short term limited benefits and healthcare sharing ministries because the issues are very different between them and as a former regulator myself I can tell the regulatory issues are very different as well. So, that is a frustrating sort of conversation to be able to have. And that's by design by a lot of folks and that's concerning. We are very concerned, similar to Georgetown, with improper marketing. So we've actually done work around this with the National Association of Insurance Commissioners (NAIC). We are members of an NAIC subgroup which is dealing with a model regulation around all of these products except for healthcare sharing ministries. Also, I'm the former chair of the NAIC working group that developed the NAIC Model Law related to these products. I would note that from a state perspective, states license the insurers and they license the agents. They take the forms and the rates on the insurers and they review those. They respond to complaints. They actually have data on these plans and the federal government has none of this. If you read through the rule it's anecdotes and blog posts around this. And while there are problems and there are concerns, there's a 94% satisfaction rate in the fixed indemnity market and the thought of the federal government taking these products away is going to be a big problem I think for consumers across the country and your consumers as we look at it.

I would note that states are continuing to look and gather data on this. Short term limited duration has a market conduct annual statement process that is currently ongoing. So

they're collecting data on the number of plans. I would note the number of individuals who have purchased short term limited duration plans has plummeted in the last few years. So, the sense that there's significant problems is very different. Certainly, the issues around marketing, especially around improper marketing of healthcare broadly, part of which has been exacerbated by the federal government's involvement and removing the states from Medicare Advantage, are significant. And the NAIC has added lead generation models into the Unfair Trade Practices Act as a proposal to help deal with this issue. We also strongly support disclosure. The simple reality is if an individual misses the open enrollment deadline and does not have a special enrollment period, they literally cannot buy private market coverage except for short term limited duration coverage in the market. And the idea of a four month time limit is going to be extremely problematic. We had some discussions around aligning those incentives around the ACA open enrollment period to ensure consumers have access over the whole time frame that they will be uninsured but the solution that the federal government has proposed is forcing consumers who missed the open enrollment deadline and do not have a special enrollment period to consistently change plans and have new rules and be subject to underwriting time and again throughout the process. We are concerned with that.

The fixed indemnity market is going to be an existential crisis if it's done as it is written. As Cmsr. Considine indicated, the federal law creates a section which includes fixed indemnity that excepts them from federal regulation. The rules are counter to the existing statute. We do support broadly the idea that there should be broad consumer disclosure. We support states taking action. As Ms. Volk noted, there are a number of states that have banned short term plans or a number of states that have limited access to short term plans. They've limited time frames and they've expanded disclosures. Same thing with fixed indemnity. So, the idea that the states are not acting on this is just simply not correct . I would encourage each of you to reach out to your departments, a number of whom have issued letters in opposition to the federal rule, and chat with them about what they're seeing and whether or not there are laws that should be changed in your states.

In closing, there are very different solutions around short term and fixed indemnity insofar as marketing issues go. And I will also note, a Secret Shopper survey in one state speaking to sales representatives and not agents creates an issue. I acknowledge the issue that Ms. Volk has highlighted and it comports with others that have seen similar issues when you go through sales representatives, rather than using licensed agents. And I think that has been part of the marketing problem - the use of non-licensed agents, which has been exacerbated by the lack of federal action on a number of things. So, states have been forced to act and trying to figure it out without federal help on a number of these things.

Ronnell Nolan, President of Health Agents for America, thanked the Committee for the opportunity to speak and stated that there are a couple of concerns about the Georgetown report. Number one, we know that Congressman Smith from Missouri just came out and said 1.6 million folks would be affected if short term medical plans were taken away. And I agree that 20 representatives is not a good way to determine what's actually going on in the market. Short-term medical plays a huge role for those not only that are not in a special enrollment period but for those that do not get a tax credit. So, if they do not get a tax credit they can choose the plan they want that has all the bells and

whistles that a marketplace plan has. But it's their choice. We all know the ACA is not affordable. Premiums are not affordable. If you look at premiums for an individual without a tax subsidy you would probably be blown away. People can't afford it. So these plans play a role and we appreciate transparency as agents.

Michael Hickey, Regional Director of Gov't Relations at Aflac, thanked the Committee for the opportunity to speak and thanked NCOIL for the letter that was sent to the agencies. It's great when we hear from the state legislatures. I also want to thank Mr. Wieske. He actually said a lot of what I wanted to say and part of our problem is at Aflac we don't offer short term limited duration policies. We offer fixed indemnity plans, hospital indemnity, cancer, specified disease. And they often get lumped together and considered short term limited duration. And the way we look at this federal rule right now is that it would put a lot of our products out of business. I won't get into the tax problems because this isn't the forum for that but I did want to thank Mr. Wieske and NCOIL for their comments.

Ms. Volk stated that I do want to point out that for the people that were shopping, the tax credits at this moment are available to all. There is no longer a 400% poverty cut off. And the particular consumers we were using were eligible for the greatest subsidies for their premiums and out of pocket cost. So they would have gotten a plan with a $) deductible, 94% AV coverage, $0 premium. And I should add to that they all seem to be being sold through an association. There was a reference to a one time fee that would lock in your rates for three years if you paid it. So, we took that to be a reference to association plans and I know and I know Mr. Wiekse knows about the challenges of capturing sales through associations for state regulators and getting that count in the market conduct annual statement at the NAIC. This is not to disparage reputable brokers, but we took the path that I think most people would take to shop for anything whether it's health insurance or TV, we go to Google. And we even used healthcare.gov and it didn't come up as the first option. So, I'm just trying to make folks aware of what many people will use as their shopping mechanism will unfortunately not only not lead them to the the optimal plan in the marketplace with $0 premium and $0 deductible, it will mischaracterize what that coverage is and mischaracterize the coverage that they're being sold.

Miranda Motter, Senior VP of State Affairs at America's Health Insurance Plans, thanked the Committee for the opportunity to speak and stated that I would just reiterate a couple of the things that Mr. Wieske and others said just in terms of how important fixed indemnity products are. We know that Americans need to be protected from a few bad actors who certainly commit fraud and abuse. But we want to be really clear and make sure that we don't throw the baby out with the bathwater, because we do know that Americans do agree that these kinds of plans are an important choice for them and those Americans do have these plans and are satisfied with that coverage. And so we just want to ensure that the personal choice, control, and financial security through these products remains.

John Ashenfelter, Associate General Counsel at State Farm, thanked the Committee for the opportunity to speak and thanked for the letter it sent to the tri-agencies. We agree with the statements from Mr. Wieske and from Aflac and others related to the fixed indemnity issue. It is very important that it stays in line with the federal statute which actually exempts these products, so we would appreciate the continued focus of the

states in terms of that exemption and protection of a very important and quite frankly, essential policy in the fixed indemnity products.

ADJOURNMENT

Heating no further business, upon a Motion made by Sen. Utke and seconded by Rep. Ferguson, the Committee adjourned at 1:00 p.m.

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

National Council of Insurance Legislators (NCOIL)

Medical Loss Ratios for Dental (DLR) Health Care Services Plans Model Act

***Sponsored by Del. Steve Westfall (WV)**
***Co-sponsored by Rep. Rita Mayfield (IL)**

Draft as of October 25, 2023. To be discussed during the Health Insurance & Long Term Care Issues Committee Meeting on November 16, 2023.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Medical Loss Ratios for Dental (DLR) Health Care Services Plans Act."

Section 2. Purpose

The purpose of this Act is to provide for transparency of the expenditure of dental health care plan premiums, and to require annual reports and remediation if the dental loss ratio exceeds a certain percentage.

Section 3. Definitions

(a) "Commissioner" means the Insurance Commissioner of this state.

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

(c) "Dental health care service plan" or "plan" means any plan that provides coverage for dental health care services to enrollees in exchange for premiums, and does not include plans under Medicaid or CHIP.

(d) "Dental loss ratio" or "DLR" means percentage of premium dollars spent on patient care as calculated pursuant to subsection (i) in this section.

(i) The dental loss ratio is calculated by dividing the numerator by the denominator, where:

(A) The numerator is the sum of the amount incurred for clinical dental services provided to enrollees and the amount incurred on activities that improve dental care quality; and

(B) The denominator is the total amount of premium revenue, excluding federal and state taxes, licensing and regulatory fees paid, , and any other payments required by federal law.

(1)(a) The Commissioner shall define by rule:

(I) expenditures for clinical dental services;

(II) activities that improve dental care quality;

1. Activities conducted by an issuer intended to improve dental care quality shall not exceed five percent of net premium revenue

(III) overhead and administrative cost expenditures; and

(ii) The definitions promulgated by rule pursuant to this Section must be consistent with similar definitions that are used for the reporting of medical loss ratios by carriers offering health benefit plans in the state. Overhead and administrative costs must not be included in the numerator.

Section 4. Transparency of Patient Premium Expenditures

(a) A carrier that issues, sells, renews, or offers a specialized dental health care service plan contract shall file a Dental Loss Ratio (DLR) annual report with the Commissioner that is organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The filing must also report additional data that includes the number of enrollees, the plan cost-sharing and deductible amounts, the annual maximum coverage limit, and the number of enrollees who meet or exceed the annual coverage limit.

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

(c) If data verification of the carrier's representations in the DLR annual report is deemed necessary, the commissioner shall provide the carrier with a notification 30 days to submit any information required by the Commissioner.

(d) By January 1 of the year after the Commissioner receives the dental loss ratio information collected pursuant to subsection (a) of this Section, the Commissioner shall make the information, including the aggregate dental loss ratio and other data reported pursuant to this Section, available to the public in a searchable format on a public website that allows members of the public to compare dental loss ratios among carriers by plan type by:

(i) Posting the information on the division’s website; or

(ii) Providing the information to the administrator of an all-payer health claims database. If the Commissioner provides the information to the administrator, the administrator shall make the information available to the public in a format determined by the Commissioner.

(e) The Commissioner shall report the data in this Section to the Legislature.

Section 5. Excess Revenue; Patient Rebate

(a) Once the Commissioner has collected the data pursuant to Section 4, the Commissioner shall aggregate average ratio of losses to premiums collected for each

carrier by year for the immediately preceding 3-year period or for the entire period if less than one full year during which the carrier has provided coverage for dental care, whichever time period is shorter, for each market segment in which the carrier operates.

(b) The Commissioner shall promulgate rules to create a process to identify, by market segment, any carriers that significantly deviate from a statistically normal range of dental loss ratios in each given year reported.

(c) The Commissioner in identifying carriers pursuant to subsection (b) above shall calculate a DLR that is 2 standard deviations from the mathematical average of the data submitted.

(d) The Commissioner shall report consistent with the manner set forth in subsections 4(e) and 4(d) above to the Legislature and make public those carriers that report a DLR both lower and higher than 2 standard deviations from the mathematical average.

(e) The Commissioner shall investigate those carriers that report a DLR lower than 2 standard deviations from the mathematical average, and may take enforcement actions against them, including ordering such carriers to rebate, ***in a manner consistent with section X of the ACA*** all premiums paid above such amounts that would have caused said carrier to have achieved the mathematical average of the data submitted in a given year for a given market segment.

(f) A carrier shall provide any rebate owing to an enrollee no later than xxxxx of the fiscal year following the year for which the ratio described in subsection (a) of this section was calculated. The Commissioner may establish alternatives to direct rebates to include premium reductions in the following benefit year.

(g) The Commissioner may promulgate rules that create a process to identify carriers that increase rates in excess of the percentage increase of the latest dental services Consumer Price Index as reported through the US Bureau of Labor Statistics.

(h) The Commissioner may, after three (3) annual data collections pursuant to Section 4, and analysis pursuant to Section 5 subsections (a) through (c), promulgate rules that establish a DLR percentage by market segment. Such DLR rules shall become effective no sooner than 42 months after the effective date of this Act.

Section 6. Rules

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

Section 7. Effective Date

This Act shall take effect xxxxxxx.

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Belmar, NJ 07719
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Resolution in Support of Embedded Provisions in the State Insurance Code to Protect Health Savings Accounts-Qualified Health Insurance Policies from Certain State Benefit Mandates

Sponsored by Sen. Jerry Klein (ND)
****Co-sponsored by Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President; Sen. Beverly Gossage (KS); Rep. Rachel Roberts (KY)***

****Draft as of October 17~~June 20~~, 2023.***

****To be discussed and considered~~introduced~~ during the Health Insurance & Long Term Care Issues Committee Meeting on November 16~~July 20~~, 2023.***

WHEREAS, the National Council of Insurance Legislators fully supports the state-based system of regulation for health insurance, consistent with federal statutes, rules, regulations and guidance; and NCOIL supports states continuing serving their role as sources of healthcare innovation in the most meaningful way; and

WHEREAS, individual insureds and/or enrollees and those in the group market require all the resources they need, to effectively manage the ever-increasing cost of health insurance; and

WHEREAS, qualified Health Savings Accounts, coupled with high deductible health plans, are one such tool that helps individuals or those in the employer group market manage those costs; and

WHEREAS, A Health Savings Account ("HSA") is a trust or custodial account offered with a high-deductible health insurance plan that meets specific requirements in the U.S. Internal Revenue Code, as interpreted and administered by the federal Internal Revenue Service. An eligible individual can deduct contributions from income taxes and use contributed funds tax-free for qualified medical expenses; however, consumers cannot benefit from an HSA unless they are enrolled in an "HSA-qualified" plan; and

WHEREAS, many states have recently introduced or enacted sweeping benefit mandate bills and co-pay accumulator bills, to help insureds and enrollees with the cost of health insurance and medical services, by providing for so-called "first dollar or zero dollar coverage" or coverage that otherwise restricts the amount of the applicable deductible, co pay or coinsurance; and

WHEREAS, NCOIL recognizes that certain of these state benefit mandate bills, while well-intended, may have the effect of disqualifying an HSA in a given state because the federal HSA statute requires that HSA-qualified plans apply a minimum deductible (single and family) to all covered benefits that are not defined as "preventive care"; and that a plan will fail to so qualify if a state law requires coverage without (or with limited) cost-sharing for benefits that are not "preventive care"; and that such disqualification may prevent account owners from continuing to make tax-deductible contributions to their HSAs and also cause an insured or enrollee to have to possibly re-file their federal taxes and where relevant, their state taxes, and pay penalties; and these consequences were unseen and cause unintended harm to the individual; and

WHEREAS, it would serve and further legislative economy, to have each state adopt a provision embedded in its insurance code, as eight states have done, to protect the efficacy of HSAs, via a legislative "carve-out", as opposed to the necessity of amending each and every state benefit mandate bill, such as those involving diabetes, breast cancer, prostate cancer and other diseases; that this would ensure that a health insurance plan that is an HSA-qualified plan is exempt from any state law that would cause the plan to be disqualified because the state law requires coverage of and/or cost-sharing for, benefits that would cause the plan to fail to meet the definition of a "high deductible health plan", as that term is set forth in Section 223(c.)(2) of Title 26 of the United States Code.; and

WHEREAS, a number of states have enacted to date such a "carveout " provision[1] and the following provision would serve as a model:

"A health savings account-qualified health insurance policy is exempt from a prohibition on cost-sharing requirements for a covered benefit that is required under state law to the extent the exemption is necessary to meet the criteria for a health savings account-qualified health insurance policy.

This section does not apply to any coverage required by state law that pertains to preventive care as defined by regulation or guidance issued by the United States Department of the Treasury under 26 U.S.C. § 223~~, as it existed on January 1, 2021,~~ with respect to any health savings account qualified health insurance policy issued, delivered,

[1] Arkansas (2021-Act 939) , Kentucky (KRS Chapter 304, Subtitle 17A. (via Chapter 133/2021), North Dakota (Century Code §26.1-36-01.1), Oregon (ORS §742.008), Pennsylvania **(**P.S. Title 72, § 3402b.5), Rhode Island (Title 27, Chapter 69), Texas (Insurance Code § 1653) and Utah (Title 31A, Chapter 22, Part 6, §657 (via Chapter 198/2022);

amended, or renewed while the regulation or guidance issued by the United States Department of the Treasury is effective."

WHEREAS, NOW, THEREFORE, BE IT RESOLVED, that NCOIL urges states to take action and pass legislation that would protect HSAs and HSA account owners, by providing a 'carveout' or exemption, embedded in their insurance code or insurance law, from relevant state benefits mandate and co pay accumulator bills, to ensure consistency with federal law, rules and guidance.

WHEREAS, BE IT FINALLY RESOLVED THAT, a copy of this Resolution shall be sent to the Chairs of the Committees of insurance jurisdiction in each Legislative Chamber in each state; and each State's Insurance Commissioner.

WORKERS' COMPENSATION INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
WORKERS' COMPENSATION INSURANCE COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 21, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Workers' Compensation Insurance Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Friday, July 21, 2023 at 9:00 AM.

Senator Bob Hackett (OH), Chair of the Committee, presided.

Other members of the Committee present:

Rep. Brian Lohse (IA)
Rep. Jonathan Carroll (IL)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Rep. Nelly Nicol (MT)
Rep. Mark Tedford (OK)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Dafna Michaelson Jenet (CO)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Rod Furniss (ID)
Rep. Camille Lilly (IL)
Sen. Michael Fagg (KS)
Sen. Beverly Gossage (KS)
Sen. Julie Racque Adams (KY)
Sen. Pamela Beidle (MD)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Gary Dahms (MN)
Rep. Liz Reyer (MN)
Sen. Pam Helming (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Bob Peterson (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Carl Anderson (SC)
Del. John Paul Hott (WV)
Del. Steve Westfall (WV)

Also in attendance were:
Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Brenda Carter (MI) and seconded by Rep. Brian Lohse (IA), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Jonathan Carroll (IL) and seconded by Rep. Rachel Roberts (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 10, 2023 meeting in San Diego, CA.

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

Jeff Eddinger, Senior Division Executive at the National Council on Compensation Insurance (NCCI) thanked the Committee for the opportunity to speak and stated that I'm going to give a pretty quick overview of the workers' compensation system. So this is the first time really that we can see data pre pandemic and post pandemic. So certainly, the pandemic had some impacts on the workers compensation line but when we start looking at the results you could see that it really did not have any bad impacts on what was already a stable and well performing system. The calendar year combined ratio which compares losses and expenses to premiums came in in 2022 at an 84 which is a three point improvement over 2021. This was the sixth year in a row where the calendar year combined ratio was below 90% and the ninth year in a row that the calendar year combined ratio was below 100% so obviously this line of insurance has seen very consistent, very good results and that has not changed due to the pandemic. The three point improvement was basically in the loss ratio so the other components of the combined ratio have remained fairly stable. So that's a 16% underwriting profit for the latest year and when you look at the investment gain on insurance transactions for 2022, it was down a couple of points from 11% the previous year to 9%, slightly below the long-term average of about 12%. But when you combine the underwriting profit with the gain on investments, you're looking at a 25% pre-tax operating gain, well above the long term average and even above last year. So when we look at the premium, we will see the impact of the pandemic. So you can see there from 2019 to 2022, the dip in workers comp net written premium and then the latest year is up 11% from the previous year to $47.5 billion, pretty much returning to the pre-pandemic levels. So, even though that's a large increase for one year, really when you look at it from 2019 to 2022 it's a fairly small increase, about 3%. So we're going to kind of dig into that a little bit as to what is behind that. So from 2021 to 2022 that large increase is really being driven by a 10% increase in payroll and that's pretty much evenly split between increases in the levels of employment and increases in the wages.

So then if we look over the pandemic period from 2019 to 2022 as I said, it's a much smaller increase, although during that time payrolls did increase more than 20% driven almost entirely by a 20% in wages. However, what's also happened during the last several years was NCCI has been filing pretty consistent loss cost decreases in the states that we handle. So this shows the latest round of filings with the largest decrease being almost a 17% decrease in D.C. and there was only one state that showed an increase. So, we've seen a pretty consistent drop in the bureau premium levels over the last decade. Just for the last year alone, it was almost a decrease of 8%. So over this pandemic period, while payrolls have been up more than 20% the loss costs have been down 20% pretty much offsetting that sp that's why it's only a slight decrease. And then looking at the other premium levels in the residual market, they've remained pretty consistent, but they've also dropped in the residual market both because we've been decreasing the rates in the residual market and also because the line is very competitive. Companies are willing to write business voluntarily, so the residual market is the smallest that it's been in recent years with a residual market share of about 6%.

The pandemic period also saw some fluctuations in some of the loss drivers. So we were seeing pretty consistent improvements in claim frequency prior to the pandemic and then the year the pandemic hit, 2020, we saw a pretty large drop in frequency of 8% and then the following year, we saw an increase of 8% and now for 2022, after the pandemic, we're back to more the average historical improvement of 4%. So during that whole pandemic period, we're looking at a decrease of 5% in claim frequency. Claim severity or the average cost per claim for both indemnity and medical over the last few years has been pretty moderate. So, when we talk about why for workers compensation can we see year after year of loss cost decreases? Remember that the exposure base is payroll, so payrolls go up, premiums are going to go up automatically and if the losses don't go up as much as the premium, we need to decrease the loss cost and so when we're in an environment where workplaces are getting safer, there's fewer accidents, there's fewer benefits being paid out.

Now, sometimes the amount of benefits could go up, but we have not seen that in recent years. So for wage replacement for indemnity, we did see a 6% increase in the latest year but over the pandemic period it's been about a 2% increase per year in the average indemnity claim. So when you consider that indemnity benefits pretty much you'd expect them to be in line with wages, but that has not been the case. So over this long time period when wages have grown 90% indemnity claim severity has only grown 57%. So it's lagged. It's been below the actual wage inflation. So again payrolls are going to go up when wages go up. If indemnity benefits don't go up as fast loss costs need to decrease. A similar story for the medical payments, even though it's up 5% in the latest year, over the pandemic period, it's been about an annual average increase of only 1%. Now you'd expect medical benefits to go up maybe with wages but also with kind of a medical consumer price index (CPI) but similar to indemnity payments we have not seen the medical payments keep pace with how we would measure “a medical CPI”. A bit closer, the changes for medical than indemnity but still below what you might see. So again with severities not even keeping pace with wages and with claim frequency dropping, this is why we're in an environment where we've seen decreases and in many cases double digit decreases in the loss cost levels for our states.

So now that we're through the pandemic, we can look back on just the impact of COVID claims in particular. So for NCCI states we did see over 100,000 COVID claims, resulting in more than $600 million paid out in losses. They're pretty much small claims about $5,000 on average and they really represented only 1% of total losses. This just shows how those amounts break out by year. So obviously 2020 was the largest and then 2021 started to taper off and there's been a really huge drop in the number of COVID claims from 2021 to 2022. So doesn't mean there's zero but they're at an extremely low level. So these are kind of the big highlights, that premium increase of 11% kind of gets that premium amount back to the pre pandemic levels. A combined ratio of 84% percent for the calendar year and even for the accident year the 97 is below 100. I didn't really touch on it, but there's the largest reserve redundancy we've seen probably in history. So there are carriers sitting on a lot of what we feel extra reserves at this point. Claim frequency has decreased back to normal levels of about 4% a year and indemnity and medical severity are up for the latest year, but still fairly moderate.

PRESENTATION ON TRENDS IN STATES AFTER ADOPTION OF DRUG FORMULARIES

Sen. Hackett stated that next on our agenda is a presentation on trends in states after the adoption of drug formularies. With us today is Ramona Tanabe, CEO of the Workers Compensation Research Institute (WCRI). As a reminder, NCOIL adopted a Workers Compensation Drug Formulary Model Act in 2019. That Model can be viewed in your binders on page 171 and on the website and app. Today's presentation will provide good information for this Committee to consider before we go through the model for readoption at the five year period next year.

Ms. Tanabe thanked the Committee for the opportunity to speak and stated that WCRI, if you're not familiar with us, we are an independent nonprofit research organization and our mission is to be a catalyst for significant improvement in workers compensation by providing credible, high quality independent research so that when there's a policy debate it's an informed policy debate with data. So that said, today I'm going to talk about some of the states that have adopted drug formularies and what we see of the effects. I know there's a Model that was adopted by NCOIL in 2019. There hasn't been a state that adopted a drug formulary since then but before that, 17 states have adopted drug formularies for injured workers. Today, we're going to talk about California and New York specifically. A drug formulary is essentially an approved drug list, and drugs that are not on the list require pre-authorization before they can be dispensed or prescribed. So 17 states have adopted drug formularies and they all have different features to them. So you can't quite do a comparison of one to another because they all have different requirements for pre-authorization. Many had different phase in periods and some states wrote their own drug formularies. So the states that are in dark blue are the ones that have adopted drug formularies as of the beginning of this year and 10 of the 17 are based on either Official Disability Guidelines (ODG) or American College of Occupational and Environmental Medicine (ACOEM) guidelines. California that we're going to talk about today has something state specific that works in conjunction with the ACOEM guidelines and the purpose for California was to define reasonable and necessary pharmaceutical treatment for injured workers.
So when we think about drug formularies after the implementation, there are a number of questions that we ask. Did it reduce the utilization of prescriptions? What was the impact on drugs that were either on the formulary or not on the formulary after the implementation date? And what about the different types of drug groups, did it hit everything differently? And also physician dispensing, I know there's another Model I think it's referred to as something with repackaging that NCOIL adopted. There, what's the effect on physician dispensing and generic use within the formulary? And most importantly or sometimes least importantly, did it reduce payments for the spend on prescription drugs.

So this is a summary of the effect of pre and post formulary for California and New York and it's answering those questions and you can see in the left hand column for each of those for California and New York, the numbers are all negative. They're compared to the group of states that don't have a formulary in place and because there might be externalities that also affect what's happening within the payments for prescriptions and the reason those non formulary columns are not the same is because there are two different periods. They adopted them at different points in time and the pre period and the post period are different time frames. So you can see there are pretty significant effects and we'll go through each one of these in detail. So first California – California's was adopted on January 1st of 2018 and you can see California and the blue line there this is looking at the number of prescriptions per medical claim and the yellow line there

shows the non formulary states. So there was a significant decrease in California. What this doesn't show is what percentage of claims actually received prescriptions. So when we look at that you can see on the left hand side the percentage of medical claims that received prescriptions. California looks more similar to non formulary states after the decrease in 2018. And then on the right hand side, the number of prescriptions per claim when you have one, how many did you get? So it also decreased the effect of requiring pre authorization for certain types of drugs. The proportion of prescriptions and prescription payments in California before the adoption of the formulary was about half of the prescriptions that were issued in California before it was adopted. So they call them non exempt and exempt drugs from the formulary or ones where you don't require pre authorization but non exempt and unlisted drugs require preauthorization. And so when we look at what happened to those different groups of exempt drugs, non exempt drugs and unlisted drugs, you can see that the non exempt drugs had a large decrease in that time period. So we're looking at the number of prescriptions per claim that had a prescription and the exempt drugs, the ones that didn't require pre authorization were pretty static over the time, a very slight increase over time. And unlisted drugs were not or were infrequently prescribed. So that one stayed pretty stable as well. This is just a different view to look at how did California compare to those non formulary states for those other measures and for those non exempt drugs there was a small decrease in non formulary states but not to the extent of California so the effect of the formulary was significant.

The physician dispensing in California also had a large decrease compared to the non formulary states. The physician dispensing was also a piece of the formulary that they had requiring pre authorization so hand in hand, they worked together. We don't see any change in that in the pharmacy dispense prescriptions so those didn't increase or decrease. They were essentially the same. And this is compared to other states, what was happening in terms of physician dispensing and pharmacy dispensing. So, California had a much larger decrease than states that didn't have any regulations affecting drug formularies. The other thing we wanted to look at was what types of drugs were mostly affected and you can see the largest one there was the 50% decrease for the muscle relaxants, musculoskeletal therapy agents and those include things like Flexeril and the dermatologic agents are the gels and patches. Those didn't decrease as much, but they did decrease. The next largest one was opioids, but also at the same time you can see in the non formulary states there was an 11% decrease in opioids. There was a lot of attention paid to opioids during this time period so some of it were external to the drug formulas that were in effect at the time. So in summary, California's adoption of the drug formulary was large and immediate. You could see an effect in the quarter after its adoption. It restricted non exempt drugs and it required pre authorization and a prospective review before it's prescribed. The prescriptions that exempt from pre authorization didn't increase. We saw those stay pretty flat. And the combined effect of those was an overall decrease in the number of prescriptions and a shift towards the mix of drugs dispensed. So there was a cost savings also that happened because of the drug formulary.

Next we're going to look at New York. New York is a little bit more complex. It was adopted the year after California, but they had very different phase-in provisions and timing. New York was adopted in the fourth quarter of 2019, so the phase-in that was due to happen in 2020 there were some intentional delays because of COVID and things that were happening there for lack of a better term, they didn't want to disrupt some of

the treatments that were happening for injured workers to shift from formulary to non formulary or non formulary to formulary. So we looked at a slightly longer time period for New York to see one year after the implementation what was happening. You can also see an effect compared to the non formulary states there. The other thing you notice in the non formulary states during the beginning of the pandemic the first two quarters of 2020, there was an increase in the average prescription payment. The largest effect of the New York formulary was a decrease in the prescription payments. So this is looking at the number of drugs that had a prescription and you can see compared to the non formulary states, New York also had a pretty large decrease between the end of 2019 and the beginning of 2021. This is looking at those measures - the questions that I posed at the beginning of the presentation and compared to the non formulary states and you can see that the largest effect in New York is that first bar there, the prescription payments for medical claims were decreased by 34%. And that wasn't happening in the non formulary states. So what kind of drugs require pre authorization in New York? They do have an approved drug list, so it's drugs that aren't listed on the formulary and a combination of those that aren't directly listed or compounds. So some of those are pre made or patent drugs that are specifically made for an individual. And brand name drugs that have generic equivalents also require pre authorization as do brand name drugs that have the same active ingredient but might be at a slightly different strength. So those also require pre authorization which is affecting brand name dispensing. The same as California, what percentage of the pre formulary effective date accounted for the non formulary drugs? And it was about half, half of the payments and half of the prescriptions were drugs that were not on the formulary. So it should have a large effect. What kind of drugs were being dispensed in that area? We saw dermatological's and the lidocaine products. There was also the effect of these higher priced NSAIDs (nonsteroidal anti-inflammatory drugs), Fenoprofen calcium that came into effect in 2019. And you see that in California that it does show up later outside of the formulary opioids but opioids were also affected by some other provisions like PDMP's (prescription drug monitoring programs) that were being implemented by states over time as well as new drugs that are being introduced and show up in the workers compensation system for injured workers.

So when we look at the different types of drugs within New York for formulary drugs and non formulary drugs, this is looking at the number of drugs per claim where there is a prescription. We can see the decrease in the non formulary drugs by that green line in the middle. But you see a corresponding increase in the formulary drugs without limits, the top line there, the dark blue one. And so that's a substitution, the physicians are choosing to practice differently and prescribe different types of drugs. Not much of a change in formulary drugs that required limits as well. And what types of drugs were being dispensed or changed with the formulary impact? You can see a large decrease, for the opioids, a little bit for the muscle relaxants and anticonvulsants. There was an increase in dermatologics and some of those have to do with things are outside of the formulary that are new formulants. Interesting to note, the anticonvulsants, probably 98% of them are permitted and don't require pre-authorization under the formulary but New York's drug formulary works in conjunction with other controls that they have in place, including medical treatment guidelines. And the medical treatment guidelines specified that anticonvulsants are used as second step therapy for things like back and neck pain and so one would first have to exhaust first line therapy drugs before moving to anticonvulsants for pain so that's why there was a decrease in those. So in summary, the drug formulary in New York was also immediate and sizable and the drugs that

required preauthorization were very much reduced. The prescriptions were increased by kind of a substitution effect, a shift in the mix of the types of drug dispensed and there was a substantial cost savings for prescriptions. And lessons from California and New York are that formularies decreased the prescription drugs that required preauthorization, there were small increases in drugs that didn't require preauthorization, and that the payments also decreased for both states. The trends that we see is that there are also new drugs that require preauthorization and what the lesson from this is is that it's not a static document and that there are continuous reviews required overtime just like any price control such as a medical fee schedule or any utilization review that type of thing. So in California, we saw these higher cost NSAIDs in the years following the effective date of the drug formulary and we also saw in New York some of the dermatologics, the lidocaine drugs increased after the implementation to be a much larger share than it was previously, requiring again review of this.

Rep. Liz Reyer (MN) stated that I really appreciate the data on workers comp and just have a couple of questions on whether you've looked at two things. One, the satisfaction of both patients and providers from past research I've been involved in. I know that formularies are often linked to frustration and declined satisfaction. And then more importantly, outcomes. If you've seen any impact, positive or negative, on the patient and a return to health type of metric. Ms. Tanabe stated that we have not done any studies on the patient satisfaction or injured worker satisfaction and pre and post formulary. However, as outcomes one of the things we would look at in workers compensation is return to work and was there a delay? Was there a difference? And we don't see any significant difference pre and post.

Rep. Tammy Nuccio (CT) stated that looking at your presentation, I have two questions. The first is from the utilization of the formulary. Is it basically just looking at how infrequent they are prescribing these certain types of medications because they have to go through a process now? So is it just a reduction in prescription of these certain classes of drugs? Ms. Tanabe stated that the data that we look at includes all of the prescriptions that are written on a claim over a period of time. So we looked at the period before the formulary was implemented and then the period after to look at specifically the formulary list and the non formulary list, did it change in those types of drugs? So yes, we're looking at before and after for all of those different metrics. Rep. Nuccio stated that so in essence, you're basically just putting in a pre-authorization I believe then for certain types of drugs, whereas they weren't before if I'm hearing you correct. Ms. Tanabe stated that for some because we saw a decrease because sometimes there was rather than have a pre-authorization there was a shift to use a drug that was on the formulary which is what we saw in New York. Rep. Nuccio stated that and then the last question that I have is you looked at New York and California, which seemed to have pretty significantly higher rates than non-formulary states to begin with. But if I looked at your data as it was coming up, it looked like the institution of a formulary kind of brought them in line with non-formulary states so I don't know that necessarily if you have a state that's on that non formulary line with a pretty steady line now and not high utilization you'd see the same sort of results, would you agree? Ms. Tanabe stated that we also studied other states that have recently adopted formularies, Arkansas and Kentucky being two of them. And we did not see as significant effects, mostly because they weren't high to begin with and they weren't commonly prescribed drugs that ended up not on the formulary list. So it does have a differing effect in different states.

Rep. Stephen Meskers (CT) stated I have a two part question. Within the prescribing medication, did you look to see how many of the medications were off patent versus on patent? Because I'm just wondering in the cost structure, I know many of the drugs that are off patent still only have a singular producer so I'm wondering if you had any background on the patent versus non patent? Ms. Tanabe stated that where we see the effect of the patent falling is usually in the pricing, the payments because it converts to a generic even though it's no longer covered, but it could still be prescribed. And you could see that affect overtime. And when we know that something has either gone off patent or changed classes, we specifically look for those drugs to see what the effect is on the overall prescriptions. Rep. Meskers stated that within those studies, have any of the states looked at the opportunity to create a manufacturing formulary or to work in conjunction to actually produce some of those drugs? Because what I'm finding is that the fall off is not as significant, the cost of production, the cost of manufacturing is low and a lot of the drugs that have come off patent still have a huge margin of profit and I'm wondering whether there's a way to drive those prices lower by making a formulary that actually works on a manufacturing basis. Ms. Tanabe stated that I have not heard of that.

Rep. David LeBoeuf (MA) state that I have one question around some of the data. I know there are some states that either have or are looking to have medicinal cannabis covered by workers comp. How has either use of that alternative played into some of the data that you see, or what you're hearing from some of the states that have formularies? Ms. Tanabe stated that is a good question and I think there are six or seven states that currently reimburse for medical marijuana under workers compensation and the reimbursements would be not directly to a dispensary, they would be reimbursed to the injured worker and so the data are actually not existent in what we've seen in the data so far. We continue to watch that though.

PRESENTATION ON MINNESOTA WORKERS' COMPENSATION SYSTEM

Jennifer Wolf, President of the Minnesota Workers' Compensation Insurers Association (MWCIA) thanked the Committee for the opportunity to speak and stated that MWCIA serves as the rate making organization here in the state. I've been in this role for about 18 months and I will share that the last 18 months we've really been working with our carriers, our agents, and other members of the stakeholder community to really understand how we can continue to serve and make workers compensation sustainable here in the state. So let me share a little bit about MWCIA and then I'll share some measures about Minnesota's work comp system. First of all, our mission at MWCIA is to advance Minnesota's public welfare and our economic security by supporting a sustainable workers compensation system. And I'll share with you that the concept of our public welfare is really a nod and recognition that workers compensation does have a societal impact. We're protecting the lives of citizens and ensuring employers bear the cost of coverage, not the states. That phrase, public welfare, is directly taken from our enabling statute, which is to promote the public welfare and to regulate insurance rates so that their premiums are not excessive, inadequate or unfairly discriminatory. So, our core reason for existence is to provide a rate making report. We publish that rate making report annually. We've been doing that since we were reorganized in the 1980s. But a rate making organization in the state has been around for 101 years so we're excited to continue that tradition, making sure that the rates here in Minnesota are

adequate and also that we provide value and do research and provide insights into Minnesota's workers compensation system.

Just a little bit about what MWCIA does. We develop base rates, our rate making report has pure premium base rates that are released on an annual basis. They go into effect in January of every year. We're about to file here in the next couple of weeks our 2024 rate making report. We also support workplace safety. We promulgate experience rating modification factors which provide credits and debits to employers based on their individual loss experience. We maintain the workers compensation manuals for the state that includes our basic manual, our classification manual, forms and other manuals. And we ensure that the rules based on those manuals are applied consistently and equitably across the state. We receive workers compensation policy data which is used by the Department of Labor and industries to confirm that employers are complying with coverage requirements in the state of Minnesota. We do a lot of education and outreach to stakeholders about the Minnesota Workers Compensation system. We participate with the Department of Economic Development to educate new employers about workers compensation coverage requirements and making sure they understand the difference in coverage for independent contractors and employees. We do a lot of education with carriers to make sure that they're properly reporting data to the state so that we can have the highest quality of data to inform our rate making process. And then we use that data to not just create our annual rate making report, but to do other research which gives us insights into what's happening in Minnesota's workers compensation system. We've recently collaborated on several research reports with NCCI and the other independent rating bureaus to look at issues related to COVID. We've done two studies on COVID, what we saw first in COVID and then what we're seeing in long-COVID claims. We've looked at mega claims recently.

So that's a little bit about how MWCIA serves Minnesota's work comp community. Now I'll share a little bit about Minnesota's workers compensation landscape. Minnesota has a very healthy private insurance marketplace. We have over 220 carriers writing coverage in the state. Those carriers serve more than 28,000 employers across Minnesota and in 2022, we had $1 billion of direct earned premium and over the last decade we have seen premium growth of 17%. And in 2022 it mirrors country wide trends, premium now is above its pre-COVID levels and that was really a product of both employer growth and also payroll growth. The assigned risk market has remained remarkably stable for decades. We're at about 3.5% percent of the private insurance market. We have more than 2 million employees across the state who are covered by private insurance in Minnesota. And in 2022, more than $457 million was paid in direct losses. I want to share just a little bit about my perspective on why Minnesota has created a sustainable insurance market for workers compensation. In the last decade, Minnesota has seen a cumulative decrease in pure premium base rates of 26% and there are several trends influencing that decline. First and foremost, we continue to see a loss of frequency, which is really positive news for our employers and workers in the state. We mirror trends across the country that there is a cumulative, although modest, year on year decline of the number of injuries and illnesses that are impacting workers.

Our annual year over year decline is about .4%, but over a decade that has that does add up. Cumulatively, we've seen a decline of low back strains and strains of 23% and low back injuries have declined by 28% in the last decade. Another contributing factor to the sustainability of Minnesota's market is there has been a real focus, both from a

legislative and a regulatory perspective, to proactively manage medical claim costs in workers compensation. The state has implemented treatment guidelines. They have implemented fee schedules for a variety of different services. And we also have electronic medical billing in workers compensation and that has been very effective. In most areas medical costs are at the median or below average compared to other states and particularly compared to our regional neighbors. Another I think important factor in Minnesota's workers compensation insurance system is a real commitment to the Workers Compensation Advisory Council process. So the Department of Labor and Industries facilitates throughout the year a Workers Compensation Advisory Council. It's made up of representatives of labor and management and they come together and do an agreed upon bill process and that agreed upon bill is generally given to the legislature and enacted and that makes sure that the changes to Minnesota's workers compensation system represent a balanced perspective. I like to think of workers compensation as that fragile balance between making sure that the benefit levels are adequate for injured workers but are at a reasonable cost to employers. And so working together, they propose legislation that both parties can accept. In 2023, there was a significant bill passed in Minnesota that increased permanent partial disability (PPD) rates for injured workers and it also provided some adjustments to the dispute resolution process and we saw some reductions in our hospital fee payment system. But that commitment to making sure there is measured and modest change has really created a very even Minnesota workers compensation system. And I wanted to share one of the most unique aspects about the Minnesota workers compensation system is the WCRA (Workers Compensation Reinsurance Association) and Minnesota is the only state that has reinsurance for Minnesota's workers compensation claims that reach a sort of catastrophic level that is provided by a statutory entity. So our insurers are required to purchase reinsurance through the WCRA. It's the only one in the country that has a statutorily created reinsurance association.

And then I just thought I would highlight some current issues that are impacting Minnesota's workers compensation environment. These issues are not dissimilar to other issues that we see in other state workers compensation systems. The state is really trying to grapple with how to cover mental health conditions and in particular how to address post-traumatic stress disorder (PTSD). Minnesota has a presumption for PTSD for first responders and most recently, there was consideration of expanding the PTSD presumption to healthcare providers. The legislature enacted a study on PTSD in the healthcare industry but there has been a lot of consideration and a lot of discussion about how we address mental health, anxiety, depression, and PTSD within the workers compensation system. We are now from a rate making perspective looking at what will happen to workplace illnesses as we have seen COVID go from the pandemic to endemic in our communities so we'll be watching that very closely over the next several years to see how COVID will continue to impact our workplaces. We are looking at extreme climate events. So here we've been experiencing lovely weather in Minnesota but our southern neighbors, it's very, very hot. But in the winter, Minnesota has seen more extreme winter conditions and those winter conditions are translating to an increase in slips and falls throughout the winter and so we're looking at how will more extreme weather events impact our businesses and our workers. And then mega claims is something that we're looking at. There are many trends that are being driven in the workers compensation system by a very small percentage of the claims. And so we're seeing an increasing number of claims that have $1 million or more in total cost and

those very significant claims oftentimes are driving the larger claim trends that we're seeing.

Rep. Tim Barhorst (OH) stated that I'm from Ohio and we have a monopolistic system, so it's a little bit different than yours obviously. The question I have is when you contract with providers, is that a standard contract, do your insurance carriers facilitate that and have their own networks? And if you do your own contracting, what's the structure? Because in Ohio we're on a Medicare plus model. I think it's 114% of Medicare and I'm just curious where you guys are at. Ms. Wolf stated that our insurance carrier members will develop their own provider contract networks. Here in Minnesota however, employees actually have the choice of provider so the carriers can't direct care but from a regulatory perspective on pricing, there is a resource-based relative value scale (RBRVS) that has been implemented.

Sen. Michael Fagg (KS) then asked a question regarding Minnesota's experience with its PTSD presumption. Ms. Wolf stated that the PTSD presumption was enacted in 2018 and in terms of the rate making process, rate making looks at the previous experience so we would just be getting experience related to PTSD. I could not tell you specifically what has happened at that class code level but I'm happy to follow up with our actuaries to get more information. If I'll just grab your contact information.

Sen. Hackett stated that we're a state-run system in Ohio and when we talk about PTSD, a person has to have an accident in Ohio to be able to collect. Is that the same way in Minnesota? Ms. Wolf replied, no - PTSD does not have to be associated with a physical injury to qualify in the state of Minnesota. Sen. Hackett asked how can you cover one area of mental health and not protect all those other areas of mental health with first responders? Don't you worry about lawsuits from first responders who have other mental health areas that they think came from their job? Ms. Wolf stated that is absolutely a topic of rigorous debate within the Workers Compensation Advisory Council. At the moment there is a pretty concrete and firm definition of meeting that PTSD standard. We could get you the legislation on that. And there is of course concern about making sure that first responders and all employees have their mental health conditions addressed. But the PTSD, you have to meet specific requirements to be diagnosed with PTSD, and that's how the claims are processed.

Rep. Nelly Nicol (MT) asked if you can you back up a little bit and explain who exactly is doing your reinsurance and if there are different carriers for each tier? Ms. Wolf stated that there is only an association and it was created by statute and they provide the reinsurance based on different thresholds and I could get you some more information. I'm not an expert on WCRA but I'm happy to connect you to the Executive Director there.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Sen. Hackett stated that last on our agenda today is the consideration of readoption of model laws. As I said earlier, all model laws must be readopted every five years or they automatically sunset. Today we have four model laws that are to be considered for readoption. They are: the Model Act on Workers Compensation Coverage for Volunteer Firefighters; the Workers Compensation Pharmaceutical Reimbursement Rates Model Act; the Construction Industry Workers Compensation Coverage Model Act; and the

Model Act Regarding Workers Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships.

Hearing no questions or comments on the Models, upon a Motion made by Rep. Jonathan Carroll (IL) and seconded by Rep. Brenda Carter (MI), the Committee voted without objection by way of a voice vote to re-adopt the Models.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Rachel Roberts (KY) and seconded by Rep. Carter, the Committee adjourned at 10:30 AM.

LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
LIFE INSURANCE & FINANCIAL PLANNING COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 21, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Life Insurance & Financial Planning Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Friday, July 21, 2023 at 3:00 PM.

Representative Carl Anderson, (SC), Chair of the Committee, presided.

Other members of the Committee present:

Rep. Deborah Ferguson, DDS (AR)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Michael Webber (MI)
Sen. Walter Michel (MS)
Sen. Jerry Klein (ND)
Asw. Pam Hunter (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OH)
Rep. Ellyn Hefner (OK)
Rep. Tom Oliverson, M.D. (TX)
Rep. Amy Walen (WA)
Sen. Mary Felzkowski (WV)
Del. Steve Wesftall (WV)

Other legislators present were:

Rep. Brian Lohse (IA)
Rep. Megan Srinivas (IA)
Rep. Camille Lilly (IL)
Sen. Michael Fagg (KS)
Sen. Beverly Gossage (KS)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Sen. Vickie Sawyer (NC)
Asm. Erik Dilan (NY)
Rep. Bob Peterson (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Del. John Paull Hott (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Deborah Ferguson, DDS (AR), NCOIL President, and seconded by Del. Steve Westfall (WV), the Committee voted without objection by way of a voice vote to waive the quorum requirement.

MINUTES

Upon a Motion made by Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, and seconded by Del. Westfall, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 10, 2023 meeting in San Diego, CA.

CONTINUED DISCUSSION ON NCOIL LIFE INSURANCE IS A PROMISE FOR LIFE MODEL ACT

Rep. Anderson stated that we'll start today with a discussion on the NCOIL Life Insurance is a Promise for Life Model Act (Model). This won't be much of a discussion, but rather more of a brief update, since the sponsor of the Model, Sen. Travis Holdman (IN), NCOIL Immediate Past President, wasn't able to be here today. You can view the Model on page 268 in your binders and on the website and the app. Sen. Holdman did ask me to report to everyone that since he was not able to be here today and since there has been significant regulatory development on this issue among the States, he would like the Model to be held at this meeting and he would like to see how things develop over the next few months before possibly moving the Model further at our next meeting in November. It may end up being that such regulatory activity reaches a level that makes the Model unnecessary and that states that are interested in responding to this issue can utilize the Resolution that NCOIL adopted on this issue as guidance.

The Hon. Nat Shapo, former Illinois Insurance Director and speaking now on behalf of the Life Settlement Association (LISA), thanked the Committee for the opportunity to speak and stated that I'll give a quick update just to give a little more detail on what was just said, Mr. Chairman. I represent LISA and the life settlement companies interest in this is that they see that these enhanced cash value offers as unfair competition and they're basically mimicking life settlements but not following the extensive consumer protections and the Life Settlement Act, and also violating basic life insurance pillars of the insurance codes, such as unfair discrimination, and the standard nonforfeiture law's smoothness requirement. We presented on this multiple times and appreciate the opportunity and the interest of NCOIL very much. I think it's pretty obvious the correlation between NCOIL's interest and some substantial activities in the states. We now count nine states that we're aware of that have taken some kind of action on these products, including three which recently have declared filings to have been in violation of the code and have effectively rescinded those. We're continuing to meet with regulators and appreciate their willingness to kind of take a second look at the issue and they've been open minded and have had good dialogue and discussions on that. And we'll continue to do that and it's an important oversight review function that legislators carry out and it's been terrific attention you've given to this since the Fall of 2021 and we really appreciate that and a part of oversight is continuing to follow up and we thank you for that.

Rep. Anderson stated that if there are any questions on this Model, please reach out to Sen. Holdman, myself or the NCOIL staff.

PRESENTATION ON MINNESOTA PROJECT TO INCREASE ACCESS TO LONG-TERM SERVICES AND SUPPORTS

Steve Schoonveld, FSA, MAAA, Managing Director, Global Insurance Services at FTI Consulting, thanked the Committee for the opportunity to speak and stated that I'm pleased to talk about what's going on currently in Minnesota and it's very convenient that you are meeting here in Minnesota given that this project just began a few months ago. So as you heard yesterday from Minnesota Assistant Commissioner Julie Marquardt, Minnesota does a lot of things well within health insurance and they do a lot of things

well in long term services (LTS) and supports as well. I'll refer to long term care (LTC) and LTS simultaneously. It means the same thing. As I promised I will provide a quick update on LTC insurance products and usually you do that with sales. So the slide you see now takes you through the sales between 2021 and 2022 and when you look at the screen, just note there was a significant increase in sales in 2021 due to the Washington State programs exemption deadline in the fall of that year. So essentially a Washington State fire sale happened and at the top you notice that sales were impacted by 37% more than usual for hybrid products in that year and 118% more in the standalone space. So when you put those two to discount the Washington fire sale effect, the minus 22.4% increase in sales over 2021 and 2022 is actually a positive 13% increase. That fire sale had its own issues and you can talk to me about that afterwards if you want but not good for here necessarily. Furthermore, Life Insurance Marketing and Research Association (LIMRA) surveys its members that are currently selling, so the numbers that come from LIMRA, don't really consider the in force block as much. So I've updated that to include the National Association of Insurance Commissioners (NAIC) Form one information which has over five million of in force stand alone LTC policies in the nation. You add that to the hybrid products which are truly LTC as well in many ways, and we're close to about seven million policies in force today dealing with through the private insurance market and through a slew of carriers. Now, one thing you take away from this slide and might be new to you and others in the audience is that we're not just talking about standalone LTC. We're talking about a plethora of ways people can fund their LTC needs. Hybrid life insurance with LTC. Hybrid annuities, not summarized here, but there are hybrid annuity and LTC products. There's also short term care and supplemental benefit products as well. Supplemental health products as well.

A second observation here as you can see I calculated the average premiums in 2022 and for standalone LTC you see that average premium was $3,737. In the hybrid space around $7,500. Clearly out of the range for most in the middle class and so I wanted to bring that up as well that yes, there's industry that's serving a population quite well here, but not reaching the middle class and hence the need for this work in Minnesota. So let me go on to that. One last observation about today's industry. So the industry is focused now on wellness care coordination and innovative product designs. In the past few months, there have been three or four new carriers entering the market with product designs and markets that differ from the past, including variable life chassis products, joint life solutions with LTC, new carrier entrants with wellness incentives and programs that are baked into the product. So encouraging people to stay healthy, stay well, stay in their home and not need LTC services and supports which is what we all want, correct? So also including care coordination and support is a major focus now of the innovative products we're seeing today and companies are implementing these for the in force as well. It's not just for new business. But you may have also heard that there was once over 100 carriers selling standalone LTC and there's only 12 left now but let's drill down on that a little bit. And then the second bullet up there talks about this. So according to Form one of the NAIC experience report of the top 20 carriers within in force LTC policies, 14 are still actively in the market. They may have pivoted to hybrid products. They may still be in the stand alone space, but 14 out of 20 are still in the market. It's a pretty good number. And then when you look at the remaining companies, 80 of them have less than 10,000 policies. If you have less than 10,000 policies were you really in the market is my question. And there it’s an average in force of about 1,500 policies. So that means that 34 companies have 10,000 or more in force policies today based on that and the NAIC reporting form. So the notion that there are hundreds of carriers selling

LTC is just overstated or exaggerated. Yet some carriers attempted to sell LTC policies, but ceased rather quickly for many reasons. Maybe distribution didn't appreciate it. Maybe they found another avenue for their clients. The lackluster sales might have been just the client base that that carrier particularly serves. And then some might have changed direction from a company that is working an individual to a company, maybe working in the group space. So there's more than just that. And finally, there's the impact of Medicare Advantage.

So I mentioned here the insurance product diversity, but there are other sources where LTC needs are met. For example on the bottom of the slide here, Medicare Advantage plans there are 3,000 Medicare Advantage plans in the country, 500 of which cover adult daycare, transportation and meals. Medicaid Managed Long Term Services and Supports (MLTSS) plans, manage acute and LTC for the dual Medicaid populations and half the states have such programs with a lot of private insurers and companies often risk bearing entities for that care. And paid family medical leave (PFML), Minnesota just passed PFML during the last session and that's a key solution for many, many folks out there. And then finally, there are significant community resources and waiver programs and Medicaid alternative care programs that help reduce that demand. All right, that was your update on the LTC industry. Let's talk about Minnesota and what we're doing. Here in Minnesota, the Department of Human Services issued an RFP in collaboration with their Own Your Future initiative. This initiative has been exploring LTS reform for over 10 years and the goals as you see on the slide are to: improve access to LTS for Minnesotans that typically do not qualify for Medicaid; examine and evaluate integrated LTS funding options; and transform the LTC funding system in its totality. The goal is to encourage simplicity, integration, equity, and accessibility of LTS services. So Minnesota's work is about right now the process to finding that solution that's unique for Minnesota. Like I said, Minnesota does a lot of good things well in the health and the LTC and LTS space. So they need to build upon that. We had FTI put together a three team approach with Altarum and the Actuarial Research Corporation (ARC) to help Minnesota and the Own Your Future campaign through this process and we put stakeholders together to have comprehensive recommendations, which are due later this fall. And those stakeholders include the needs of individuals, families, caregivers and the lack of caregivers, government programs, insurance programs and other types of stakeholders, including consumer representatives. And so this stakeholder group, made-up of Minnesotans who are knowledgeable and experts, are thinking about their friends, their neighbors and their families in Minnesota rather than a predetermined solution. So it's been a very interesting stakeholder conversation for the last few months.

And then simultaneously there are additional projects underway that provide a deep dive into the data on LTS and the need to enhance the caregiver supply and support. So the Minnesota Department is putting together a series of research studies that complement one another and have looked at look at various angles, including the lack of caregiver supply that's anticipated in the coming. Those findings have each been very, very complementary to one another. So they're developing a set of implementable embedded recommendations. We keep joking that this report is not going to get dusty, either virtually or physically and it'll be ready to go come Fall. But the key is that each state is different. Each state has different economics around their LTS needs. They have different maturity in terms of how they deal with the Medicare population and this is specific to Minnesota. So many state legislators and Offices of Aging are starting with

studies like this rather than just proposing options they've heard from afar and see if it will play in here. Public, private, coordinated plans that were offered in the RFP for us to examine are on the screen now and generally these fall under these categories, but the stakeholder group has actually gone in a different direction. You'll see that in a moment. But these four typical plan designs are kind of a back end catastrophic plan, which kind of covers the risk beyond two or three years. And you might have heard that in something called the "Wish Act" which was a nationally discussed endeavor to kind of replace Medicaid. Number two is a similar catastrophic plan, but focused on kind of long duration home and community support so not as broad of a program. And then number three is an early intervention program that's similar to Washington Cares. That gets some funds in people's hands initially so that they're able to remain in the home stably. And then incentives to enhance the access to LTC insurance coverage. What did this stakeholder group decide to focus on? And this is where we kind of lightheartedly talk about the red box up there. So what's the target population that they're really focusing on? So we took Minnesota specific data, which covered the programs already present to examine the populations that are least served, that are missing out essentially until they're qualified for Medicaid. And as you can see here, the middle income level has very few options. You know they're relying on private pay. They rely on one another for care. And there's little for this population to turn to when they need the care navigation support.

So, think about this. Think about yourself. If you have a care need or a loved one with the care need, where would you go? Who would you call? You'd probably call a friend. It would be nice to have a care support, care navigation structure that the state might sponsor to enable people to find the care they need when they need to find the programs that can help them as well. So we call this the red box as the slide says and the goal is to keep many from departing that box, slipping into Medicaid. And the X's you see in the box for the Older Americans Act, the Medicaid early waiver programs and alternative care programs are there to interject and go upstream and keep the individual and the family from falling into Medicaid. So those are the waiver programs you hear about the 1115 and so forth that enable states to help reduce that demand on Medicaid. And here in Minnesota, they work very, very effectively. They're just not well known quite yet. So now we're not looking to undo what's working well in Minnesota, but to build upon it and enable it to do more and integrate for the benefit of Minnesotans and the desire to reduce Medicare reliance. I just want to highlight a few areas where Minnesota is doing a tremendous job on the slide here. And that's the partner agencies, the Senior LinkAge Line and the Minnesota Senior Health Options (MSHO) program where there are eight carriers, some for profit, some not for profit that are doing those programs, those Medicare and Medicaid dual eligible programs where someone gets a coordinated level of care. It's not about acute in one bucket and LTC needs in another bucket. It's not about your hospital needs in one bucket and your facility needs in another bucket. They manage it together and it works very effectively and keeps the heads out of the beds if you will. It keeps them home and in a stable and safe environment and a cost effective environment. So they've been doing that for more than 25 years and have been very successful with that primary acute and LTC service delivery. Why not the people in the red box? Why shouldn't they have the same type of care coordination structure? Now the stakeholders did identify some areas of improvement by the stakeholder group. A strong need for LTS education. I kind of mentioned that already. The historically underserved populations, the vulnerable populations. Yes, in Minnesota, there's a lot of rural populations as well as tribal

populations too, that tend to be underserved and they want those to be addressed as well in a robust way.

And then again, like I said before, technology accessibility, the workforce, are part of the solutions. And then finally that caregiver support and navigation. Again trying to go upstream with these interventions to keep people off of Medicaid. So what are some of those potential designs that stakeholder groups come up with? They focused on care navigation and supports more so than financing initially. Yes, the financing is critical but yet having that care navigation and support structure is important. The need for educating family and friends and neighbors is even greater and the program Minnesota has in place works well but needs to be better leveraged. So we call it Senior LinkAge on steroids. So Senior Link Age is a great program reaching out to consumers, but it doesn't reach enough yet so we're trying to enable that even further. Option one you see on the screen here. One of the potential designs that is under consideration by the stakeholder group is an early intervention and support approach where picture this as a care navigation service or a website or an app where Minnesotans of all levels of need can get support. In the red box, above the red box, below the red box. I jokingly say behind the red box sometimes. Trying to focus on all Minnesotans so they know where to go for support. That would include some type of informal caregiver training, access to programs that we discussed earlier, and even a marketplace for home and community based services and a marketplace for LTC insurance, short term care insurance, or other kind of supplemental insurance products. So that's option one. Option two borrows from those MLTSS plans I mentioned earlier and tries to go upstream with that care coordination and this one is important because trying to tie the acute care needs and the LTC needs together in a coordinated way is what people want. They don't want to be divided. They want to have one quarterback to go to for their assistance across the spectrum. Like I said, it's been very successful in Minnesota, also in Florida and California. And why not for the red box? But this can be accomplished with a supportive one year benefit plan which begins at 60 or 65. You purchase it at 60 or 65. It could be a mandated plan with some subsidies for the non-Medicaid population because why would you want to provide a mandated program when someone already has coverage through Medicaid?

And then there could be options to enhance and lengthen their coverage voluntarily. Other than the mandate to purchase, this design could be done today. No regulations in any state that I know of, and I filed many products before across the nation, would have to change in order to bring kind of the Medicare side and the LTC side together. And it would be portable as well. So nothing would have to change in insurance regulation and it could readily increase the LTC insurance carrier supply as well, because you'd have individuals focused on both managing Medicare and their LTC needs and if they do it well, they can win twice. So finally option three is the catastrophic coverage type plan that's similar to the "Wish Act." It's intended to remove the Medicaid spend down from many in the red box. It removes it with a two year waiting period instead. Questions though that the stakeholder group has on this is how does this integrate with Medicaid? And we're trying to find ways to resolve that so that the state is not turning away federal Medicaid funds, but finding ways to kind of reapportion them within the overall program. So one thing to keep in mind here is that these are potential designs. They have options. Is it payroll tax funded? Is it premium funded? That's still yet to be discovered. It doesn't need to be that a payroll tax approach necessarily. It may or may not be employer or employee based. And then general revenue funding may be appropriate or

a blend of these approaches. But the goal is to find out what works for Minnesota and what would work for your state specifically as well. So my last slide is how do we determine what works? And part of what the RFP called for is essential criteria. And this is something that came out of the work about 12 years ago with the Academy of Actuaries and the Society of Actuaries and we developed only seven essential criteria elements back then. The stakeholder group in Minnesota came up with 11 so they added some good ones, some non-actuarial ones, which I was very pleased to see. And you can see up on the screen here we have access, cost efficiency, benefit, sustainability, all the way down to the supportive side where if it's adaptable, if it's understandable and if there's equity of access. In a state like Minnesota where you've got rural, urban and tribal, you need to have equity of access.

So what this does is it allows the stakeholder group to examine the totality of the LTS system and say I have a proposed change like option one or option two and then they can evaluate how effective that option is. And you get into a scheme of where you're not thinking about the best interest of those stakeholders, you're thinking about the evaluation of the entire system. So this framework works very well so far in comparing these options so that you can get to something that works extremely well. Now, we also asked them to evaluate the current system and those scores you don't want to see. But going forward, the idea is that with these criteria elements in mind can we improve the access for Minnesotans to the LTS they really need? Particularly in the red box but yes, applying to the entire population in total. So like I said, our work is nearing completion. We anticipate a report by early Fall. If you or your colleagues are contemplating similar proposals, keep in mind that a study is necessary to develop that recommendation and it needs to be your state specific. Every state is different when it comes to their Medicaid approaches and their LTS approaches. And so having that unique study and not just borrowing from across the nation from somebody else's program is essential. It's very important.

Rep. Anderson thanked Mr. Schoonveld and stated that there are many of us that are sitting around the table where we've got a few more years and we'll be at 65 so we're grateful for the information and what you have done in Minnesota and sharing it with us.

DISCUSSION ON NCOIL RESOLUTION OPPOSING THE RETURN OF A U.S. DEPARTMENT OF LABOR FIDUCIARY RULE

Rep. Anderson stated that next on our agenda is a discussion on a Resolution Opposing the Return of a U.S. Department of Labor (DOL) Fiduciary Rule (Resolution), a Resolution which I'm sponsoring. You can view the Resolution on page 271 in your binders and on the website and app. The Resolution is very straightforward and builds upon a Resolution that NCOIL adopted in 2016 when the DOL was in the process of developing a similar fiduciary rule that was ultimately vacated by the courts. You can view that Resolution in your binders on page 273 and on the website and the app. The DOL is back at it again. As you can see from both Resolutions, the main issue is that there simply isn't a need for federal involvement in this area of revising professional responsibilities for financial professionals providing investment advice. That area is reserved for the states and under the proven state based legislative and regulatory structure tens of millions of Americans have been able to receive sound retirement assistant products and services from financial professionals who have consistently served the best interests of customers. Furthermore, 39 states have already adopted

the NAIC's Stability and Annuity Transactions Model Regulation addressing conflicts of interest and the promotion and sale of annuities. And as an agent myself, I know the importance of always acting in the best entrance of my clients but that doesn't mean that unnecessary federal government intervention here is appropriate. The state based regulatory structure governing the manufactured distribution and sale of retirement related financial products is effective and proven.

Bianca Alonso Weiss, State Gov't Relations Manager at the National Association of Insurance and Financial Advisors (NAIFA) thanked the Committee for the opportunity to speak and stated that NAIFA is proud to have collaborated with NCOIL to draft this Resolution. NAIFA supports a standard of care for securities and investments that both adequately protects consumers and preserves the ability of lower and mid market investors to access affordable professional advice. NAIFA believes that a broad fiduciary approach could adversely impact this group from accessing investment products, advice and services and fails to recognize the inherent differences between the investment advisor and broker dealer business models. Financial protection should not limit financial security options. NAIFA encourages regulators and policymakers to support the best interest standard to significantly enhance consumer protections without making financial products inaccessible for working class Americans. Since the DOL first began its fiduciary regulatory project, the consumer protection landscape in the U.S. has changed significantly. The first development was the 2019 promulgation of a rule by the Securities and Exchange Commission (SEC), referred to as Regulation Best Interest or Reg BI. This rule provides strong protections to consumers who engage as registered representatives of broker dealers on a commission basis to purchase products considered to be securities. The states are now adopting similar rules for insurance agents who recommend annuities based on the amended Suitability in Annuity Transactions Model adopted by the NAIC. To date, 39 states have adopted this rule or a similar version. NAIFA actively participated in the SEC and NAIC deliberations to require financial professionals to work in the best interest of their clients without limiting consumer choice or creating barriers that could prevent all Americans from accessing needed financial products, services and advice. The SEC's Reg BI and the NAIC model protect our members, clients and all American consumers from potential conflicts of interest in these situations without returning to the failed DOL fiduciary only policy. NAIFA applauds Rep. Anderson for spearheading and sponsoring this Resolution and urges NCOIL to move adoption. We are looking forward to continuing efforts to ensure the DOL refrains from further rulemaking to revive or enact a burdensome fiduciary standard.

Rep. Anderson stated that I do note that some technical and editing changes need to be made to the Resolution in the form of correcting the reference to the NAIC model regulation and other formatting changes. They are all technical and non-substantive. Okay. I will now entertain a motion to adopt the Resolution with those technical changes to be made. 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 by way of a voice vote to adopt the Resolution with those technical changes to be made. Rep. Anderson thanked the Committee and stated that the Resolution will now be placed on the Executive Committee agenda for final ratification.

UPDATE ON INTERSTATE INSURANCE PRODUCT REGULATION (IIPRC) ACTIVITIES

Rep. Anderson then recognized Sen. Mary Felzkowski (WI), Vice Chair of the Committee, who presided over the remainder of the Committee's meeting. Sen. Felzkowski recognized Karen Schutter, Executive Director of the Interstate Insurance Product Regulation Compact (IIPRC) for an update on the latest IIPRC activities and developments.

Ms. Schutter thanked the Committee for the opportunity to speak and stated that NCOIL has been a longtime supporter of IIPRC even before it was developed. You worked side by side with your regulators to draft the Compact as we call ourselves now and to really help modernize the product approval process for life annuities, LTC and disability income. These are products that compete with your banking and securities products and had historically been very inefficient to go state by state to get those filed because they're really the same product. You can take them and move to another state or move into your state. So unlike your homeowners and auto, these are really mobile products and conducive to uniformity and collaboration among the states. Also in the 2000s, there was a period of time where there was the threat of federal preemption so states came together through NCOIL through the National Conference of State Legislatures (NCSL), through the NAIC, National Governors Association (NAG), and created this Compact. So for many of you, this Compact has been in place in your state for many, many years. You should be very reassured that you have active legislative participation in our Compact. What we do as states is come together, develop the product requirements for those products I mentioned and companies come make one filing to us. We give it a very thorough review. We have many credentialed actuaries as you can tell from our budget. We look at those products very carefully and once they meet compliance they can be used in your states. As I said, we have a very active legislative committee. As committee members, we have Rep. Deborah Ferguson, DDS (AR), NCOIL President, Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, Rep. Matt Lehman (IN), NCOIL Immediate Past President, and we also have Asm. Roy Freiman (NJ), Sen. Laura Fine (IL), Rep. Jim Dunnigan (UT), and Rep. Brian Kennedy (RI). It was one year ago that NCOIL reinforced their support for the Compact. We've had one legal challenge to the Compact and I think it really reinforced how important the Compact was. And so NCOIL came forward and recognized that this Compact was one that Congress did not directly, but impliedly gave consent that the states should handle the business of insurance, especially in this area.

So I want to give you an update of where the Compact has been in that past year. First, I have amazing news to tell you. We have a new member to the Compact, so we're now at 47 compacting states. I'd love for you all to give a round of applause to Sen. Klein because North Dakota is joining the Compact on August 1. I really appreciate him sponsoring the bill along with his House counterparts. I had the pleasure of going to Bismarck twice this year. It was great and it was a very active discussion. They will be joining August 1 and companies can use the Compact on August 16th. We have 47 compacting states so it's more than the majority of states that are in the Compact and let me just give you a quick overview of some of the product lines that we're right now talking about. Just so you know, they're very relevant. We have 100- plus uniform standards across all of our product lines. We're just coming on with group whole life, so that's a new product line for us and you might have heard this indexed linked variable annuity product. These are kind of the hybrid product that have been out in the marketplace for 10 years. They act like a variable annuity, but they don't quite fit within

that schematic so we're working on standards for that because that's a big and growing product in your marketplace. We're also going to work to accommodate non employer groups so that companies can use Compact products for those associations, those affinity groups. Today they can only use our standards for employer groups. The other thing I wanted to mention is Compact Roundtables because some of you around the table have attended those. We've had three in the last year. We are going to have another one on October 25th in Omaha, Nebraska. So thank you to Rep. Ferguson, Rep. Lehman, Rep. Dunnigan and NCOIL staff for joining those Roundtables because they bring together Commissioners, regulators, consumer representatives, state legislators and industry to talk about what's going well about the Compact and what can be improved - how can we further serve our state? So we're actually talking about that now, not only can we do the work that you've brought us together to do, which is to approve products under very thorough standards and issue in that state, but can we use our expertise to help states in other areas? So we'll be talking about that and keeping you apprised of that. Finally, we're having our in-person meeting. We try to have those along with the NAIC in-person meeting so that minimizes travel. We're having that on Tuesday, August 15th. Unfortunately that conflicts with the NCSL meeting so for those legislators on our legislative committee, we're working to get a room at NCSL so that you can participate in our call if you're available.

Rep. Lehman thanked Ms. Schutter and stated that it's really been great working with the Compact. Rep. Lehman asked which states are not Compact members? I know, but it would be nice if maybe the room knew. Ms. Schutter replied New York, California, South Dakota and Florida. So New York, California, Florida, the big three and then South Dakota but I am going there actually in August to meet with them. They're going to put it on their legislative calendar. And then as Rep. Anderson knows South Carolina did withdraw from the Compact. They had some concerns about LTC in their marketplace and we hope in the next session or the session after that they will rejoin and not participate in LTC but we work with our members when they have concerns. And we continue to work with those big three states and hopefully going into more advisory adjunct services could give them a comfort level to come into the Compact. Rep. Anderson thanked Ms. Schutter and stated that South Carolina has a new insurance Director, Dir. Michael Wise, so we've got to let him get settled and then we're going to discuss returning to the Compact. But we want you to come to South Carolina. We start our new session January 9, 2024, and we want you to come to South Carolina so we can get it passed. Ms. Schutter thanked Rep. Anderson and stated that so far the discussions with Dir. Wise have been productive and we look forward to working with him and you further.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Ferguson, the Committee adjourned at 4:15 PM.

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

National Council of Insurance Legislators (NCOIL)

Life Insurance is a Promise for Life Model Act

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

Draft as of February 8, 2023. To be discussed during the Life Insurance & Financial Planning Committee Meeting on November 16, 2023.

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Life Insurance is a Promise for Life Act."

Section 2. Legislative findings and purpose

Under long-established life insurance norms, carriers make a promise for life: They assess the applicant's known risk, match premiums to benefits by treating like risks alike, then treat risks of the same class and equal expectation of life at policy issuance the same throughout the duration of their policies, according to the terms set at issuance. Treating like risks alike encompasses the traditional and accepted anti-tontine principle that persisting policyholders may not receive higher surrender benefits in relation to their premiums than received by prior surrendering policyholders of the same risk class.

Sections 4 and 5, consistent with these established standards, do not change, but rather support the implementation of, bedrock insurance law and policy. Section 4 affirmatively requires the insurance commissioner to take regulatory action against what is already illegal: Unfairly discriminatory enhancements to cash surrender benefits on seasoned policies which—for the purpose of inducing termination of the very purpose of life insurance, the death benefit—offer identical risks more in return for the same premiums than received by prior surrendering policyholders. Section 5 ensures informed underwriting and risk classification making in an information age, without asymmetries and adverse selection, by codifying the insurer's historical access to pertinent risk information. Section 6 creates new consumer protection law (in most states) in the information age by prohibiting insurers from requiring genetic testing for applicants.

Section 3. Definitions

(a) "Cash surrender value" means any amount that is paid by the insurer in return for the policyholder's surrender or termination of the death benefit of the policy.

(b) "Genetic information" means information regarding the presence or absence of variations or mutations, including carrier status, in an individual's genetic material or genes that are scientifically or medically believed to cause a disease, disorder, or syndrome, or are associated with a statistically increased risk of developing a disease, disorder, or syndrome, which is asymptomatic in a person at the time of genetic testing or screening.

(c) "Genetic testing or screening" means any method of obtaining genetic information from the proposed insured for an application for life insurance.

Section 4. Enforcing fair discrimination in cash surrender benefits

The insurance commissioner:

(1) Must disapprove an endorsement or other amendment filed by the insurer that issued a life insurance policy if such a change would provide additional cash surrender value or otherwise modify the method of calculating the policy's cash surrender value established at issuance;

(2) Must rescind any regulatory approval or acceptance of an endorsement or other amendment described in subparagraph (1) above that was granted before the effective date of this law, as having been inconsistent with law at the time the approval was granted; and

(3) Must otherwise prohibit and prevent insurers from engaging in any other method of providing additional cash surrender value or otherwise modifying the method of calculating cash surrender values after policy issuance.

Section 5. Ensuring accurate risk classification

An insurer may require an applicant for a life insurance policy to provide any information known to the applicant or anyone else providing information on the application that is pertinent to the longevity risk posed by the insured, including genetic information resulting from any screening or testing regarding the individual's susceptibility to future health conditions.

Section 6. Protecting consumers from unreasonable testing requirements

Notwithstanding section (5):

(a) A life insurance policy shall not be underwritten on the basis of a requirement that the applicant or insured individual undergo genetic testing or screening; and

(b) The issuance of a life insurance policy shall not be conditioned on the requirement that the applicant or insured individual undergo genetic testing or screening.

Section 7. Rules

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

Section 8. Effective Date

This Act shall take effect xxxxxxxx.

ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
ARTICLES OF ORGANIZATION & BYLAWS REVISION COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 21, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Articles of Organization & Bylaws Revision Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Friday, July 21, 2023 at 4:15 PM.

Senator Walter Michel, (MS), Chair of the Committee, presided.

Other members of the Committee present:

Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Rep. Carl Anderson (SC)

Other legislators present were:

Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Rep. Michael Sarge Pollock (KY)
Sen. Arthur Ellis (MD)
Sen. Paul Utke (MN)
Sen. George Lang (OH)
Rep. Bob Peterson (OH)
Rep. Tom Oliverson, M.D. (TX)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

MINUTES

Upon a Motion made by Sen. Vickie Sawyer (NC) 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 November 17, 2022 meeting in New Orleans, LA.

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

Sen. Michel stated that the Committee is meeting today to discuss and consider some proposed amendments to the NCOIL Articles of Organization & Bylaws. Those amendments can be found on the conference app and on the website and they also appear in your binders starting on page 279. I'll turn things over to Will Melofchik, NCOIL General Counsel, who can go through the amendments.

Mr. Melofchik stated that the first proposed amendment is to Section 4(C) of the Articles of Organization on page 279 in your binders. The language is straightforward in that the goal is to limit the number of legislators from any one State that can vote on any matter before any one Committee. The reason is to prevent one state from dominating a vote

on a matter before a Committee as the optics aren't great if a Committee had, to use an extreme example, 10 legislators from one state all vote the same way on a Model Law or Resolution, especially one that is controversial. Importantly, this doesn't limit the number of legislators from a state that can be a member of a Committee, it just limits the number of legislators that can vote.

If there are more than four legislators from a state on a Committee, a process will have to be developed that determines which legislators are able to vote. Based on preliminary discussions, the thought is that the Chairs and Vice Chairs of state insurance committees would take preference and then perhaps there could be a designation process in advance of each conference that sets forth which legislators from a state can vote. Also, it's important to note that there is a somewhat similar mechanism already in place for the Executive Committee. On the same page in your binders, in Section 5(B), it says that "not more than four (4) representatives of each Contributing State of NCOIL" can be on the Executive Committee.

Sen. Klein stated that a formal designation process should be developed for determining which legislators can vote in scenarios where there are more than four legislators from a state on a Committee, and it might be a good idea for the designation process to be set forth in the Articles of Organization.

Sen. Klein then made a Motion for language to be added that describes the designation process, specifically that the state would designate the four voting members of an NCOIL committee. Rep. Carl Anderson (SC) seconded the Motion. The Committee then voted without objection by way of a voice to adopt the amendment with the additional language presented by Sen. Klein.

Mr. Melofchik stated that the next proposed amendment is a late addition and was not included in the 30 day materials. In Section 5(B) of the Articles of Organization on page 279, in the fourth sentence that starts with "A state committee chair from a Contributing State…." Language is proposed to be added at the end of that sentence: "….unless, upon good cause shown, such attendance is deemed by the President to be unreasonable." This deals with the requirement that state Committee Chairs must be physically present at their first Executive Committee meeting in order to be recognized as a new member.

Recently, we were presented with a scenario where a member who is Chair of their state's insurance committee and attending their first NCOIL conference couldn't attend the Executive Committee on Saturday due to religious reasons. Accordingly, we think this language is reasonable to accommodate those types of situations. Hearing no questions or comments, Mr. Melofchik proceeded to the next amendment.

Mr. Melofchik stated that the next proposed amendment is to Section 3(E)(2) and (3) of the Bylaws which is on page 284 of your binders. This amendment is straightforward and just delineates another method that legislators can use to sign up for Committees. And it also describes how legislators that serve on their state's insurance committee and are attending their first NCOIL meeting are able to sign up for Committees in advance of the conference, which is currently allowed under NCOIL Bylaws.

Currently, such legislators can send an e-mail or letter to NCOIL staff requesting to join certain Committees and then that is presented to either the Committee Chair or President for approval. So this proposed amendment would just add a standing committee registration form to what the legislator can send to staff requesting to join certain committees. Cmsr. Tom Considine, NCOIL CEO, stated that this amendment would bring the Bylaws into consistency with actual practice.

Hearing no questions or comments, upon a Motion made by Rep. Anderson and seconded by Sen. Klein the Committee voted without objection by way of a voice vote to adopt the amendments. Sen. Michel stated that amendments will now be presented to the Executive Committee for final ratification tomorrow[2].

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Anderson, the Committee adjourned at 4:45 PM.

[2] During the Executive Committee's meeting the following day, the amendments were removed from said Committee's consent calendar in order for this Committee to continue working on the amendments. This Committee will meet in November to discuss and consider the amendments again with additional language provided.

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. No more than four (4) legislators from any one State may vote on any matter before any one Committee. If a State has more than four (4) legislators serving and present on a Committee, then the four (4) legislators voting shall be determined in the following order:

1. Chair, Vice Chair, Ranking Member of the Committee that oversees insurance matters;

2. If 1. above has been exhausted, then members serving on the Committee with authority over insurance matters shall have preference in order of seniority in the legislature;

3. If 1. and 2. above have been exhausted, then members shall have preference in order of seniority in the legislature.

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 the~~wo~~ Immediate Past President~~s~~. 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 unless, upon good cause shown, such attendance is deemed by the President to be unreasonable. 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 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, the current NCOIL officers seeking to advance through the chairs, 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 seeking 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 or Standing Committee Registration Form 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 or Standing Committee Registration Form 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
Amended Annual Meeting, New Orleans, Louisiana, November 19, 2022

FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 20, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Thursday, July 20, 2023 at 4:00 PM.

Representative Forrest Bennett (OK), Chair of the Committee, presided.

Other members of the Committee Present:

Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Jerry Klein (ND)
Sen. Pam Helming (NY)
Rep. Tim Barhorst (OH)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Stephen Meskers (CT)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Linda Chaney (FL)
Rep. Brian Lohse (IA)
Sen. Michael Fagg (KS)
Sen. Pam Beidle (MD)
Sen. Arthur Ellis (MD)
Sen. Lana Theis (MI)
Sen. Paul Utke (MN)
Sen. Walter (MS)
Asm. David Weprin (NY)
Rep. Bob Peterson (OH)
Rep. Ellyn Hefner (OK)
Del. John Paul Hott (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Tammy Nuccio (CT) and seconded by Sen. George Lang (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 Sen. Jerry Klein (ND), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 11, 2023 meeting in San Diego, CA.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL INSURANCE E-COMMERCE MODEL ACT

Rep. Bennett stated that we'll start today with a discussion on proposed amendments to the NCOIL Insurance E-commerce Model Act (Model). The amendments are sponsored by Louisiana Representative Edmond Jordan, who unfortunately isn't here today, but he'll be arriving tomorrow. You can view the amendments on page 139 through 141 in your binders and they're on the website and app as well. We won't be voting today on these amendments, but I think it's likely that we will probably vote on this in November after today's discussion. With us here today are Molly Zito, Deputy General Counsel at United Healthcare, and Wes Bissett, Senior Counsel at the Independent Insurance Agents and Brokers of America (IIABA) who can provide some background on this issue and the amendments and speak to their respective positions.

Ms. Zito thanked the Committee for the opportunity to speak and thanked Rep. Jordan for putting forth these amendments to NCOIL's Insurance E-commerce Model Act. Beneficiaries of employer sponsored health benefit plans are digital savvy, and they're very familiar with e-delivering in many facets of their lives. Utility bills come that way along with credit card bills and even personal line insurance. And people have come to expect that they can access their documents easily on their phones and their computers. So what these amendments do is it mirrors an Employee Retirement Income and Security Act of 1974 (ERISA) safe harbor that allows employers to attest that their employees are digital savvy and wired at work. And then they will be defaulted into electronic delivery of their health benefit plans. Although the amendments allow for default electronic delivery of health benefit plans, it does allow an individual to opt out to receive paper copies. And again, this mirrors an ERISA safe harbor that is currently in place but that safe harbor is more administratively burdensome in that it requires the employer to determine who's opting in and out and what this one does is it has the insurer actually keeping track of that. So again, thank you to Rep. Jordan and we hope that the Committee can support these amendments when they come up for consideration.

Mr. Bissett thanked the Committee for the opportunity to speak and stated that I would echo the very positive things that Ms. Zito said about Rep. Jordan. He was the original sponsor of the underlying Model and of these particular amendments. I thought we heard some very good testimony from Ms. Zito just now and from her and her colleagues in San Diego talking about how these amendments and these changes in law ought to mirror what a number of states have already done in the existing 20 plus years in place now regarding the ERISA wired at work safe harbor. We don't object in any way whatsoever to the purpose and objective of these amendments, and strongly agree with the other interested party testimony that we've heard in San Diego and today that these changes really ought to mirror what the ERISA wired at work safe harbor looks like and what a number of states have done. The only thing we note is that some of the elements in that ERISA safe harbor and in the state laws that have passed recently that we view as important are not yet in the amendments and so we are looking forward to working with Ms. Zito and other interested parties and Rep. Jordan. I'll give you the one

particular issue that we're focused – states that have addressed this topic typically require that a covered person be provided with a notice as part of that opt out opportunity that informs them of things like the types of notices and documents that would be provided pursuant to this, and that the employee have an ability to obtain a paper copy of any notice and withdraw their consent and also importantly, if they don't want their work email address to be the one where they're receiving these documents, to be able to provide an alternative email. I don't think that those are objectionable and I suspect we'll all be working together going forward on these issues and we hope to have a product developed well in advance of the November meeting that can hopefully be voted on and approved by this group.

Rep. Bennett thanked Ms. Zito and Mr. Bissett and stated that I think we'll be ready to vote on this in November and if you have any questions or comments please reach out to me or Rep. Jordan.

DISCUSSION ON NCOIL RESOLUTION IN SUPPORT OF EXISTING LAW EXEMPTIONS FOR NEW DATA PRIVACY LAWS

Rep. Bennett stated that next on our agenda is a discussion of a Resolution in Support of Existing Law Exemptions for New Data Privacy Laws (Resolution), a Resolution which I am sponsoring. You can view the Resolution in your binders on page 145 and it is also on the website and app. We had a productive conversation on this issue at our meeting this past March in San Diego, and I think this Resolution is a positive step forward in those discussions. The Resolution is fairly straightforward. Essentially, it recognizes that many states have been and are continuing to develop data privacy laws, Oklahoma included, and it calls for states that are considering such legislation to incorporate certain exemptions that recognize the requirements that clinical researchers must already comply with. And I want to reiterate that this is about requirements that clinical researchers must already comply with, so that there aren't duplicative and conflicting data privacy mandates. Depending on how the discussion goes today, we could vote today, or we could wait until November. One minor change I'd like to make to the Resolution is really just shifting some existing language around. If you look on the second page of the Resolution where it says “be it now further resolved…” - the language “not already subject to such framework” is proposed to be deleted and then a bullet point below would be added that would read “entities or information already subject to existing legislative data privacy regimes.” So it's not a substantive change, it's really just moving existing language around.

JP Wieske, VP of State Affairs at Horizon Government Affairs thanked the Committee for the opportunity to speak and thanked Rep. Bennett for sponsoring the Resolution. We really appreciate this work. Specifically, with the issue that we're facing in the states, the Resolution is meant to be guidance to the legislators as you're looking at data privacy frameworks and just as an example - my understanding is unless late amendments are offered to a Montana bill, the result will be Montanans not being able to be eligible for clinical trial data going forward and there will be no clinical trials in Montana. And those are sort of the problems that we're facing in the states. The member companies that we work with have a number of issue in the states where they had to fix this ad nauseam on a state by state basis as data privacy comes up and so our hope is this language will serve as some guidance inside states that are looking to do data privacy frameworks. And this Resolution went out to all the interested parties we could find to see if there's

any concerns and I think we addressed them all. I would be happy to answer any questions and would appreciate your support.

Rep. Bennett then opened the discussion up to legislators. Hearing no comments or questions from any legislators, Rep. Bennett stated that since we have been discussing this issue since last November and since there appears to be no concerns, I will entertain a Motion to adopt the Resolution with the change in language I mentioned. Upon a Motion made by Rep. Tammy Nuccio (CT), Vice Chair of the Committee, and seconded by Sen. Bob Hackett (OH), the Committee voted without objection to adopt the Resolution as amended by Rep. Bennett. Rep. Bennett thanked the Committee and stated that the Resolution will be placed on the Executive Committee's agenda for final ratification.

DISCUSSION AND POSSIBLE CONSIDERATION OF NCOIL FEDERAL HOME LOAN BANK (FHLB) INSURER-MEMBER MODEL ACT

Rep. Bennett stated that next on our agenda is a discussion and likely consideration of the NCOIL Federal Home Loan Bank (FHLB) Insurer Member Model Act (Model), which is sponsored by Sen. Travis Holdman (IN), NCOIL Immediate Past President, and co-sponsored by Sen. Walter Michel (MS). You can see the Model on page 150 in your binders and on the website and app. It is likely that we'll be voting on this Model today as we have received no comments in opposition on this issue since we began discussing it in November of last year. Unfortunately, Sen. Holdman couldn't be here today, but he asked his colleague Rep. Matt Lehman (IN), NCOIL Immediate Past President, to speak on his behalf.

Rep. Lehman stated that the Model deals with a fairly straightforward issue that's received no opposition in the states that have already dealt with this. It's good that that we're bringing this now as for Model development. The speakers we have here today can provide you with a bit more detail but essentially the laws passed in over 20 states allow the FHLB to more efficiently access insurance company collateral in certain situations which results in those banks being able to lend insurers money on more favorable terms in the states that have those laws. So I think it's just bringing some great parity and when states have dealt with this issue these types of laws have been passed without opposition and it seems like something ripe for NCOIL to take up as a national Model.

Derek Akin, VP and Assistant General Counsel at the FHLB of Dallas thanked the Committee for the opportunity to speak and stated this topic has been discussed at prior meetings but for those unfamiliar with the FHLB system, we were created by Congress in response to the Great Depression, and our mission is to provide liquidity to financial institutions, banks, credit unions, and insurance companies. We do that by lending money and taking in return collateral that is often housing based. Under the Federal Deposit Insurance Act, home loan banks have exemptions from both stay and voidable preferences. Those are not afforded to our insurance company members so this legislation is designed to give our insurance company members parity with banks. We have passed this now in 25 states with Mississippi being the most recent going into effect July 1st of this year. We view this as beneficial to insurance companies in the states that have passed it as they're able to have more favorable terms on their collateral, which opens up additional liquidity for those insurance companies. Melissa Dallas, FVP, Corporate Secretary and Counsel at the FHLB of Cincinnati thanked the

Committee for its work on this issue and stated that if anyone has any questions on the Model, I'm happy to answer those.

Sen. Michel stated that I Chair the Senate Insurance Committee in Mississippi and we passed very similar legislation this past session and we found that it improved the loan process for our insurance companies, which provided additional liquidity for catastrophic events like tornadoes or hurricanes or hail storms and it offered more favorable loan terms to our member insurers. We had great support on the legislation and our insurance Commissioner was very much on board and I support this Model and encourage Committee members to consider introducing it in their own states as well.

Hearing no further comments or questions, upon a Motion made by Del. Steve Westfall (WV) and seconded by Sen. Pam Helming (NY), the Committee voted without objection by way of a voice vote to adopt the Model. Rep. Bennett thanked the Committee and stated that the Model will be placed on the Executive Committee's agenda for final ratification.

DISCUSSION ON RESOLUTION IN SUPPORT OF ESTABLISHING NATIONAL STANDARDS AND PROCEDURES FOR THE REPORTING AND PAYMENT OF PREMIUM TAXES DUE AS A RESULT OF INTERSTATE INSURANCE TRANSACTIONS

Rep. Bennett stated that last on our agenda is a discussion on a Resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes as a Result of Interstate Insurance Transactions (Resolution). You can view the Resolution on page 147 in your binders and it's on the website and app.

Bill Bryan, Director of Providence Insurance Partners, LLC, thanked the Committee for the opportunity to speak and stated that the Resolution before you needs some more work and it was submitted pretty close to this meeting such that everyone didn't really have a chance to review and provide feedback. The feedback that we have received asked some good questions and raised some issues as to clarity and to the intent and ultimate impact of the Resolution. So everyone has agreed to make some revisions that will not only clarify, but I think also narrow the intent of the Resolution down to what we really were trying to accomplish in the first place and then that will be ready for presentation at the November meeting.

Rep. Bennett asked Mr. Bryan to summarize what the Resolution seeks to accomplish. Mr. Bryan stated that first of all, let me let me just say what the Resolution isn't and then I'll say what it is. What it's not is any attempt to change in any way, shape or form how insurance may be obtained or how the drug procurement rules work - that's all subject to state statutes and there's legal decisions and we have no intention or hope of ever doing anything different about that. Taxation is also quite clear. There's established rules on that. And I think there may have been some suggestion or some implication in the Resolution that there was going to be some impact in terms of more reporting requirements or compelling reporting that some parties who raised objections were not comfortable with. The core purpose of this effort is to facilitate the payment of direct procurement taxes by insureds when they are owed in an efficient and easily determined manner. There is not currently a uniform national standard for that. In some states it's quite simple and easy and in those states the insureds that we have encouraged to report and pay those taxes have had an easy time doing so. In other states, it is less so

and we are hoping that NCOIL can help lead the effort to standardize those things. Again, it's not going to change anything legally as to anyone's obligation - those obligations exist. If you directly procure insurance, you, the insured party, are responsible for paying the procurement tax to your state of domicile. We just want to make it clearer, simpler and easier to do that so that people can be in compliance.

Sen. Hackett stated that Ohio Treasurer Robert Sprague was here yesterday and I discussed this issue with him. In Ohio we pay premium taxes and the companies pay it and they pass it on to the consumer on their products. And so can you explain a little how it would change in Ohio? Mr. Bryan stated that the obligation for the reporting and collection of premium taxes is different depending on the way that insurance is placed. In the most conventional way with conventional placement of insurance through a registered licensed insurer in a state, that's clear how that's done. The companies report and pay. In surplus lines it's quite similar and in that case the brokers collect and remit. In independent procurement, which is the third and least known method of obtaining insurance, that is not the method because the actual burden for payment falls upon the insured and not on anybody else and so it's a self-reporting, self-paying function and again there are some tools that are quite useful and sophisticated. Florida developed a piece of software called the Surplus Lines Information Portal (SLIP) and the software works for both surplus lines and direct procurement. In Florida and Georgia and other states that are using that, it's pretty straightforward and useful. But as an example of some issues, Georgia licensed the software and had it in place but didn't have anything on their Department of Insurance website to explain how to access it and use it so it took us a while to interact with them and to get that cleaned up. And now it's working very well in both of those states as well as in others that have other systems that are effective. And thank you for mentioning Treasurer Sprague as he is somebody who is charged with the balancing of books in Ohio and he is eager to participate in something that's going to make tax collection more regular and efficient.

Rep. Bennett thanked everyone for their comments and stated that I understand that the Resolution needs some more work and hopefully we will have something prepared for discussion at the November meeting.

ANY OTHER BUSINESS

Rep. Bennett stated that I would like to raise an issue for potential consideration by this Committee going forward - the earned wage access provider market. You may have heard about this issue in your state, but essentially these are providers who grant workers access to wages that have already been earned before their scheduled payday. You may have seen ads for these products. But they are not well regulated yet and a few states have taken action and enacted laws with licensing and other provisions and I think since this Committee is the NCOIL Committee with jurisdiction over banking issues, this could be something worthwhile to discuss and consider developing some sort of Model or Resolution. If you have any questions or comments, please reach out to me or NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Nuccio and seconded by Del. Westfall, the Committee adjourned at 5:15 PM

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
FINANCIAL SERVICES & MULTI-LINES ISSUES COMMITTEE
INTERIM COMMITTEE MEETING – SEPTEMBER 29, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Financial Services & Multi-Lines Issues Committee held an interim meeting via Zoom on Friday, September 29, 2023 at 12:00 P.M. (EST)

Representative Forrest Bennett of Oklahoma, Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Mike Meredith (KY)
Rep. Edmond Jordan (LA)
Sen. Paul Utke (MN)
Sen. Shawn Vedaa (ND)
Asm. David Weprin (NY)
Sen. Bob Hackett (OH)
Rep. Jim Dunnigan (UT)

Other legislators present were:

Rep. Linda Chaney (FL)
Rep. Deanna Frazier Gordon (KY)
Sen. Walter Michel (MS)
Rep. Carl Anderson (SC)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

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

INTRODUCTORY REMARKS: CHAIR BENNETT

Rep. Forrest Bennett (OK), Chair of the Committee, thanked everyone for joining this meeting today and stated that we're here today to continue discussion on some items that have been on this Committee's agenda since our meeting this past March in San Diego. We'll begin with discussing proposed amendments to the NCOIL Insurance E-Commerce Model Act, and we'll then discuss a resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes Due as a Result of Interstate Insurance Transactions. After this, for everyone's sake, I'll just refer to it as "the Independent Procurement Resolution." There won't be any votes on these items today but I hope that after today's meeting and the discussions that follow it, we'll be able vote on these items at our next meeting in November.

CONTINUED DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL INSURANCE E-COMMERCE MODEL ACT (Model)

Rep. Bennett turned it over to Rep. Edmond Jordan (LA), sponsor of the proposed amendments to the Model. Rep. Jordan thanked everyone who's been working on this issue and providing feedback as it's been very helpful. In 2020 as most of you know I've sponsored the underlying Model that we're discussing today with sets forth provisions on how certain insurance documents can be delivered to policyholders electronically. And since that time almost every state has adopted the Model in some manner. I'm proud to sponsor amendments to that Model which generally mirror the laws of several states that have enacted this, including my home state here in Louisiana, that permit health plan sponsors to consent on behalf of covered persons for e-delivery of certain health plan notices and disclosures. I think it's important for us to remember that these laws preserve a covered person's ability to opt back into the paper delivery system. So, if they don't want to stay with the e-delivery they can certainly go back into the paper delivery system if they so choose. But there is an attestation process involved that requires the confirmation that employees routinely use electronic communications doing that normal course of employment so you have to have that as well. I understand that there's some edits that have been made to these amendments that are being developed to clarify some of these issues and I look forward to reviewing them and hopefully getting this across the finish line in November.

Molly Zito, Deputy General Counsel at United Healthcare, thanked the Committee for the opportunity to speak and thanked Rep. Jordan for sponsoring these amendments. And I wanted to just give you an update as Rep. Jordan alluded to, we are working with the Independent Insurance Agents and Brokers of America (IIABA) on updating some of the language from the amendments and we're hoping to get that finished in the next couple weeks. We've been back and forth and we want to make sure that we have it finished well in advance of the 30 day materials and we'll do that and Rep. Jordan we'll certainly work with you before submitting the final product to NCOIL.

Hearing no further questions or comments from interested persons or legislators, Rep. Bennett stated please be sure to submit any thoughts or comments on this issue to Rep. Jordan, myself, or NCOIL staff.

CONTINUED DISCUSSION ON DRAFT RESOLUTION IN SUPPORT OF ESTABLISHING NATIONAL STANDARDS AND PROCEDURES FOR THE REPORTING AND PAYMENT OF PREMIUM TAXES DUE AS A RESULT OF INTERSTATE INSURANCE TRANSACTIONS

Next is the continued discussion on the Independent Procurement Resolution. The discussion on this started at the Spring Meeting this past March and it's generated a lot of feedback, a lot of which may be misguided just based on what I've gathered because it doesn't seem like there's much concerning to me. But I look forward to hearing from interested parties and other legislators. And that's why we're having this discussion so everyone can provide their comments and we can work towards addressing any issues. Of course, we want to focus on producing the best possible work and being transparent about the process. I look forward to hearing more feedback today in light of the revised version of the resolution which was recently distributed which I hope you've all looked at. I anticipate further revisions will be made. There is no sponsor yet to this Resolution. Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, is considering signing on to

sponsor but he has wanted to wait before more of a consensus can be reached on some of the issues.

Before I open up the discussion now, I do want to note one thing that I think has persisted throughout the conversations I've had and others have had about this. And that is that it deals with creating a mechanism by which states can collect unpaid tax revenue. That seems like an issue that everybody should be able to agree on no matter who you represent. I'm a Democrat in Oklahoma and I'd love to be able to bring in more tax revenue without having to raise taxes but it seems like an issue that we can all agree on. I look forward to hearing from anybody who may disagree but anyone who wants to be speaking today I'd like them to address that issue specifically, especially if they've got an issue with it and why they think there might be problems with having an NCOIL Resolution related to it. And lastly, I want to point out that some issues have been raised with respect to this impacting the surplus lines market but the revised version strikes all references to surplus lines and if you read this resolution and disagree with that please let us know. We can make further edits to make sure that surplus lines are not mentioned. As I noted in the beginning, we're not going to be voting on this but I did anticipate this topic being the one that we would have more conversation around so I'm hopeful that starting today we can kind of get to pointing towards the consensus on the issue so that we can have a vote on it one way or another in November.

Alex Gonzalez, representing Providence Insurance Company which is one of the proponents of this Resolution, thanked the Committee for the opportunity to speak and stated that I was a former Deputy Insurance Commissioner and Acting Commissioner at the Texas Department of Insurance (TDI) but that was many years ago. After TDI I went to a major law firm and in that time my favorite client was the Surplus Lines Stamping Office of Texas for 30 years so I'm fairly familiar with surplus lines and I see a lot of my surplus lines colleagues on this call. Now because I was the Surplus Lines Stamping Office general counsel I did not represent surplus lines agents or eligible surplus lines carriers and I didn't represent insureds that were adverse to those entities. However, I did represent, and I am currently representing, several large insurance brokers, carriers, major policyholder corporations, and international non-admitted direct placement transactions.

Now the reason I was able to do this and not run into a conflict is because surplus lines insurance is distinctly different from independent procured, it’s two different concepts. I'm glad Rep. Bennett raised that issue right off the bat. Surplus lines is very complicated. That's why we have so many specialists around the country and the Stamping Offices provide valuable service to their insureds. Independent procured is not quite as complicated. There are some specialists, not as many as in surplus lines. But there's two basic requirements for independent procured and then there's a third implicit requirement and I'm going to through this real quickly but I think you need to know this so you 'll see the intent of the Resolution. The first is that the transaction has to be principally negotiated outside the insured state. So, if the insured is in Oklahoma there cannot be an insurance broker in the state of Oklahoma. The insurance company cannot show up in Oklahoma. It has to be principally negotiated and placed outside the state. That's important to understand. The second is that the insured have to pay the direct placement premium tax. And then there's a third requirement which is typically implicit and is also kind of a driving influence here is that you can't have an insurance agent or other representative of the insurer of the insurance company in the state. So

basically your insured is left on its own to pay the tax. The insurance company cannot help. The insurance company can encourage them to pay the tax but the insured is on its own. They can have an attorney or they can have an accountant but there's a lot of folks that know surplus lines but not that many that know independent procure tax.

The issue is that the procedures to pay the tax are not uniform and they're not clear. So, in some states like my home state of Texas we have procedures and forms that are easily found on the Texas Comptroller's webpage. You can just go on the web page type in "independently procure tax" and you can find the form and it's easily paid. But you have to know that you don't go to the Surplus Lines Stamping Office, you don't go to TDI, you have to go to the Comptroller. And you have to know that. Somebody has to know that. But in other states it's vague and it's ambiguous. I went to one state and I was trying to help this client. I went to one state and I've been doing this for 40 years and I couldn't find the form. I finally found it and I found a Google archive version of it. I know there's probably some specialists and some other folks that know how to find it easier but I'm just saying that's what it took me. So, you can imagine one of your insureds trying to find this. Independent procured insurance is not suitable for homeowners, auto - personal lines. This is basically commercial businesses, typically large ones like Exxon, who used to be my client. But sometimes it's smaller companies that have 100 employees or something like that. It's not for everyone. It's not for every transaction. But if it is appropriate and they want to pay the tax they ought to be able to find a way to pay the tax and that's the issue now. Florida has developed a surplus lines insurance portal. In Florida and in the 10 states that use this particular software, you pay the independent procure tax through that portal so you have to know that that's where you pay the independently procured tax.

So in Florida it's very transparent. It's their program and there's another state I went to visit with the Commissioner and we told them about it and it turned out they didn't have it on their web page. They immediately put it on their web page. They tripled the reported independent premium tax within two months just by a simple change by letting folks know that you pay the independently procured tax through the portal. Turning to the Resolution, the first draft was ambiguous. It had problems. The reference of surplus lines was misleading and shouldn't have been there. We're going to take it out. The reference to non-admitted carriers paying and reporting the tax was a good idea but bad result. We're going to take it out. We're working on a new version of the Resolution that is very streamlined and we're going to meet with some interested parties soon and we're hopeful that what we produce will be acceptable to all.

John Meetz, Director of Gov't Relations at the Wholesale Specialty Insurance Association (WSIA), thanked the Committee for the opportunity to speak and stated that we appreciate the fact that staff took some time to make some revisions on this. We appreciate NCOIL for hearing our concerns and frankly we are in full agreement with the stated goal of the Resolution which is collecting uncollected tax revenue. Nobody disagrees with that and I think there are certainly some processes among individual states where that can be improved. I think we talked a little bit about how the Resolution does not affect surplus lines insurance. WSIA represents both surplus lines brokers who place surplus lines insurance and the non-admitted carriers who underwrite those transactions. Those non-admitted carriers also underwrite the independently procured transactions. So that's part of why we're involved in this discussion here and we really appreciate Mr. Gonzalez for laying out some of the potential amendments to the

Resolution, specifically the part that would require insurers to report premium taxes. It sounds like that may be coming out but it's still in the most recent draft that I saw so just a couple of notes on that. That is problematic for a couple of reasons.

The responsibility for filing and paying taxes in a non-admitted insurance transaction falls on the surplus lines broker or in the case of independent procurement on the insured themselves. And that's not a loophole or an accident, it's intentional public policy and it's designed to facilitate non-admitted insurance as a safety net for the admitted market. Non-admitted insurers do not have access to the data necessary to determine the home state of the insured as defined by the federal Non-Admitted and Reinsurance Reform Act (NRRA). So, we're very pleased to hear that may be coming out. But we would not support any Resolution that includes that. And real briefly one more comment, you know, we do have some lingering concerns with maybe the underlying intent of the Resolution itself and that's just because independent procurement is extremely rare. There are certain assumptions that are made about the entities that seek insurance without the assistance of a licensed agent or surplus lines broker. They are large entities. They are sophisticated companies. So much so that they're aware of and capable of navigating their regulatory and tax obligations for procuring their own insurance. To the extent that the Resolution is seeking to make that process more accessible to your average Joe, I think NCOIL needs to seriously contemplate that question. To the extent that we need to have discussions with states to make it so that your sophisticated entities can find a form on their website, we're all for that. I think that's an admirable goal and I think that those discussions can be had. What we want to avoid is a situation where we're trying to proliferate independent procurement to non-sophisticated entities. I think that's more of a philosophical question but just wanted to pose that to the group and mention that which is part of our lingering concern. We're very pleased to continue ongoing discussions with that.

Rep. Bennett asked for more information regarding the position on a requirement that insurance regulators and tax regulators having all the information about taxes due. Mr. Meetz stated that the regulatory and tax obligations legally in the U.S. on non-admitted transactions fall on either the surplus lines broker or the insured. And so they are the responsible entities in this case and we think they should continue to be held responsible for all of their tax obligations and all of their regulatory obligations in those cases. The non-admitted insurer is not necessarily privy to the information. I know it seems weird but they're not actually privy to the information that's required for submitting the taxes because they don't necessarily know in a multi-state transaction what the “legal home state” of the insured is. So, it's a very complicated situation. Non-admitted insurers do submit their premium information but that is for solvency purposes. So, they do that on the Schedule T to their state of domicile. They are regulated in that way. But the responsibility for paying the taxes falls on the insured in independent procurement and on the surplus lines broker in a surplus lines transaction.

Janet Pane, Executive Director of the Excess Line Association of New York (ELANY), thanked the Committee for the opportunity to speak and stated that we appreciate the edits to the Resolution but we remain a little bit unclear on exactly what the Resolution solves for in its current state. So, maybe just a little bit of my background for those of you who don't know me. In my previous role which was 24 years at Willis Towers Watson and the last role running the Global Services and Solutions Network for the multinational clients seeking insurance coverage for global risks, I have a lot of

experience with independent procurement. And my experience with this particular type of placement is that they are largely and meant to be used by large, sophisticated buyers who have large tax teams who understand their tax obligations and they are placed with largely insurers located in the Caribbean, Bermuda, the U.K., and Puerto Rico who is the client that Mr. Gonzalez is representing with this piece of this Resolution. So, those insurers are not located in the U.S. and would not be subject to the additional reporting requirements suggested by the Resolution. So, any subsequent laws proposed by the state represented here would also not be applicable to where most of these independent procurement transactions are being placed.

And in the case of Mr. Gonzalez's client, it is a Puerto Rico insurance carrier so I reiterate that I'm not sure that the Resolution is solving the problem you wish to solve. And we firmly stand behind and we absolutely believe that the state should be seeing their taxes but I think our other concern is that we don't want to expand independent procurement to consumers because consumer protection is something that the regulators are very concerned with and we don't believe they want to see a growth in independent procurement in this consumer segment as the buyers really benefit from having a licensed broker or agent advocate for them in the event of a claim and that claims advocacy role doesn't exist in independent procurement. So, I think that's really the thrust of it is we don't think that this is targeting the right solution. I'm all for upgrading the websites so that we get the admirable goal of tax payments more clear for those good citizens who wish to pay it and we support that wholeheartedly. But that's not addressed in the Resolution. So, with that we still have some concerns around the Resolution.

Rep. Bennett stated that as explained to me the purpose of the Resolution is to facilitate the payment of insurance premium tax payments. Is that how you see it? Ms. Pane stated that it's not how it's written. I think that's what we've heard the intention of it is but let me ask you how will these buyers who don't know how to pay their taxes today be found by these entities who wish to have the rights assigned to them? We're not sure how this independent procurement is working. If there's no one soliciting the business which is not allowed by independent procurement, who's advising that insured on how to pay the tax? So, I think there's just some confusion in the way it's written. Rep. Bennett stated that I'm hoping that with some more work we'll get this a little bit more cleared up.

Cari Lee. representing the Council of Insurance Agents and Brokers (CIAB), thanked the Committee for the opportunity to speak and stated that we would echo some of the comments that Mr. Meetz made and we'll work with our members to submit some formal comments on this Resolution but I would definitely agree with some of the other speakers who said that independent procurement is associated with Microsoft and very large companies who are making those types of procurements or they're going out searching on their own and they're very sophisticated buyers. This is not your personal lines you and me going out to get homeowners on our own without an agent and I think from a regulatory standpoint in those cases you really do need that licensed agent. So, we'll put our comments together and get those into you and work with the rest of the parties to hopefully reach a consensus for the Resolution.

Hearing no other comments or questions from legislators or interested parties, Rep. Bennett stated please submit any thoughts or comments to me and to NCOIL staff.

ADJOURNMENT

Heating no further business, upon a Motion made by Sen. Hackett and seconded by Sen. Utke, the Committee adjourned at 1:00 p.m.

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

National Council of Insurance Legislators (NCOIL)

Insurance E-Commerce Model Act

Sponsored by Rep. Edmond Jordan (LA)

Adopted by the Financial Services & Multi-Lines Issues Committee and Executive Committee on March 8, 2020

Proposed Amendments sponsored by Rep. Edmond Jordan (LA) and are to be discussed during the meeting of the Financial Services & Multi-Lines Issues Committee on November 17~~July 20~~, 2023.

Table of Contents

Section 1. Title

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

Section 2. Purpose

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

Section 3. Definitions

As used in this Chapter, the following definitions apply:

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

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

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

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

Section 4. Electronic delivery of insurance documents and notices

A. As used in this section, the term:

(1) 'Health benefit plan' means a policy, contract, certificate, or agreement entered into, offered by, or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a vision or dental benefit plan and a self-insured plan not subject to ERISA.

(2) 'Plan sponsor' means a person, other than a regulated entity, who establishes, adopts, or maintains a health benefit plan that covers residents of this state, including a plan established, adopted, or maintained by an employer or jointly by an employer and one or more employee organizations, an association, a committee, a joint board of trustees, or any similar group of representatives who establish, adopt, or maintain a plan.

B~~A~~. Subject to the requirements of this Section, any notice to a party or any other document required by law in an insurance transaction or that is to serve as evidence of

insurance coverage may be delivered, stored, and presented by electronic means if the electronic means meet the requirements of the [Uniform Electronic Transactions Act/state technology law].

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

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

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

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

(a) The hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(b) The types of notices and documents to which the party's consent would apply.

(c) The right of the party to withdraw consent to have a notice or document delivered by electronic means, at any time, and any conditions or consequences imposed in the event consent is withdrawn.

(d) The procedures a party must follow to withdraw consent, which can be no more burdensome than providing consent, to have a notice or document delivered by electronic means and to update the party's electronic mail address.

(e) The right of a party to have any notice or document delivered, upon request, in paper form.

E. (1) The plan sponsor of a health benefit plan may, on behalf of covered persons enrolled in the plan, provide the consent to the mailing of all communications related to the plan by electronic means otherwise required by paragraph (1) and (2) of subsection (D).

(2) Before consenting on behalf of a covered person, a plan sponsor must:

(a) confirm that the covered person routinely uses electronic communications during the normal course of employment and is able to access and retain electronic communications that may be delivered by the insurer; and

(b) Inform the party that such consent will be provided, and that notices and documents related to the plan may be delivered to the party's work electronic mail address unless the party affirmatively opts out of delivery by electronic means or provides an alternative electronic mail address.

(3) Before providing delivery of a notice or document by electronic means pursuant to this subsection, the insurer for the health benefit plan must:

(a) Provide the party with a clear and conspicuous statement informing the person of all of the following:

(i) The types of notices and documents that may be delivered to the covered person by electronic means.

(ii) The right of the party to withdraw consent to have a notice or document delivered by electronic means at any time without charge.

(iii) The procedures the party must follow to withdraw consent to have a notice or document delivered by electronic means and to update the person's electronic mail address.

(iv) The right of the party to have any notice or document delivered, upon request, in paper form free of charge.

(b) Provide the party an opportunity to opt out of delivery by electronic means;

(c) Document that the applicable provisions of the conditions under [insert citation from state UETA or similar law] are satisfied; and

(d) Satisfy the other requirements of this Chapter.

(4) When a notice or document is provided electronically to a party pursuant to this subsection, an insurer shall apprise the party of the significance of the notice or document when it is not otherwise reasonably evident and of the right to request and obtain a paper version of such notice or document.

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

Section 5. Change in hardware or software requirements

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

(1) The revised hardware and software requirements for access to and retention of a notice or document delivered by electronic means.

(2) The right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed at the time of initial consent.

Section 6. Applicability

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

B. If a provision of this Title or other applicable law requiring a notice or document to be provided to a party expressly requires confirmation of receipt of the notice or document, the notice or document may be delivered by electronic means only if the method used provides for active confirmation of receipt by the recipient.

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

Section 7. Contracts and policies not affected

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

Section 8. Withdrawal of consent

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

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

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

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

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

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

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

Section 10. Alternative method of delivery required

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

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

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

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

Section 11. Limitation of liability

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

Section 12. Posting Policy on Internet

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

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

(2). After the expiration of the policy, the insurer shall either

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

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

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

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

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

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

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

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

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

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

Section 13. Receipt of Claim Payments by Electronic Transfer

All claims brought by insureds, workers' compensation claimants, or third parties against an insurer shall be paid by check or draft of the insurer or, if offered by the insurer and the claimant consents, electronic transfer of funds to the order of the claimant to whom payment of the claim is due pursuant to the policy provisions, or her/his attorney, or upon direction of the claimant to one specified. However, when the employer has advanced the claims payment to the claimant, the check or draft shall be paid jointly to the claimant and the employer; or, if consented by all parties, the electronic payment shall be paid to the trust account. The check or draft shall be paid jointly until the amount of the advanced claims payment has been recovered by the employer. The electronic payment shall be held in trust until the amount of the advanced claims payment has been recovered by the employer.

Section 14. Rules

The Insurance Commissioner may adopt rules to implement the provisions of this Act.

Section 15. Effective Date

Section 14 of this Act shall take effect immediately. The remaining sections of the Act shall take effect 180 days following enactment.

The following laws will be referenced throughout the agenda topic "Earned Wage Access: Early Payday or Payday Loan?"

Missouri SB 103

Nevada SB 290

Resolution in Support of Establishing National Standards and Procedures for the Reporting and Payment of Premium Taxes Due as a Result of Direct Procurement~~Interstate Insurance Transactions~~

Sponsor TBD - To be ~~introduced for~~ discussed and considered during~~ion~~ the Financial Services & Multi-Lines Issues Committee on November 17~~July 20~~, 2023.

WHEREAS, the Nonadmitted and Reinsurance Reform Act ("NRRA"), which came into effect July 21, 2011, establishes that only an insured's home state is permitted to collect premium taxes due as a result of payments made to an insurance carrier for a policy issued outside of said insured's home state, unless 100% of the risk covered by the said policy is also located outside of the insured's home state;

WHEREAS, despite provisions of NRRA which called upon the states to create national standards and procedures for reporting and collection of premium taxes due as a result of interstate insurance transactions, ~~and two major efforts, the Nonadmitted Insurance Multi-State Agreement ("NIMA") and the Surplus Lines Insurance Multi-State Compliance Compact ("SLIMPACT"), by groups of states to achieve such a result,~~ no national standards or procedures, other than the general guidelines set forth in NRRA have yet been established;

WHEREAS, one of the lawful methods of obtaining insurance from a carrier located outside of an insured's state of domicile is known variously as Direct, Independent, or Foreign Procurement ("Foreign" in this case referencing outside of the insured's state of domicile, but within the United States);

WHEREAS, when an insurance policy is obtained through Direct Procurement, it is the obligation of the insured (and not carriers, brokers, or other intermediaries) to report and pay premium taxes due to the insured's home state;

WHEREAS, although some states have established and published clear and efficient procedures for the reporting and payment of premium taxes for Directly Procured policies, others have not, resulting in confusion, under-reporting, and underpayment;

~~**WHEREAS**, the lack of national standards and reporting and enforcement mechanisms has resulted in an ongoing loss of tax revenue to the states, the size of which is currently unknown but is at minimum in the hundreds of millions of dollars[3];~~

WHEREAS, ~~continued~~ shortfalls by the states in the identification and collection of premium taxes due as a consequence of directly procured insurance policies results in lost

~~[3] As an example, one state recently conducted an investigation and found that its five largest corporations all owed unreported premium taxes for policies obtained from carriers in other jurisdictions.~~

revenue to the states, and could alsointerstate insurance transactions may result in further federal intervention, a result that would be counter to NCOIL's charter and purpose;

WHEREAS, while the preservation and reinforcement of the primacy of each state in overseeing insurance activities within its borders is a cornerstone of NCOIL's mission, NCOIL's members recognize that certain market conditions and critical needs of their citizens may be met in a timely fashion only through the acquisition by its residents and corporate entities of insurance products from carriers in other jurisdictions;

WHEREAS, as evidence of the demand for additional insurance capacity and flexibility, a bill known as the "Self-Insurance Protection Act" was introduced in the U.S. House of Representatives on April 23, 2023[4];

WHEREAS, if enacted, the effect of the Self-Insurance Protection Act as presently drafted would be to broaden ERISA pre-emption to include stop-loss insurance coverage for self-insured group health plans, and thus remove all state jurisdiction over said coverage, and also to eliminate taxation on premiums for such coverage, both of which outcomes would be highly detrimental to state insurance regulation and antithetical to NCOIL's core mission;

WHEREAS, inasmuch as the discouragement of lawful and compliant interstate insurance transactions, whether through active opposition or through lack of clarity in compliance, reporting, and tax remittance procedures, may be used by proponents of initiatives such as the Self-Insurance Protection Act as evidence in support of the need for such radical and unwanted changes;

WHEREAS, companies – whether they are true carriers or "captives" behaving as *de facto* carriers – which fill such unmet insurance needs should in all cases be required to report and remit (or cause to be remitted) all premium taxes due to each state in which an insured is domiciled, as required under NRRA;

WHEREAS, such tax reporting and remittance obligations should apply uniformly, whether a policy is obtained from a registered Excess and Surplus Lines carrier; from a Non-admitted carrier through the compliant use of Independent (also known as Direct) Procurement; or from a "captive" insuring individuals or companies domiciled in other jurisdictions;

WHEREAS, in *State Board of Ins. v. Todd Shipyards Corp*. (370 U.S. 451) (1962), the U. S. Supreme Court upheld the Constitutional right of individuals and companies to obtain insurance from carriers outside of their states of domicile;

WHEREAS, NOW, THEREFORE, BE IT RESOLVED that NCOIL urges each of the states and U. S. territories, as well as the District of Columbia, to work cooperatively to accomplish the following:

[4] 118th Congress, 1st Session, H. R. 2813

• Establish and publish clear guidelines for the reporting and remittance of premium taxes due as a result of direct procurement~~in each state~~;

• Make clear distinctions between the various types of interstate insurance transactions, including Excess and Surplus Lines; direct~~Independent~~ Procurement, and captive insurers, and clarify that the intent of any new legislation and/or regulation is to impact direct procurement only, and not any other type of insurance ~~establishing and publishing procedures for the reporting and remitting of premium taxes for each type~~;

~~• Formally recognize the rights and responsibilities established in the various codes and judicial decisions referenced above, and specify state expectations for demonstration of compliance with same;~~

~~• Require each insurance company or other risk bearer licensed in any jurisdiction to report annually (or more frequently) to its licensing agency any premium taxes that are due to other states, irrespective of whether or not the insurer must report and pay said taxes directly ;~~

• ~~Take measures~~ enact legislation and/or regulations to permit insureds who are ~~directly~~ responsible for reporting and remittance of premium taxes for policies acquired through ~~Independent~~ direct Procurement to assign said functions to issuing carriers, and/or to third parties such as third party administrators or accounting firms, while cautioning that such assignment will not relieve insureds of their legal responsibilities to report and remit premium taxes;

~~• Encourage each state and territory to enact laws and/or regulations which give insurance carriers the right to report premium tax obligations to the states in which they are due, and shield carriers against any claims and/or legal action taken against them by insureds as a consequence of such reporting;~~

• Take all steps necessary to ensure compliance.

BE IT FINALLY RESOLVED, that a copy of this resolution shall be sent to legislative leaders in each of the states and territories; the chairpersons of the Insurance and Revenue Committees (or equivalent) of each state legislative body; the Treasurer (or equivalent) of each state and state and territory; the Department of Insurance (or equivalent) in each state and territory; the National Association of Insurance Commissioners (NAIC); and all other parties who may have an interest in the lawful reporting and collection of premium taxes.

NCOIL – NAIC DIALOGUE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
NCOIL – NAIC DIALOGUE COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 21, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) NCOIL – NAIC Dialogue Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Friday, July 21, 2023 at 10:45 AM.

Representative Deborah Ferguson, DDS, (AR), NCOIL President and Co-Chair of the Committee, presided.

Other members of the Committee present:

Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Rod Furniss (ID)
Rep. Matt Lehman (IN)
Sen. Beverly Gossage (KS)
Rep. Michael Sarge Pollock (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Sen. Bob Hackett (OH)
Rep. Tom Oliverson, M.D. (TX)

Other legislators present were:

Asm. Tim Grayson (CA)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Brian Lohse (IA)
Rep. Megan Srinivas (IA)
Rep. Camille Lilly (IL)
Sen. Michael Fagg (KS)
Rep. Michael Meredith (KY)
Rep. Rachel Roberts (KY)
Sen. Pam Beidle (MD)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Rep. Mike McFall (MI)
Sen. Gary Dahms (MN)
Rep. Liz Reyer (MN)
Sen. Walter Michel (MS)
Sen. Pam Helming (NY)
Rep. Tim Barhorst (OH)
Sen. Geroge Lang (OH)
Rep. Bob Peterson (OH)
Rep. Forrest Bennett (OK)
Rep. Ellyn Hefner (OK)
Rep. Mark Tedford (OK)
Del. John Paul Hott (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Rep. Matt Lehman (IN), NCOIL Immediate Past President, and seconded by Rep. Brenda Carter (MI), 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. Lehman, the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 10, 2023 meeting in San Diego, CA.

INTRODUCTORY REMARKS

Rep. Ferguson stated that before we get started, I just want to thank all of the Commissioners for being here. We started this Dialogue with the Commissioners several years ago and as I said at our opening meeting, we really value our relationship with the Commissioners. We function together. We're the legislative part and they are the regulatory part and we couldn't do it without each other. So, we're grateful for this Dialogue to really discuss important issues that come before both of our groups. Rep. Ferguson then asked all of the participating Commissioners to introduce themselves: Idaho Director and NAIC Immediate Past President Dean Cameron; Indiana Commissioner Amy Beard; Louisiana Commissioner Jim Donelon; Minnesota Commissioner Grace Arnold; and Oklahoma Commissioner Glen Mulready.

Commissioner Tom Considine, NCOIL CEO, then stated that to take a moment as a matter of personal privilege, this is the Summer Meeting and between now and our Annual Meeting is election day and it will be the first time in Louisiana that Cmsr. Donelon is not on the ballot in a long time. And I've known Cmsr. Donelon for decades. We served together. He held office back when I was in the corporate world doing work. He was accessible to people on all sides. He went on to have an unbelievable career that continues today at the NAIC and in Louisiana. I said to him yesterday, and I meant it, and I'll say it now that the day after his term concludes there should be a statute unveiled outside the Insurance Department in Louisiana. Cmsr. Donelon, we thank you for all you've done and all the good kindnesses you've shown to NCOIL and to me personally over the years.

Rep. Ferguson stated that I've said many times, that's one of the things I value most about NCOIL is just the people that come are just a wealth of information with experience and I'm just very grateful that we have you all to go to for questions and input.

RECAP OF NAIC D.C. FLY-IN AND PREVIEW OF NCOIL'S D.C. FLY-IN

Rep. Ferguson stated that first on our agenda is a recap of the NAIC's D.C. fly-in and a preview of the NCOIL D.C. fly-in. Every year we take a group of legislators to D.C. to meet with Members of Congress and their staff. In October, NCOIL will have its eighth consecutive D.C. fly-in. The fly-in is a great opportunity for us to meet with Members of Congress and discuss NCOIL initiatives and to educate them about the importance of

the state based system of insurance regulation. Some of the issues that we plan to discuss this year are: the reintroduction of the Prohibit Auto Insurance Discrimination (PAID) Act which seeks to prohibit auto insurers from using certain factors in underwriting such as educational level or marital status; preserving the ability of the states to regulate state healthcare via an amendment to the Employee Retirement Income Security Act of 1974 (ERISA) to add a statutory waiver provision; and enacting a long term reauthorization of the National Flood Insurance Program (NFIP). We understand that the NAIC held its annual fly-in earlier this year. Would you be able to please provide us with a recap of that along with noting the main issues that you discussed when you were in D.C. at your meetings?

Dir. Cameron stated that we had a very successful fly-in. This was the first in-person fly-in in the last three years. I pushed really hard last year as NAIC President to have it in person but we just couldn't get it put together with all the restrictions that were in place. We had 30 jurisdictions that attended and we had 133 meetings. We met with our Congressional delegations. We also supported the long-term reauthorization of the NFIP. We'd love to see Congress stop playing politics with it and to have a long-term solution there. We support a vote on the Financial Stability Oversight Council (FSOC). The insurance industry's the only economic financial industry who's not represented with a vote on that council and so we've pushed for that. We have promoted and shared our efforts as state regulators to avoid targeted attacks on seniors with fraud and other means. We also expressed the importance of policyholder protections in insurance receiverships, and shared our experiences with Medicare Advantage and the marketing of Medicare Advantage plans in states. You may know that we regulate Medicare supplements but we don't have very much authority under Medicare Advantage plans. We believe consumers ought to have the same regulatory protections regardless of the product that they purchase and so we promoted that. We had lots of other discussions where we were also opposing federal preemption of state's rights and opposing federal preemption of state data privacy and cyber-security safeguards. And then we also, as we talked about this morning, oppose expansion of risk retention groups. We believe that non-for-profits have access to coverage. Our C Committee's doing a study to make sure that's the case and we believe that those non-for-profits need the same consumer protections as anybody else buying coverage.

Rep. Ferguson asked if the meetings with Congress lead to any federal action? Dir. Cameron stated that it does at times but as you know it is slow progress in our nation's Capital. First and foremost, we like to cement our relationships with our Members of Congress and also to point out who they can come to in the event that they've got insurance questions or insurance regulatory questions and that's a great success. For example in that last piece, the risk retention piece, that was being heavily promoted at the last minute and would have potentially passed had we not done the fly-in and had those relationships and being able to reach out and convey our concerns.

Cmsr. Mulready stated that regarding the Medicare Advantage piece, state legislators and regulators don't control those plans but multiple voices is helpful. That was something where I know certainly with my delegation every single one of them we hammered on that. We get the phone calls. We get those complaints on Medicare Advantage and we have to tell them, "tell the feds" - and it goes into a black hole. They don't have the resources. The Centers for Medicare & Medicaid Services (CMS) has made the decision now because as they've checked around things were kind of quiet.

Well, my response to that would be, “Yeah they’re quiet. It’s not during the enrollment period here - come talk to us at the end of the year.” And so they’re going to let it ride and see if that works. However, when the Chief Administrator for CMS was in front of us like this I know I jumped in and asked a question about granting us more authority and she was very open to that, that they’d love to work more collaboratively with us but ultimately they’ve not done that. But we want to continue to keep pushing on that issue because it’s a big issue for each our departments.

Sen. Beverly Gossage (KS) stated that I appreciate that you were speaking up about Medicare Advantage plans. As an agent who writes Medicare Advantage and supplements, it's frustrating with the federal government because there are some bad actors out there who are putting ads on television with Joe Namath or whomever and they really are not taking care of the consumer like the local agent would. And we know that if it was in the hands of the state regulators that would be a very different story. Instead, they overreact and say you must record every single phone call even if they called to ask you a question, you have to keep that for 10 years, etc. and actually make it difficult for good people to help seniors and so I fully support that and thank you for asking that. Dir. Cameron thanked Sen. Gossage and stated that we thank you for the compliment. We worked very hard on it last year and are continuing to work hard on it. We also did a lot of media outreach. I personally ended up doing two media events where I was interviewed by over 30 television and radio stations across the country and had nearly 40 million views on it and we focused on Medicare Advantage in them and the improper marketing and approaches. Most of us who have folks within our departments still try and help to the best of our ability but as Cmsr. Mulready said, our abilities are limited and we have seen some movement from the federal government on willing to hand some more of that over to us. They may not be willing to give it all up but they’re willing to give some additional authority I believe.

UPDATE ON ACTIVITIES OF TRIBAL INSURERS AND THEIR ROLE WITHIN THE STATE-BASED SYSTEM OF INSURANCE

Rep. Ferguson stated that we did invite the General Counsel for the Sovereign Nations Health Consortium to come to this meeting but he unfortunately had to cancel. I think it would be beneficial for us to all hear from them, but I know we all have some concerns about the tribal nations and how they're selling insurance products. Nonetheless, we do want to hear from you. I know at our last Dialogue in San Diego we discussed the work of the NAIC's American Indian and Alaska Native Liaison Committee regarding the insurance issues specific to tribal nations and we discussed the survey that was conducted by that Committee relating to the growing insurance markets and business models of certain tribal insurers. Can you share with us any updates on the work of that committee and the results of the survey and what, if anything, the NAIC is doing moving forward on this issue and you might want to summarize it for people who weren’t here last time or don’t understand the issue of what the tribal insurers are doing.

Cmsr. Mulready stated that I chair the Native American Liaison Group for the NAIC and in three weeks at our national meeting we’ll have a presentation in that group on a similar update on what is happening around the states so you get to hear some of that a little bit early. It’ll be presented by my legal team. The Sovereign Nations Health Consortium for those of you that may not know, it’s a group out of Utah and I was disappointed personally too that their General Counsel, Mark Echo Hawk, canceled for

this meeting as I would love to have heard anything new that he had to say. He presented to our group at our Portland meeting about a year ago. And this is a group that is selling health insurance to tribal members and non tribal members on reservation and off reservation and so Utah has had a number of conversations with them. They have specifically put in writing, asking them about the McCarran Ferguson Act and their response to that. They have not heard from them on that. They have agreed I guess with Utah to now back off and only sell to tribal members. Anecdotally, it appears to me from all the conversations I've had with other States and what's happening there is that this group is not looking for a showdown. The state of Washington has a cease and desist in place with them, and on the very last day of that cease and desist they offered to withdraw from their state. And so I think they're not looking for that legal challenge and I understand the state of Colorado, they have agreed to withdraw from there. I met with their executive team personally as they came to Oklahoma. I asked them similar questions. Their response to me on the McCarran Ferguson issue was that McCarran Ferguson was silent on tribes so therefore, that allowed them to go about their business how they chose. I'm not an attorney but it's an interesting legal interpretation of that. So we continue to monitor what's happening around those states. As far as we can tell, they've been selling products only in about 15 states. They're not across every state. I can tell you that in my meeting with them I asked about future expansion and their plans for that and they certainly expected to expand into the life insurance business. But they believe that they are not held to any state laws as a sovereign nation and so eventually it may end up in court and we'll have a decision I suppose.

But at this point there is nothing in court at the moment. I'll also tell you from my conversation with them when we met in my office, they clearly misunderstood how the insurance business operates in our country and at the NAIC and getting licensed in each state and capital requirements. Because I asked them why they wouldn't just go down the traditional path of becoming a traditional admitted insurance carrier and clearly they misunderstood the capital requirements and how that all works. So, my financial team followed up with them to explain that all in writing and direct them on how that all works that if they chose to go down that path they could do that and we were there to help them do that. I will comment that in the meantime too, we have encountered some other situations. One in particular, I may have shared last time I was with you. But we learned of it through an op ad in our Oklahoma City newspaper where there was an op ad about some changes that they thought should be made in the captive insurance space and it was signed by this tribe in Oklahoma. It was signed by their insurance commissioner. I read that and I thought I was the insurance commissioner so we then went out to investigate that and our fraud unit went out and I think clearly what we have happening there and probably in some other situations is some, not ready to quite call them bad actors, but folks that are taking advantage of tribes. And that tribe is involved in name only. They were clueless about the insurance. I think some group based out of another state, not out of Oklahoma, had gone to them with this idea of we can operate as a sovereign nation, start our own insurance company, we'll funnel X percentage of the money to you and you're really just kind of lending your name. And I'm pretty sure that's what's happened here. And so we're investigating a number of different things at the local level there in Oklahoma but I think it's just sort of the tip of the iceberg on this issue.

Rep. Ferguson asked Cmsr. Mulready if in most places they have backed off of selling outside the tribe. Cmsr. Mulready stated that yes - when pressed with a cease and

desist or other threats of action they did stop and that's why I'm saying I think they're not looking for a legal showdown. They have backed off each time to date and they've not pressed that so, we'll see if that continues. But they have agreed to only sell to tribal members. And that's a different issue.

UPDATE ON DRAFT NAIC CONSUMER PRIVACY PROTECTION MODEL LAW

Rep. Ferguson stated that next, we'll have a update on the draft NAIC Consumer Privacy Protection Model Law (Model). The NAIC is working to amend its Insurance Information and Privacy Protection Model Act and its Privacy of Consumer Financial and Health Information Regulation with the end result being a new NAIC Consumer Privacy Protection Model Law. Just last week a new draft of the proposed amendments was released and they can be viewed together with the cover page on the website and our app and on page 217 of your binders. Can you provide us with an update as to what the comments have been like thus far; a summary of the latest amendments; and what the timeline for the next draft is and possible adoption?

Cmsr. Beard stated that as you said, there is a second draft of the Model available on the NAIC's website that is open for comment until July 28th. So, I'll do a little bit of a summary of what the Working Group (WG) has done since we last met. The comment period for the first draft closed in April and the WG reviewed the written feedback it received and held public calls and a few meetings and the feedback that was received on the initial draft included some industry concerns with the Model being overly burdensome to the insurers and licensees. It had an opt in provision. It requires prior consent for consumers for marketing purposes. And there were concerns with enhanced third party oversight, consumer notices, and concerns with a timeline for deleting personal information. So, last month the WG held a two day in person meeting in Kansas City and they considered all of these comments and concerns and it looks like they discussed providers, the definitions of insurance transactions and other permitted transactions, marketing, joint marketing agreements, marketing consent, and the content and frequency of consumer notices. So, the WG has met in regulator only sessions seven times since June 22nd and on June 26th that's when the second version was exposed for comment period. So, with the updated draft the WG is trying to take into consideration the feedback that it received and wants to keep an eye towards uniformity and consumer protections. The WG is going to have a public call on July 25th to discuss the changes and receive additional comments and the goal is to have the Model ready for consideration for adoption by the H Committee at the NAIC Fall National Meeting in Orlando. So, to date the WG has met multiple times and intends to meet publicly at least five more times before presenting to the H Committee this Fall and we welcome the conversation and your thoughts on this draft and we're happy to assist you with getting involved or helping to provide the documents on our website.

Rep. Ferguson stated that of all the bills I think this is the one I hear the most concern about in my conversations with people. Rep. Lehman stated that I do respect the process you've gone through. I still have some concerns with the issues you pointed out from the first draft and I don't think they were really addressed in the second draft: the third party language, the notification of clients to opt out for marketing, scrubbing our clients every 12 months when we have retention requirements elsewhere that require to keep it longer. But I want to ask kind of an overarching view of all of this and I know NCOIL will probably submit some comments. But the one suggestion I would have is

many states have passed data privacy laws. I think 15 or 16 states have passed laws and a lot of these are out there to kind of set the stage for the federal government to get involved and set a universal standard across all jurisdictions because the problem you have now is if I'm operating in multiple states, I've got to comply with multiple data privacy laws. So, are we going down a path where what we're going to want to implement here might be somewhat of a moot point? Because I know we regulate insurance on the state level but as we passed Senate Bill 5 in Indiana, we exempted out the entities that were part of the Gramm-Leach Bliley Act and the Fair Credit Reporting Act and that falls to the majority of insurance and we've quasi exempted out of our statutory data privacy laws those entities and now we're kind of bringing them back in through a regulatory model law. So, I foresee conflict with moving forward with the feds and the states and then the NAIC saying, "Hey we want to adopt this model law that we want to bring back to your states and then implement it." Because I think it's going to be a heavy lift in our states when we're waiting to see what the feds are going to do and we've already passed a data privacy law that kind of goes contrary to some of this. So, I know you're comment period is closing quickly and we'll provide something from NCOIL but kind of in the general sense, is there any discussion at all about maybe kind of hitting the pause button just to see where we end up in the next 12 months?

Cmsr. Beard stated that I'm not aware of any considerations to pause. However, I'm sure that the NAIC, especially the WG and then the Chair of the H committee, is always open to receiving feedback and comments and so that's something that could be incorporated into the comments that you mentioned NCOIL might provide and that will be taken under consideration. And then some of the consumer protections that are being reconsidered in the second draft include trying to limit who is effected by the Model. So, for example third party service providers has been refined and it won't include an affiliate for example. And so there are some modifications to try to limit that overreach. I know that at the federal level the U.S. House Financial Services Committee approved a vote that would amend the Gramm-Leach-Bliley Act to give consumers more control over their personal information which is similar to what this Model would encompass. And so, the NAIC has not taken a position on that federal bill, but we continue to monitor it and if necessary we will be able to make comments but as for this WG's draft there are several more meetings in the works between now and the H Committee for the group to consider what comments they receive back.

Rep. Stephen Meskers (CT) stated that in looking at the Model I haven't followed the process and procedure as we go forward. It seems to me, I sit on the Insurance Committee and I Chair the Commerce Committee, and consumer privacy is a major complaint at the state and federal level. But the harvesting of the data in many cases us used and sold to reduce the cost of various services that have been provided. I can understand within insurance why you want your privacy and in various areas I think there's different levels of security. It seems to me that one of the procedures in terms of both public hearings and raising model legislation I'm not sure if we should be thinking regionally on floating the model legislation in a legislative session in neighboring states and come back with feedback from those neighboring states to then further work on the model legislation so that we have public hearings. And we begin to get regional associations for those model laws. I'm wondering what your thoughts are on that and if that's the procedure we follow now and we've considered that. Because as you begin to try to bring a national platform on insurance legislation it seems if you bring it at the regional level you might be able to get better coordination and more impactful changes

that suit whether it's the west coast, the east coast, or the center of the states. And I don't know if we've used that procedure before. So, I throw that out as a question to you.

Cmsr. Beard stated that I think that we're open to any innovation and innovative ideas for being able to move forward with any of the Models that were drafted including this one and so, it's not something that I'm aware of that we've considered before but this might be something to float around to see if that's the approach that would be effective in adopting this going forward.

Dir. Cameron stated that I'll just jump in to put a maybe a finer point on a couple of items. Remember that when we started the process, we were trying to prevent federal preemption. That appears to be not necessary now so now the NAIC, which isn't known for operating too fast, we're trying to have a very thoughtful approach and process as we develop things and mostly our focus is on protecting consumers and making sure that their information is appropriately protected. We're all just in the wake of a very large data breach. I won't say the name but it impacted several companies. I just got a call last week from a company in my state who thought that they were free from being impacted, now they find out that the reinsurance company that they bought reinsurance from is impacted and they might be indirectly. So, I think first of all we'd love for NCOIL to make comments on the Model that's being drafted. As to whether there will be a pause or not that is still up for discussion depending on if it's reached the point where there's consensus that it's good enough. As far as the regional approach, we've never taken that type of an approach – it's maybe not a bad idea. I do know that a lot of us have considered passing model laws and have looked to other states to see things and sometimes it's not the natural region that you belong to and there's nobody here from Oregon or Washington but Idaho probably wouldn't follow them. We might follow Montana and Wyoming and Utah and be more in line that way. But when we started looking at it, we started looking at what the Carolinas had done and what some of the other states that are similar minded have done. We're open to suggestions that you have. We need your input and suggestions on the Model, so we'll look forward to seeing those.

Cmsr. Mulready stated that I know in a past meeting there was discussion about NCOIL developing a similar Model. I'm assuming from this discussion you've set that aside, but has NCOIL taken an official position on HR 1165? Rep. Ferguson replied, no. Rep. Lehman stated that and maybe to that point, Dir. Cameron I think you said something that we 100% agree with and that is oversight. We want to keep state based regulations. So the genesis of this was to make sure the feds don't get involved. I do think this is maybe an issue and we've offered this in the past and I'll offer it again which is to bring us into those conversations. I know we're not on your different committees or your subcommittees but I'll come out to Kansas City and sit down and walk through what this is going to look like when we get to the actual legislative side of all this too. Because I do think this is a kind of an all hands on deck approach because as we've heard data privacy is what's driving the conversations around everything today. It's "what are you doing with my data?" I do think that as we looked at that, it's being geared to more the ones where we just don't know. Insurance companies are very transparent as they're heavily regulated as are our banks, etc. It's those unregulated industries like Facebook and other social media, those people who are collecting massive amounts of data, totally unregulated. I think that's what's driving this whole privacy discussion. So I

don't know that insurance needs to get too far ahead of their skis on privacy when we're already heavily regulated but I would offer NCOIL's assistance in any way we can to be a part of that moving forward with that process.

Dir. Cameron stated that we would love to have NCOIL involved and I think it's important and I would just indicate to you, it's not been too long ago that we had a fairly significant breach on a fairly significant company and it was a ransomware breach where the company, in spite of the federal government telling them not to pay the ransom, told us that they had to pay the ransom or they would cease to exist as a company. Now, just think about that for a minute. You think about the hundreds of thousands of policyholders who would be impacted. You think about the state's economic situation that's impacted based on that ransomware and you think about how that then impacts the guaranty funds and all the other companies that it creates an issue with. So, it's super important and it's super important that we be thoughtful and super important that we get it right and we welcome the collaboration with you on it.

Rep. Ferguson stated that there are already so many Health Insurance Portability and Accountability Act (HIPAA) restrictions on healthcare providers. There all kinds of privacy issues already addressed. What does your Model do with health that's not already being done with existing HIPAA regulations and those kind of things? Cmsr. Beard stated that in the first draft there was a discussion of HIPAA and Health Information Technology for Economic and Clinical Health Act (HITECH) compliance and there were some concerns with that and so that was under consideration. And in the late June meeting, the group exposed some comments related to that and so the second draft is really looking at those specific consumer protections where the comments were made and there needs to compliance with HIPAA and HITECH in the current version but it's up for consideration and we welcome collaboration and want to walk through all of these issues to make sure that things are fully flushed out and make sure that we're collaborating between NCOIL and NAIC because as you said you are the legislators who will be enacting this possibly in your states and so the practical implications of some of these provisions are important and we welcome the discussion.

Rep. Michael Sarge Pollock (KY) stated that I'm going to speak on behalf of the small insurance agents. I'm one of them and I'd like to have that conversation with you regarding what we have to go through as far as mom and pop insurance agency. So there obviously are some concerns and I really appreciate you making sure that we do have a voice at the table before the final draft is out but obviously just making sure that we do not handcuff ourselves in a lot of ways. Obviously this is a huge topic of protection. We get that. But also some consideration of the small insurance agencies is important. Cmsr. Beard replied absolutely, I agree and we worked in Indiana on the cyber-security data model law to make sure that producers and independent agencies were carved out of some of the more burdensome protections in there that would disproportionately affect them and still provide enough consumer protection to make sure those changes weren't going to adversely affect consumers. So, I think the same considerations in this draft can be taken under consideration as well. Cmsr. Donelon stated that I just want to echo what Cmsr. Beard just said and I've had a meeting just in the hallway before with the Independent Insurance Agents and Brokers of America (IIABA) before this meeting started urging concern for the independent agents in the process. We are one of the states that has adopted the NAIC's Insurance Data Security

Model Act. We did so with lots of input from our agent force and with their approval and support of the final version so we're mindful.

DISCUSSION ON NAIC'S DEVELOPMENT OF MODEL BULLETIN ON ISSUES RELATING TO ARTIFICIAL INTELLIGENCE (AI) AND THE INSURANCE INDUSTRY

Rep. Ferguson stated that as we all know, we've seen this unprecedented growth in AI across all types of industries but certainly we want to look at it for the insurance industry. As AI relates to NAIC, your new H Committee is considering developing a model bulletin outlining the regulatory framework for the use of AI for the insurance industry. Can you share with us some of the details as to what the bulletin might look like and when it will be exposed for comments and what kind of timeline there will be for adoption?

Cmsr. Beard stated that for the AI model bulletin, currently there is a draft that is exposed out there. It was exposed on July 17th and the NAIC wanted to make sure that this bulletin was not just a product of a WG or a silo of the NAIC but that it was a work product of the entire membership. Earlier this year the Commissioners met and determined that there was consensus that the NAIC should move forward with developing an AI regulatory framework for use by the insurance industry. And so, at our Fall meeting in December the H Committee announced that the regulatory framework would take the form of the bulletin and the bulletin is supposed to be principal based, not prescriptive. It should prioritize governance, protocols that rely on external and objective standards. For example, those used by the National Institute of Standards and Technology (NIST). And then there is validation and testing of AI which there are certain practical limitations to testing, but we wanted to make sure to include that function in the bulletin and it stopped short of requiring data value by the insurance regulators. It's the responsibility of the licensees to conduct due diligence on their third party data and third party data vendors. So it really is a more principled based document that outlines what the AI and machine learning protections are. And it is corporate governance and transparency standards that are in place for a lot of insurers already and it's just codifying that into one document and it heavily reflects some NIST documents. So we wanted to work within that sphere and not work in a silo where we are just all trying to learn about AI. And we have had many education sessions on what AI is and what machine learning is. We've had industry discussions. We've received comments. And so there was a small group of insurance commissioners that were a part of a drafting WG that then produced this draft for the entire membership to review and comment on and that's where the product is today, for review and comment. The comment deadline is September 5th and initial comments are going to be heard and discussed at the upcoming summer meeting in Seattle.

Rep. Ferguson stated that for those of us who aren't familiar with NIST can you please tell us who NIST is and what they do? Cmsr. Beard stated that NIST is the National Institute of Standards and Technology and they put forth standards and best practices for technology uses such as data security things like that. And they have released recent guidance on some of the related issues that we look at when we are looking at AI machine learning that are the gold standard for use within multiple industries.

Dir. Cameron stated that it was two years ago at this meeting where I think Cmsr. Mulready and I sat at this table and announced that we were coming up with the H committee because we were proud that we were making that progress and we wanted to

see how quickly the industry would get back to the NAIC to let us know that we had announced it publicly before it was ready to be announced. And the industry did very well as I didn't leave the meeting before I received calls about it. And last year we had an extra Commissioners conference as we tried to work through our strategic plan and it was in that meeting that we decided that a model act was not what we wanted to do. We felt like the core of what we needed as insurance regulators was we wanted to give sort of a bulletin of best practices of what can be done. I know we'll get a chance to review it and we would certainly take your feedback and suggestions to us on that as well because that's a work in progress.

Sen. Bob Hackett (OH) then spoke to his experience in Ohio with cybersecurity legislation and stated that I love NIST but when you look at NIST, they're so huge and what we did is we brought all the industries in because each industry was good so we wanted to take how the NIST principles and standards apply to different industries. You have to be really careful if you use all of NIST's standards because that's not the way NIST was set up. I like NIST. I'm not criticizing them but you have to realize when you look at them they're really involved and they have a lot of standards but a lot depends on when you bring in all the different industries. And one of the things we wanted to do was protect businesses from major lawsuits and we didn't want to run the small businesses out and create premiums that were unbelievably high. So, we created a really good bill in Ohio that we think protected the companies from major lawsuits but we needed the associations involved with every industry. That's the thing that you must be really careful of with NIST. When you study NIST it is very, very involved. So, that's the only thing I'm telling you is to be wary of that and make sure it fits with the different industries. Don't create a standard thing that just takes the NIST principles that may not apply to certain industries because you'll run away the small companies.

Cmsr. Beard thanked Sen. Hackett and stated that I would agree that NIST is very expansive and comprehensive and I do not begin to purport that I'm an expert on NIST but I do know that we looked at the NIST principles, but also other AI guidance or other standards that were implemented by maybe regulators of other industries or other countries that had started the process of adopting basic standards for the governance of AI and machine learning. And so we took into consideration multiple industries' drafts of other principles and that was part of our educational review when we were looking at learning about AI and machine learning and looking at other industries as well as the federal government and what they have implemented and whether we want to go that route or not.

Rep. Megan Srinivas (IA) stated that I'm very interested to see how you incorporate NIST and all these different guidelines into the AI standards that you're looking at. One of the things that NIST has really been focused on lately is branching off of AI and even going into quantum computing because of the potential for good and the potential for security breaches so I'm really curious how you might be analyzing that alongside your AI standards. Cmsr. Beard stated that she had a hard time hearing Rep. Srinivas and asked if she was saying something about a third party? Rep. Srinivas replied no - I was curious if you were incorporating quantum computing into your review as you go into the AI algorithms because that's really the next horizon that has even broader implications than what AI currently is anticipated to have. Cmsr. Beard stated that the bulletin does have a few definitions and part of the definitions include different phases of machine learning or different schools of thought and it doesn't go into those theories specifically,

but it does make a reference to them to make sure that we are inclusive of the newest technologies out there.

DISCUSSION ON NAIC'S PUBLIC ADJUSTER LICENSING MODEL ACT AND DEVELOPMENT OF NCOIL'S PUBLIC ADJUSTER PROFESSIONAL STANDARDS REFORM MODEL ACT

Rep. Ferguson stated that tomorrow, our Property and Casualty Insurance Committee will begin discussions on the development of an NCOIL Public Adjuster Professional Standards Reform Model Act sponsored by Rep. Mike Meredith (KY) and co-sponsored by Rep. Lehman. The Model comes on the heels of several states recently enacting public adjuster reform laws. Before we go any further. I'd like to offer Reps. Meredith and Lehman the opportunity to provide any remarks on the Model as well as the actions they took on this issue in their respective states. We understand that many years ago the NAIC adopted a Public Adjuster Licensing Model Act. Has the NAIC received any comments on whether or not the Model should be amended in light of the recent activity?

Rep. Meredith stated that I appreciate this opportunity and we're looking forward to introducing the Model tomorrow in the Property and Casualty Insurance Committee. If you followed what has happened in Kentucky over the last few years, we have been hit by some major weather disasters. In December of 2021 we had a major tornado outbreak that affected the western sector of our state and then that following summer, in 2022 we had major flooding actions in the eastern part of the state. During that time, we had a significant movement of public adjusters coming into the state and were doing work that was actually just interfering in the claims process many times and slowing the process down. There were some bad actors out there and we didn't have a law that was strong enough to handle that. And so we acted working with the insurance industry and the state and working with our Commissioner in Kentucky to strengthen what had been based on the NAIC Model probably about 20 years ago in an effort to update how the Commissioner can regulate those folks and deal with those bad actors.

Rep. Ferguson asked Rep. Meredith to provide some background on what exactly public adjusters do after natural disasters. Rep. Meredith stated that they will sign a contract with the insured to come in and help them through the claims process and what we have found was some were going as far as harassing the staff adjusters with the companies who were trying to do their adjusting work. We had some that had conflicts of interest with maybe a roofing company that they worked along with and had a financial interest in and were trying to up those claim costs or who were maybe involved with the restoration company or something like that. And so there were conflicts of interest issues that we wanted to address but most importantly we just wanted to make sure there was disclosure and transparency in those contracts and the ability was there for the insurance commissioner to regulate them properly. Rep. Ferguson asked whether the problem is that the public misunderstands when they call them that they're an insurance adjuster? Is there proper identification? Rep. Meredith stated that I don't think it's a lack of proper identification there necessarily. I think they come in and they sell the client that they can help get them more money out of their insurance claim and the client may not know that's going on. It may be an elderly person who has not dealt with the claims process before and they think this is somebody who is going to help me but they're also

getting a fee out of that claim as well which becomes an issue in trying to mitigate those losses.

Rep. Lehman stated that what you have in front of you from what we're proposing as a Model is essentially the Kentucky law and in Indiana we worked with our department this year to pass some pretty restrictive public adjuster laws regarding conflicts of interest and the inability for them to file complaints with the department where our department was being overrun by complaints that were being filed consistently by the adjuster and not by the insured so we prohibited that. I believe the NAIC model was finalized around 2005 so hopefully we can get some good statutes on the books and get a Model out of NCOIL and as the NAIC maybe updates its Model you can use this NCOIL model as a pretty good draft. And I think Rep. Mereidth was very good in laying this out because what we saw is there was some that called for a ban on public adjusters and we have to be very clear that there are sometimes some carriers who are not always the most easy to deal with or the best deal with and public adjusters can provide a valuable service so there has to be somebody protecting the interests of the individual. But there's a need for things to be done and we were very aggressive five or six years ago in Indiana and passed language to make them licensed and answerable to the departments and things like that. So, I think the Model is in a good place to begin with and I look forward to input from the NAIC.

Rep. Ferguson asked if the NAIC has any plans to update its Model? Cmsr. Donelson replied yes and stated that the NAIC really appreciates NCOIL's attention to this issue in particular those of us from coastal states. I've had 800,000 claims filed from hurricanes in the last two years and needless to say this is a really important issue for us. As we've seen from recent news stories, bad actors can and have taken advantage of policyholders at their most vulnerable time. Mitchell Adjusting International, LLC in Texas is accused of stealing $7.9 million from policyholders in various states. The NAIC recognized a need nearly 18 years ago when it adopted its Public Adjuster Licensing Model Act, number 228. Today, nearly all states require public adjusters to be licensed. South Dakota, Arkansas, Arizona, Alabama and Alaska are those that do not. And 20 of those states that do have implemented the NAIC model. One of the key differences between the NCOIL draft and NAIC's model is that NCOIL's model establishes fee caps on non catastrophic claims at 15% and for catastrophic claims at 10%. The NAIC model leaves a fee cap optional to the states, but it does suggest that fees for catastrophic claims be no more than 10% of the insurance settlement. The NAIC is contemplating opening up its Model for revisions to enhance consumer protections and strengthen requirements of public adjusters.

Another related issue we've seen in the market that we'd like to address is the assignment of benefits or rights to property repair contractors who do not have legal authority to represent an insured. And in fact, I just concluded session back home in Louisiana and we passed that exact ban. Delaware has also done it a year before. The NAIC model is significantly similar to ours in Louisiana with a significant exception. We passed our law the year I was President of the NAIC in 2013 and the Louisiana Bar Association took on the public adjuster industry seeking licensure that we were supporting but we stepped back from the fight between the attorneys and the public adjusters and we are the only state in America that prohibits any contingency fee arrangement between a public adjuster and their insured on the basis that contingency fees are limited to the practice of law and not available to public adjusters. That has

been priority number one in my state for public adjuster to repeal that and they ran a bill the year before to adopt the model with a 10% contingency fee cap, which is pretty much the standard around the country and it cleared the Senate almost unanimously but got hung up on a tie vote in the House in the last days of the session. Industry was very opposed to removing that prohibition on contingency fees and they were successful. In addition, the NCOIL Model adds a requirement that clients funds be handled by a public adjuster in a fiduciary capacity and maintained in a trust account similar to what is required of lawyers. The NCOIL Model adds additional protections for the insured to ensure that public adjusters act in good faith in promoting access to the insured, the property, and information related to the claim. We have language in our statute guaranteeing the insurer has direct communication rights with the insured but the NCOIL Model is even more defined than that and we compliment you for that. I did have an issue in my state with a surplus lines writer out of Tennessee coming with a policy provision that prohibited the use of a public adjuster and frankly, I pushed back on that but was overruled by our Division of Administrative Law. So we went to the legislature in this just concluded session and passed a bill guaranteeing the right to a public adjuster but for residential and I think maybe small commercial as well. So, NCOIL's additions are certainly good for consumers, especially the addition of the public adjuster's defined fiduciary capacity and trust accounts considering the amount associated with many of these claims.

DISCUSSION ON RECENT FEDERAL TRADE COMMISSION (FTC) ACTIVITIES

Rep. Ferguson stated that as you know, the FTC has been very busy recently engaging in rule making activities that can arguably be described as outside the FTC's authority and encroaching on the state based system of insurance regulation. Two examples are a rule pertaining to non-compete clauses and a separate rule pertaining to service contracts. NCOIL submitted a comment letter on the service contract rule which can be found in your binders on page 242 and on the app and the website. Rep. Ferguson asked If the NAIC has been monitoring these issues and if so, does it view the FTC's activities here in the same manner as NCOIL?

Cmsr. Mulready stated that your language is encouraging because of our frustrations with the FTC. In May we sent a letter to the U.S. Department of Justice (DOJ) and the FTC looking for an update on some of these antitrust investigations on health insurance companies and pharmacy benefits managers (PBM), and the improper marketing of health insurance. The rules that state that they will keep us up to date. Unfortunately, we have not heard a word from the FTC on any of this. Not a single response. And in polling each state regulator, not only did they not communicate with the NAIC but they haven't communicated with any of the state regulators which is part of that process or supposed to be. We recently formed an Improper Marketing of Health Insurance Working Group that is quite active in pursuing that exact thing. And something that they're now going into is lead generators and sort of looking into those as well. But unfortunately with the FTC we've had no cooperation or collaboration on that issue. So, a little background on the non compete rule, I think from the NAIC perspective we did not submit any comments on that but we're monitoring it. We're questioning whether they have the statutory authority to do so. And on the negative options component there with the service contracts, I know NCOIL submitted a letter but we have not submitted comments on the proposal but we're just kind of continuing to monitor that as well.

ANY OTHER BUSINESS

Rep. Ferguson stated that we have added two items to cover. First, as you know, some federal regulations were recently issued for comment that deal with things such as short term limited duration (STL) plans and hospital indemnity or other fixed indemnity plans. NCOIL will likely weigh in on this in some manner but we're curious what the NAIC's thoughts are on the proposals, not so much from a policy perspective but from a jurisdictional perspective in terms of federal encroachment on the state based system of insurance.

Dir. Cameron stated that certainly we are still trying to digest what the new rule has in it. There are a number of components that we have concerns with. Just as a reminder in 2016, the NAIC did send a letter in opposition to the rule that was proposed by President Obama limiting STLD plans from 12 months down to three. A number of states will be looking at it individually. I know, for example, in my state we have not only STLD plans but we also have what we call enhanced short term plans which are really the equivalent of Affordable Care Act (ACA) plans. They are by ACA's own standard there, the equivalent of a silver and bronze plan and meet all the 10 essential health benefits (EHBs) and allow for people to convert over to an ACA plan should they desire. We require that the carrier offering those plans also be offering on the exchange so there's an easy transition. CMS has said to us that they like our approach and they'd like us to make the comments and obviously the proposed rules don't align with that. So, we'll be making comments. I'm sure other states who have followed and done something similar will as well and I wouldn't be surprised if the NAIC makes some comments as well. I think for most of us we believe that individuals are better when they're insured and so we want to encourage folks to have coverage and the short term plans have a role to play in being able to access coverage in many cases they help with the early diagnosis of some of the significant health issues that people may have and if they're convertible or they can transfer over to ACA plans then they're not harmed. In our state in spite of our enhanced plans effort we really only have about 7,500 to 8,000 people that have enrolled on them as compared to those that are enrolled on the ACA plans. It's less than 10% so it's not a significant impact to the ACA plans either as maybe some might surmise. So, it certainly was an item at our discussion at our commissioners mid-year meeting and will be an item in Seattle as we work forward and submit comments. We'll be happy to share our comments with you and look forward to seeing yours as well.

Rep. Ferguson stated that you would want things to be seamless for patients when they're making the transition from short term to the ACA. Is it really seamless? Is there a continuity of care when they transition or do they have to get new prior authorization and get new medicines approved? Dir. Cameron stated that in our state it is seamless and it's required to be seamless. Not every state may have that and this is why we have state based regulation. I have devised what works in my state but it may not be what will work in Oklahoma or in Minnesota or wherever but I think that's the benefit. We are the laboratories of innovation and we get to try certain things and maybe replicate each other and try and find a solution so that people can have coverage.

Cmsr. Mulready stated that trying to come together with 50 states on a specific position on that sort of thing is extremely difficult. Right now, we are receiving comments from all states. We will submit a comment letter prior to the September 11th deadline. My guess is it would be limited to as it was in 2016, that we're opposing it from a standpoint of it's

an arbitrary position with 90 days and it should be left to the states. My guess is that would be our position. Rep. Ferguson stated that NCOIL sent a letter in 2016 as well. Dir. Cameron stated that I just also wanted to add one other issue that is in that rule that we're all trying to decipher is the tax implication that is imposed in that rule which says that consumers will be taxed if they are given this sort of benefit through their employer. We're trying to figure out the authority and how that all works and so that may be another issue that we'll want you to weigh in on.

Sen. Gossage thanked Dir. Cameron for the remarks about putting it up to the states because every state has it differently. If it's helpful I have an article that just came out that I co-authored that was picked up by Forbes and others on STLD plans. And I have actual clients who have had them, who had $100,000 worth of claims and only paid their $2,500 deductible. Mostly middle income people who don't get a subsidy on the exchange are the folks who take the STLD plans. It's only going to harm them if they only have the three months. So, I 'd be happy to share any of those stories with you if that's helpful.

Rep. Ferguson stated that the other topic planned for discussion was the work of the NAIC's Valuation of Securities (E) Task Force but we have now run out of time.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Jerry Klein (ND) and seconded by Rep. Lehman, the Committee adjourned at 12:00 PM.

PROPERTY & CASUALTY INSURANCE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 22, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Saturday, July 22, 2023 at 9:00 AM.

Representative Edmond Jordan, (LA), Chair of the Committee, presided.

Other members of the Committee present:

Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Kerry Wood (CT)
Rep. Brian Lohse (IA)
Rep. Matt Lehman (IN)
Rep. Michael Meredith (KY)
Rep. Michael Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. David LeBoeuf (MA)
Rep. Brenda Carter (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Asm. Erik Dilan (NY)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Mark Tedford (OK)
Rep. Carl Anderson (SC)
Rep. Tom Oliverson, M.D. (TX)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Dafna Michaelson Jenet (CO)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Rod Furniss (ID)
Sen. Michael Fagg (KS)
Sen. Beverly Gossage (KS)
Sen. Arthur Ellis (MD)
Del. Mike Rogers (MD)
Rep. Mike McFall (MI)
Sen. Gary Dahms (MN)
Rep. Nelly Nicol (MT)
Rep. Amy Walen (WA)
Del. John Paull Hott (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

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

MINUTES

Upon a Motion made by Sen. Jerry Klein (ND) and seconded by Rep. Rachel Roberts (KY), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 11, 2023 meeting in San Diego, CA.

INTRODUCTION AND DISCUSSION OF PROPOSED AMENDMENTS TO NCOIL MODEL STATE UNIFORM BUILDING CODE

Rep. Jordan stated that we'll start today with the introduction and discussion of proposed amendments to the NCOIL Model State Uniform Building Code sponsored by Rep. Jim Dunnigan (UT) and co-sponsored by Rep. Matthew Gambill (GA). Several states including my home state of Louisiana have enacted laws that encourage homeowners to take steps to strengthen their homes by providing them with insurance discounts if certain standards are met. And I'll just add that we just did this again with the Fortified roof program this past year. The laws do vary in terms of methods of encouragement as some states require the insurer to issue a premium discount if certain standards are met while others make the discount voluntary. And in Louisiana we do make it voluntary. Louisiana also has a program again with the Fortified roofs. Rep. Dunnigan was scheduled to be here but unfortunately he had something urgent come up and he couldn't join us. There are some technical changes to the Model that are wholly separate from the premium discount amendments that are also sponsored by Rep. Dunnigan but since he isn't here today, we're going to hold off on considering them until our November meeting.

Since Rep. Dunnigan isn't here, I'll just briefly present the amendments so everyone can follow along. The amendments are on page 317 in your binders and on the website and the app. The amendments are intended to go into the existing NCOIL Model State Uniform Building Code which is in your binders on page 321 and again, on the website and the app as well. With Rep. Dunnigan being from a state that has been experiencing an increasing amount of wildfires, he's interested in different policy approaches that encourage homeowners and renters to take steps to strengthen their property from natural disasters. As some of us know, NCOIL did discuss these amendments back in 2018 which are based on Oklahoma law but the proposal was ultimately withdrawn as a consensus could not be reached. But with the unfortunate increase in natural disasters this is a very timely topic and I'm glad that NCOIL is discussing it again. Just a couple of more notes and I'll stop. You'll see in the language that the premium discount is only required if the insurer determines that it's actuarially justified and that there's sufficient and credible evidence of cost savings which could be attributed to the construction standards set forth in the Model. Rep. Dunnigan has stressed that he thinks that's important language and protects against unnecessary discounts being issued, which could in turn significantly impact insurer solvency and end up harming consumers.

Valerie Brown, Deputy Executive Director at United Policyholders (UP), thanked the Committee for the opportunity to speak and stated that today, UP would like to highlight the differing approaches we're seeing to incentivizing, rewarding and facilitating mitigation. So, a little bit about UP. We're a national nonprofit. We serve as a trusted

voice and information resource for consumers in all 50 states. We formed after the 1991 Oakland Hills Wildfire. Our Roadmap to Recovery program has served disaster survivors since that fire and Hurricane Andrew the next year and is currently serving Hurricane Ian and wildfires and flooding across the county. We're based in California with a professional staff of 15. We partner heavily with government and non governmental organizations and we leverage our team UP partners and volunteers to provide that insurance education and information across the country. What makes us unique is our survivor to survivor volunteers. When we serve in a community, those previous catastrophic loss survivors that we've worked with continue volunteering with us to help current survivors by sharing their very unique knowledge about the insurance claims process. So right now in California, there's a lot of energy, time and money going into reducing wildfire risk. The Firewise USA program is just growing rapidly in the state. The Insurance Institute for Business & Home Safety (IBHS) is rolling out their Wildfire Prepared home and they are testing that in Paradise. We spent the last three years working on what we call the Wildfire Risk Reduction and Asset Protection (WRAP) Initiative and we have a resource center dedicated to that and what we're doing is really helping property owners know what to do in how to improve their home's chances of surviving a wildfire. We're all working on the same page to make that happen. This is our WRAP resource center, which provides those very hyper local resources and ways to assess your home and checking for those insurance discounts to motivate homeowners to take those steps and how to get started.

Some things we can't do – we can't control the weather or those earthquakes or any of these disasters. We can't put that modeling drone imaging back in the bottle. We can't force property owners to make the improvements if they can't afford to make them. And what we can't do is leave property owners and their mortgage lenders without insurance options. But what we can do is coordinate among these stakeholders and partners. We can research risk reduction. We can facilitate risk reduction and incentivize it and reward it and provide financial assistance for that. And that's one of the things we do in our WRAP resource center is not only talk about those mitigation steps, but what grants and funding opportunities are there for homeowners to make a difference. And these are the imperatives as we see them. We need to understand what is effective in risk reduction techniques and options. What's going to move the needle? What will insurers validate that will improve a home's protection? We need to establish those standards, the partnerships and viable mitigation support programs to make it. Because the goal is to preserve affordable, quality property insurance options. The options that we see are premium discounts and you can see mandatory with specific percentage, mandatory but not a specific percentage, or voluntary. California is doing a statutory limit from non renewals to provide protection in communities impacted by wildfire. Insurer funded mitigation is also an option. We're seeing some of those pilot projects. There's right now a lot of dollars being put into government funded mitigation as well and so talking about IBHS, you know the mandated discounts based on their standards, most statutes that mandate those discounts require that they meet an insurance industry standard. And as Rep. Jordan mentioned the Fortified program is a standard. There's in California also a program called Safer From Wildfires. And focusing on IBHS, what they did with Fortified really has moved the needle as far as wind events and what they're doing now in the pilot project for the campfire is taking all of the research done on fire damage and wildfire in general, and putting that into a similar program that they're piloting in Paradise, California, which was impacted by the 2018 campfire.

And I'm not going to go into detail on these as a lot of this is so you have this as reference but these are the details of the Fortified gold and silver programs. So just touching on the Mississippi code, they required the licensed insurers to provide a mandated discount rate to anyone who follows the IBHS mitigation standards. It's a very limited subset of people that are impacted and has it available to them. It's only required for policies that provide wind coverage and only to homeowners in selected coastal cities and it excludes multifamily manufactured homes and businesses. So the requirement to offer and notify, some states do require that and others don't mandate and some of these programs are just voluntary in a community and I'll touch on few of those in just a minute. And so for this one I think we all agree in the west there is a need for wildfire mitigation and so we need to provide a way to motivate people to take advantage of this. So right now in the west we're experiencing an ever growing availability and affordability crisis and you've seen national news on insurers in California specifically that are just not taking new policies, they're not issuing them. They're raising premiums on the customers they keep. Some of them are imposing mitigation requirements in excess of state requirements that are just not feasible for people to do. I have one homeowner who was required to clear 100 feet out. Their property line goes to 30. They cannot mitigate the next 70 feet because that is their neighbors property so they're in a situation where they cannot bend. And this is leaving people in rural areas, especially rural Californians, with very limited and expensive options so they're looking at surplus lines. They're looking at the California FAIR Plan which is about 300,000 policies currently but that will grow a what's causing a lot of the issues here is this risk classification based modeling, using FireLine and CoreLogic. That's what's dominating a lot of insurer's underwriting criteria and to put it in perspective, FireLine, which is used by insurers in 13 Western states has a scale of one to 30. In California, most insurers will not underwrite a home with a score of a four. You've got to be a one to three. Two years ago, it was a six. That keeps dropping. And what's interesting, it's dropped after the larger wildfires. So in 2021 and 2022, less wildfires, more acres lost but less wildfires damaging, destroying homes. But the score keeps dropping.

CoreLogic has a scale of one to 10. It's used in 15 western states and Florida. And I met a gentleman at a presentation before flying out here who was not renewed by his insurance company because he has score of a two. He's 20 blocks in from the wild urban interface area. There's nothing he can do to improve his score. He's done all the mitigations and he has a two on a scale of one to 10 and he can't get insurance. So talking about California just briefly as a case study. The tree mortality was a big driver of this beginning. Climate change is obviously pushing it over and this over reliance on the use of risk classification models. They're just creating this perfect storm we're seeing of insurance unaffordability and unavailability in those brush areas that wild and urban interface. So from our 2017 survey, 47% of homeowners were told that high FireLine score made them uninsurable. Most of those people, their insurance companies were not making recommendations of things they could do to mitigate that risk in order to reduce that risk. The survey we just completed in 2022 saw 72% of the homeowners were told a high FireLine score made them uninsurable. Bear in mind, when you look at a scale of one to 30 and you tell me high I'm thinking 15 or 20 as a score. The idea that it's a four is very confusing for consumers. And then 94% of those said that their insurer had still made no recommendations on what they could do to reduce that risk. During this time from 2020 to 2022 in the state of California we've seen an explosion of activities to define that science including the IBHS program that has rolled out but it hasn't translated yet into insurers providing some guidance on what people can do.

So who can be part of the solution? The Fire Safe Councils and Firewise communities. Obviously government and community organizations. Very much so insurance commissioners and we believe heavily that insurer-insurance partnerships and working with the community are key to making this happen. And so here are three successful programs that we've seen. Wildfire Partners in Boulder, Colorado is doing a really good job. I'll talk about them a little more in a minute. The Firesafe Council Program does an excellent job and they're good at securing community grants to help leverage what individuals are doing for the community and we're seeing in the western states, the western fire chiefs are putting in a lot of effort into coming up with programs where they're helping their communities and leveraging federal and state dollars to make that happen. Talking about Wildfire Partners, it's a partnership between Boulder County, the Federal Emergency Management Agency (FEMA) and the Colorado Department of Natural Resources. They provide an inspection looking at vegetation in the defensible space. They do a 50$ cost sharing up to $2,500 if you hire one of their contractors and this is certification that USAA and Allstate recognizes as proof of proper mitigation. State Farm uses it for renewals, not for adding new clients. And they presented to us last time that we checked with them last week that no insurer has denied coverage for a homeowner who has presented that certification so it's very good news for those consumers but it's a small program. It doesn't even cover the whole county. Nevada County, California, their Fire Safe Council has two pieces. They have their Advisory Visit on Defensible Space and so they're going to check compliance with our Public Resources Code there and that's 100 feet of defensible space. And then they'll provide grants for people who have financial need and so in that safe area is a unique partnership where Allstate and insurers actually are providing part of the dollars for those grants.

And then there's the Defense Space Verification Service and so they're coming back to see that they complied because for insurance purposes the insurer wants to know with that vegetation mitigation that it is ongoing, that it's not a one and done. Replacing your vents, doing home hardening actions are a one and done or a one and done for many, many years but for that vegetation management that needs to be done at least annually. And what we found in Nevada County the defensible space verification has usually been accepted as proof that they've done enough but now we're starting to see denials and as part of this we were finding just like with the Firewise program and the Boulder program that the insurers are offering that 5% discount but it's not mandatory, it's voluntary. It's not uniform and it's very much subject to change. This is just the chart we have. We spent those three years when everybody was locked down with COVID working on this project, the WRAP Resource Center. And these are the mitigations that we came up with that the Department of Insurance did and Cal Fire and they also align very closely with what IBHS rolled out last year in Paradise, California. This is the Firewise USAA program. This is where a community comes in and they become "recognized community" and so this again provides some discounts that are voluntary in there for consumers but it involves a larger process. It's not what an individual consumer is going to do. It's a larger effort and they have to do very specific Firewise actions for the year and get their application approved.
And so here are the discounts available on policies and the states that honor them. You can see the years that they came into being. And so here are the problems and the potential solutions that we see. So these are all good examples of voluntary programs, but without legislation that mandates compliance as automatically eligible, homeowners

can and are mitigating all that they want, but it doesn't matter to insurers. That's what we're finding. So, there's no reward for taking those steps to be a partner with an insurance company. Insurance Commissioners need an increased oversight over the use of wildfire models that don't account for mitigation or local firefighting capacity. Because we're seeing that FireLine score or CoreLogic score is being presented as the sole underwriting criteria for these issues. And then going back to just overall the big picture, establishing uniform mitigation criteria just like with Fortified homes that's accepted by all insurers so it's not mickey mouse across different states in different jurisdictions can help prevent market disruption.

And so just to talk about wildfire specifically, the pullbacks we're seeing feel very oversized compared to the damage. So between 2005 and June 2022, Headwaters Economics reported that 97,000 homes, businesses and other structures were destroyed by wildfires. The top 10 of those wildfires occurred in California, Tennessee and Texas. So just compare this to one hurricane in one year. Katrina, 850,000 homes damaged or destroyed. Sandy, 650,000 homes destroyed. So over 17 years you're looking at less than 100,000 homes having been destroyed but the market is reacting as if our stats are this is every year we're having these major disruptive events. So just keeping that in mind as you're thinking about mitigations and about the uniform mitigation criteria, without that insurers are going to have no faith in the system so setting a level playing field that consumers know where they're aiming to be so that insurers have faith they are actually doing those steps that are realistic and follow science is key.
Hilary Segura, Assistant VP and Counsel, State Gov't Relations at the American Property Casualty Insurance Association (APCIA, thanked the Committee for the opportunity to speak and stated that I would say that the key to improving insurance affordability and availability is by reducing overall losses and insurance discounts can provide a helpful financial incentive but the focus should not simply be on providing a discount. Insurance rates must accurately reflect the risk and be developed through sound actuarial standards of practice for the system to work properly and not result in harm to the market. An effective insurance based mitigation program must be carefully considered to ensure it incentivizes the right actions that ultimately benefit consumers and facilitates a healthy insurance marketplace. There are in our view three keys to an effective insurance based mitigation incentive program. First, APCIA does oppose any sort of mandate, so any program should be voluntary, flexible, and limited in scope. But we also say that laws and regulations should also be limited to residential property lines due to the complexity of large commercial line accounts. Second, it should be verifiable, grounded in science and risk based. Prescribed mitigation actions must scientifically demonstrate a reduction in risk with premium credits actually reflecting the actual level of risk reduction. Discounts must be based on actuarially credible data and applied to actuarially supported premium components for the peril. And third, any program must be cost effective, consistent and complementary. The costs and measures needed to implement an insurance based mitigation incentive programs shouldn't be excessive, thus negating any potential savings the mitigation program would provide for a consumer. It also should be consistent with any local codes and ordinances so insurance incentives help reinforce efforts of the state and local government officials and amplify other financial incentives. As Rep. Jordan mentioned, Louisiana did take steps hand in hand with encouraging the discounts on insurance. The state did fund a program to incentivize residents to take steps to fortify and helped fund it. We would certainly encourage states while they're looking at this proposal to also take a look at

providing funding and incentives in grant form to residents to take proactive actions. APCIA has been proactive in this mitigation space and we're looking forward to being a constructive partner with NCOIL as this proposal moves through the process.

Matt Overturf, Regional VP, Ohio Valley/Mid-Atlantic Region at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that to begin today's conversation, it's important to point out that insurer's core responsibility is to understand and mitigate or manage risk. Disaster mitigation is not a new issue for property casualty insurance which since its inception has concentrated on extreme weather and focused on seeking ways to minimize the physical and financial effects of weather events on policyholders. From a public policy standpoint, the property casualty insurance industry has focused on extreme weather events for decades and has been working to advance resilience in policy, and reduce the effects of weather events in the states and on Capitol Hill. With this in mind, however, NAMIC opposes the concept of mandatory discounts. Mandatory discounts effectively do little to mitigate risk. In order to effectively bend the risk curve a broad adoption of comprehensive mitigation action is required and state experience illustrates this. So looking across the states, states that have adopted only a mandatory discount have far fewer Fortified designations than states that adopt a more comprehensive approach that includes grants, building code supplements and tax deductions for example. In addition, we are also concerned with the impact mandatory discounts could have on innovation and competition in the property insurance market. If all insurers are required to offer a discount it is likely to look similar across the marketplace whereas a permissive approach would allow and encourage an insurer to offer programs in a given state to differentiate themselves among their competitors. And finally, we are concerned about the potential costs to implement such a program, specifically on smaller insurers and in smaller states. It is with this in mind that we oppose including mandatory discount language in the Model, but we do support the continued dialogue around disaster mitigation in a comprehensive manner. And I'll just close by stating that we've had several conversations with Rep. Dunnigan and other members of the Committee and we look forward to continuing those conversations as we go forward.

Rep. Mark Tedford (OK) stated that the question I would have as far as your comments on the wildfires and the damage - I think the reason why the industry looks at wildfires differently than hurricanes is because the wind pools in those states bore the brunt of it. So, in California with the FAIR Plan there's been consideration to develop a market around the FAIR Plan like some of the coastal states have done to where you're buying an insurance product that excludes the peril that's the problem and then just buying that peril from the pool in that state. Is a Model being considered for that in California? Ms. Brown replied yes and stated that with the California FAIR Plan what we have are difference and condition policies where you can add those additional perils. And like I said, currently the California FAIR Plan is only about 300,000 policies. Most people in this state are able to find insurance elsewhere so it's not that it's a huge risk that there are a lot of people being impacted by it currently. But as the market tightens they're going to see more business. And so there's that piece. But the reason I brought up the Hurricanes is just the scale. When I talk to people about wildfire risk in their head, they're equating it with every fire is disastrous where you're looking at 20,000 homes destroyed and that's not the case and so putting it in perspective is helpful to look at the scale of the disaster that actually happens. Because it's not a lot of people impacted overall but it's having a very outsized impact in the areas that most likely will not face a

wildfire and I'm not going to say will not because we all saw Malibu burned all the way to the Pacific Ocean in 2018.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, asked if there was any data on whether the discount is more effective than the loan program in terms of participation? Mr. Overturf stated that IBHS has a list they keep of who has the Fortified designations in each state. Looking at those, the states where it's just a mandatory discount they have a far fewer number. Oklahoma for example has 17 Fortified designations in the entire state. They've had a mandatory discount for six or seven years. Whereas Alabama has a more comprehensive program that includes grants and some of those other things and they have over 41,000 designations in the state. Ms. Brown stated that and I'll add for wildfires because it's not mandatory in California that you get the discount, for California we have a lot of utilities, because utilities sometimes cause the fires and a lot of jurisdictions that invested very heavily in grants and loan programs from mitigation. And those homeowners when they take those steps then are still often dropped because they're in those wildfire risk areas that are very high severity. And so you've got people who are taking the steps and then not able to get insurance. So from their perspective, having the guarantee of if I take these steps and I take advantage of these loan programs, if I can retain my insurance because again, it's affordability and accessibility, right? So in California it's a little different that we're looking at accessibility is just as big an issue as affordability.

Rep. Ferguson stated that my daughter lives in California and her insurance after the fire went from $4,000 a month to $13,000 a month and $6,000 of that is FAIR fire. What about people who have mortgages on their house, are the bankers still requiring them to have homeowners insurance? Ms. Brown replied yes and stated that for UP, we've been meeting with Fannie Mae for a couple of years now working on what that looks like and how that impacts the market and actually we just finished a white paper project with them on manufactured home insurance because that's a different animal but with wildfires it's incredibly not helpful as far as giving people the tools they need to recover.

Rep. Stephen Meskers (CT) stated that I haven't delved deeply into property-casualty but I'm certainly interested in your views here and I'm trying to understand the argument and discussion we're framing. And one is between either a mandate on the insurance companies in terms of offering discounts and providing preventative measures for property casualty damage whether it be for fires or for hurricanes, etc. The second is whether or not we as legislators should be looking at mandating practices for homeowners for that same issue. That seems to be part of the argument and I wanted to have that discussion and the second question is in terms of if we're having trouble with access to insurance, does that become a legislative issue in terms of where we mandate the level of coverage or the pooling for a certain catastrophic insurance? Because if you've got hyper local risks of fires, do you subsidize that with the assessment on the general pool.?

Ms. Brown stated that for the second piece I would actually defer to our Executive Director who I believe is going to be presenting in one of your upcoming meetings, because I know a little bit about property casualty but I 'm long term recovery and wildfire stuff. I've been doing that for 15 years so I know this piece for the consumers very intimately. That piece is above my pay grade to be quite honest but I will say if you notice our presentation we didn't make a recommendation on what to do because it

needs to be a very collaborative process to figure out what's going to work in your State. But having that framework that has uniform standards consistency, at least in your state so that insurers know what the playbook is and your consumers do and pairing that with you as legislators looking at providing those grant pools and getting those FEMA grants and then doing matches to make that work to help consumers do that, I think that's going to be very key to what you're doing. I met a gentleman who did $75,000 worth of repairs two weeks ago. He replaced the vents in his house. He put a class A roof on. He did all of these things to meet what the state standards by the California Fire Department are and it matches what IBHS requires. So he met the standards for the new home construction in California. He met the IBHS standards and he's looking at that saying, "Okay, I'm doing everything the science says I can do, including what the insurance companies research body says I can do to mitigate wildfire risk." He was still dropped and so his resource is to go to the California FAIR Plan which is just fire and then you have to add your additional, your living expenses, your content, any of those other coverages are not included. You have to add all of those on. I have a consumer two months ago who gave me a $36,000 policy per year and they can't afford it. And remember, for people who have a mortgage, they don't have an option not to have it and if they don't, they're going to get a forced lien policy. It's the bare bones policy that just covers the loan. They cannot rebuild. They've lost all the equity they've put in that house over the years. They have no additional living expense coverage. They have no contents coverage. No liability. So, they're stuck and so what do they do? And that's one of the reasons why the lenders are looking at this issue. We've met with Treasury on these issues and everybody's concerned because if we can't come up with the solution it's going to impact the larger financial market in the country.

Mr. Overturf stated that I'll just add really quick on wildfires from our perspective. It's probably the most unique of these disasters that we talk about because when it comes to wind and hail, you can mitigate your own individual property and that can help you. When it comes to wildfire it is much more community wide where you can do things to your individual property but at the end of the day to really make that impact you have to kind of go from the top down from a community across the board. You could do whatever you do to your house on a wildfire but if your neighbor has done nothing you might be a little bit protected, but still there's going to be a higher risk of damage and negative consequences to you even though you've done what you can do. You kind of have to look around you as well.

Ms. Brown stated that one final thing to throw on the uniqueness of wildfire - in most other disasters that we're talking about with these risks that you can mitigate, wildfire recovery is more expensive. Because an insurance policy is not looking at you've got to replace that foundation. There are unique costs related to total loss with a wildfire that you're not seeing in most other disaster insurance claims and so preventing those houses from burning down to the ground is incredibly helpful to everyone involved - the insurers and all of us.

Rep. Jordan thanked everyone for speaking and stated that if there are any other questions or comments on this please reach out to Rep. Dunnigan, myself or the NCOIL staff.

INTRODUCTION AND DISCUSSION OF NCOIL CATALYTIC CONVERTER THEFT PREVENTION MODEL ACT

Rep. Jordan stated that next on our agenda is the introduction and discussion of the NCOIL Catalytic Converter Theft Prevention Model Act (Model), a Model that I am jointly sponsoring with my good friend, Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President. You can view the Model on page 346 of your binders and on the website and the app. And as a reminder, we had an introductory presentation on the issue at our last meeting in March and we're now proceeding with the development of the Model. I think it's a good issue for NCOIL to get involved with. I can tell you in my home state of Louisiana, we have had some issues with this and we have tried to address it with some legislation but although we've done that a couple of months ago, some data was released showing that Louisiana has had a near 3,000% increase in catalytic converter thefts since 2019 so I'm not sure how effective we've actually been. It's one that we're continuing to address.

Rep. Oliverson stated that it's an honor to work with you again on some good policy here. My home state of Texas actually is ranked number two nationally in terms of the total numbers of catalytic converter thefts occurring annually. So, this was brought to a head in our state with the tragic and untimely death of Harrison County Sheriff Deputy Darren Almendarez who was gunned down in a grocery store parking lot by three men who were attempting to steal the catalytic converter from his personal vehicle. Texas recently passed a law very similar to the Model which essentially not only increases the penalty for theft of the catalytic converter to a felony but also allows district attorneys to prosecute offenders under the organized crime statutes. This is obviously a serious problem. This is a high number of claims. It's leading to a tragic loss of life and so I'm honored to work with you on this. I would throw out one other interesting tidbit and that is that in my home county, having recently visited with the Chief of Police for our third largest school district which is almost 200,000 students and close to 100 campuses where they actually apprehended one of these catalytic converter theft rings in one of the high school parking lots they ran into an issue where the district attorney decided that because it was a property crime and they had bigger priorities even though they'd sort of caught the main guy red handed, they decided not to accept the charges and so one of the other things that may be of interest to you in your states just depending on your appetite for this is that in Texas we recently passed House Bill 17, which added to the list of reasons why the district attorney could be removed from office through a judicial process, an unwillingness either publicly expressed or through a matter of policy to refuse to prosecute entire categories of criminal activities. So, sometimes you need the carrot and sometimes you need the stick but it's an honor to work with you on this.

Pat Martin, Senior VP & General Counsel at the National Insurance Crime Bureau (NICB) thanked the Committee for the opportunity to speak and stated that in this presentation, what I'd like to do is just touch on what was covered in the last meeting in March but also go into a little bit more detail on the Model and then also answer any questions you may have. We know that a lot of your jurisdictions have either considered or are continuing to consider legislation, either new or enhancements to existing legislation in your jurisdiction to address this important problem. And we think the Model and what Rep. Oliverson said goes a long way giving your jurisdictions some additional tools to deal with this very devastating problem. So just in terms of background, not news to anyone here, there's an explosion in this type of theft since 2016. It has gone up 1,200% since 2019. What that means in terms of numbers as reported to NICB through really the claims process we have access to claims as to catalytic converter

thefts, it's over a 110,000 thefts that were reported. And we don't know whether that represents a majority or just a portion of the theft problem because not all thefts are being reported obviously. Some victims of this crime are not reporting them because they don't want it to be part of their insurance claims history which may impact their premium. So, we think it's a much more significant problem but what we can tell this body is that of those 110,000 thefts since 2016 about two thirds of those have occurred in 2021 and 2022 and we don't have the numbers yet for 2023 so the problem's not going away and if anything that's going up. The other thing we can say with certainty is that the consumer impact is significant. So, your constituents are out there. They need their vehicles obviously to go to work, bring your kids to school. Go to extra events. To just live life. And when a converter is stolen from their vehicle, it can take weeks, sometimes months to get that vehicle repaired.

So this is a significant quality of life issue that goes well beyond just the loss of the value of the catalytic converter because the cost to make a person whole sometimes can be captured in terms of lost time at work in terms of inability to bring their children to school or not have to arrange for alternative methods or for the the cost of the insurance industry as well in terms of getting their policyholders back the whole. So the impact could be fairly devastating in some instances, not to mention sometimes these catalytic converter thefts lead to violence as Rep. Oliverson mentioned and I think as was mentioned by my colleague in the previous session where it resulted in a law enforcement officer who was trying to prevent a theft dying at the hands of these criminal actors. So, it's a significant issue and we're glad to see that many of the states are interested in addressing it. We'd just like to help you have tools to bring back to your legislative bodies to enhance the ability to address this very significant problem. I'm not going to cover what a catalytic converter is but if you have any questions regarding that please just direct them to me either in the open session or after the session. So very quickly on this, this is just to represent that the states have taken action on this both in the past and more recently in 2022 and 2023. You'll see that the majority of the activity occurred in 2022 and 2023 to address the increasing threat of the crime and the impact of the crime in the last several years. What this is also supposed to represent is the variety of ways in which states have to address this, either in short form or long form and in some ways, maybe not a comprehensive way, consistent with the Model that's being proposed. And so there's a lot of variety out there in terms of how it's being addressed and importantly, the criminal rings that deal in this fairly lucrative crime, they don't operate within state borders so a lot of this is multi district and oftentimes, even though the thefts occur in one place, perhaps the sales occur in other places because in those states there are not as many restrictions on buying and selling catalytic converters and so the bad actors are smart and they're going to limit their exposure and the patchwork of laws across the U.S. makes it easier for these criminal rings to operate. So, one of the efforts here with the Model is to bring everybody up to the same level of preventive and deterrence through this Model and to the extent the uniform Model can be adopted in large part across the many states, it would make law enforcement response to this crime more effective.

Basically, there's been four themes to addressing this problem: new or enhanced criminal statutes; scrap yard regulations like record keeping type regulations to make those transactions a little bit sticker so that law enforcement and other regulatory bodies after the fact can get the information they need as to whether a seller or buyer is a legitimate seller or buyer or is involved in some unlawful activity; buyer-seller restrictions

including identifying where the catalytic converter was recovered from or taken off of; and then in some instances including Texas, presumption of guilt or really inferences of criminal intent which is sometimes hard to establish. Just real briefly on the federal response, it's become such an issue that Congressman Baird has introduced a bill that would provide for a unified response across the U.S. and it includes certain themes that I discussed on that previous slide and are in the Model. I'm not going to go into great depth here because even though it's been introduced and there is a lot of support for it on the House side and the Senate side it's just not getting a ton of traction right now and as it goes with many things in the federal government they are probably going to address it after many of the states have. So, it's really incumbent upon this body and state legislators to take action in order to curb and deter this problem. Real quick, and this is where I want to spend a little bit of time here. We have four different buckets, or themes for the Model overview, now only one component of it is really to enhance the criminal penalties. For some states, a new statute is required but for most states it's an enhancement. Many of the states for property crimes, not surprisingly, will have a threshold amount that differentiates between a misdemeanor offense and a felony offense. The Model would make the theft of a catalytic converter a felony offense and that's important for reasons similar to what Rep. Oliverson alluded to, which is when prosecutors, law enforcement are trying to decide where to dedicate their resources they are seeking to follow what legislators are deeming to be more significant crimes. Clearly, when you identify a crime as being punishable as a felony, legislators are saying this is a more significant crime and you should prioritize that over misdemeanor offenses so making it a felony offense is an important move for many states not only for the thieves, but also as you see there below for receiving stolen catalytic converters, in many jurisdictions receipt of stolen property is a misdemeanor offense or there are less penalties associated with that. By bringing the receipt of stolen catalytic converters up to the same level of punishment as the unlawful seller it allows for greater enforcement mechanisms and increases and enhances the importance of the enforcement mechanism. There's also an aggravated theft provision in the Model for repeat offenders and those individuals who commit the theft while armed.

The Model would also provide for limitations on buyers and sellers. I'm not going to spend much time on buyers. It's typically record keeping restrictions as well as identifying the seller and putting some onus on the buyers so that the buyers can't claim to be unwitting recipients of these stolen catalytic converters. Where a lot of the action takes place in the Model is on the sellers. There is a bevy of different types of provisions that can require certain additional record keeping requirements of the sellers and some verification requirements on sellers that they be licensed or otherwise registered to be able to sell catalytic converters. That can occur with existing regulatory requirements but also certain a stickiness on, or example, the sales. Not on this slide, but one of the proposed provisions is a limitation on sellers that they not be allowed to be sold to individuals under the age of 18. Why is that - so that bad actors are not using juveniles to commit their crimes. There's also a proposed restriction in terms of regular business hours so sales occurring in the dark of night after 9:00 PM or before 6:00 AM when some of the nefarious activity may occur so trying to bring this back into the transparency of daylight and regular business hours and seek to regulate sellers so that it becomes more of a regular business that can be regulated and also for law enforcement after the fact when they're looking at this they can hold non compliant sellers responsible.

And then finally, and we think this is an important a part of the program, is an etching program. So previously I showed the federal legislation and it includes a stamping program. There's just a small difference between stamping and etching. Many of you may be aware that stamping is more of like a typeface and requires certain specific machinery to do, mostly with manufacturers. You can get it elsewhere, but mostly with manufacturers. Etching would allow for ease of execution on this for our etching tools that can be used to etch in the vehicle identification number (VIN) on these catalytic converters. It's much easier for regulators and law enforcement to track illegal converter sales and illegal activity if there's a way to identify the actual part and so part numbers and VIN numbers etched on the actual catalytic converters, sometimes with the anti-theft spray paint can be a very effective tool for law enforcement after the fact when they're trying to identify bad actors. And importantly, this would not be funded by appropriations. It would be funded by fines coming out of violations of these offenses so it would be a self funding type program and it would allow for any number of individuals and entities to provide the etching service. I know NICB is actively involved in this area. We just do it as part of one of our many services we provide the public and our members and we work with law enforcement closely to do this on Saturdays and it's not actually that surprising how many consumers are willing to take a little bit of time out of their schedules to come in and get their catalytic converter etched so that when some bad actor gets underneath that vehicle and looks up and sees the etching decides I'm just going to go to the next house. It doesn't take long to remove a catalytic converter, it could be less than two minutes if you have the right tools and so it is actually a fairly effective way to turn would be thieves of a catalytic converter to see that there is actually some identification on the catalytic converter that they're thinking about stealing.

Sen. Arthur Ellis (MD) stated that I'm always aware of unintended consequences to legislation so in making the buyer of a stolen catalytic converter subject to felony penalties, if you have a legitimate buyer, a legitimate business, what responsibilities will they have to verify that that seller is legitimate also? I mean someone with our modern technology and computer knowledge can easily forge things and make their documents look like they are real so how would you address that particular scenario? What type of responsibility would the buyer have to do due diligence in dealing with the seller? Mr. Martin stated that is a great question because it's harder on that side of the equation. For sellers, folks who have ongoing business, and most who are licensed are regulated there already by the state. It's going to be easy for them because they have existing systems. On the buyer side maybe it's a one-off buyer or maybe it's a scrap dealer. But the suggested buyer restrictions would be a validation that you have a business that is licensed or regulated and most of that can occur through open source. You can go on the internet and you can see where a particular individual or entity is licensed with the state to conduct that type of business. Also the seller under the Model is required to provide the purchaser with certain validation documentation so the buyer should also be receiving that documentation and that includes things like a valid ID, maybe proof of their licensure an also information regarding where the catalytic converter came from. So it's a very appropriate question to ask. How much are we going to actually require of our buyers and how much will they actually do? But I think in combination with the seller restrictions and the transaction documentation that would go to the buyer and then the buyer has kind of minimal requirements to make sure that they have a legitimate seller, it provides some mechanisms to put some onus on the buyer as well.

Rep. Jordan then recognized Nick Steingart, Director of State Affair at the Alliance for Automotive Innovation (Alliance) for comments. Mr. Steingart thanked the Committee for the opportunity to speak and stated that the Alliance represents the manufacturers that produce nearly every new vehicle sold in the U.S. on an annual basis. We heard from NICB both in San Diego and now so I won't rehash short of the issue and the trend and what's causing the uptick in the catalytic converter thefts. I think they have very thoroughly explained why there has been this increase over the last couple of years. Obviously this is an issue that's touched and hit the automotive industry and consumers hard over the last couple of years so we're glad to see NCOIL working on a Model. My comments are relatively brief. We think by and large this is a fantastic Model. I would urge a bit of caution against the VIN program in the final section of the Model. Now, we understand this is voluntary so there's no mandate or requirement of consumers to have their catalytic converter etched or stamped or marked or whatever method you want to use. But in our experience, it's potentially a costly program that delivers negligible returns and that's for a couple of reasons. One, if your catalytic converter is stolen it doesn't really do you any good if it was marked or etched or stamped - your vehicle is virtually undrivable, if not illegal in most places and thieves can simply deface or scratch off the etching without damaging the valuable parts of the catalytic converter which are on the inside of the part. Two, we don't think it serves as a really meaningful deterrent. Let's say in a generous scenario, one out of every 100 vehicles is stamped with a VIN or a tracking or a serial number, it might on an individual basis save you from having your converter stolen but is it going to make a widespread impact if a thief knows he can just slide under the car next door and steal that converter? Maybe not. We think that the best way to target these thefts is by cutting off the illegal market which the rest of this Model does a good job of dealing with those limitations and restrictions on purchasing and selling of catalytic converters. So, there are a lot of layers in the Model that we think do serve as a good meaningful widespread deterrent to crack down on catalytic converter thefts and we think that's the best way to target this illegal market is by going after those unsavory actors who might be purchasing and reselling these converters for the contents. So as I mentioned I think 95% or more of this Model we completely agree with and is in line with legislation that we've supported in the states over the past couple of years and focus on those chain of custody requirements and those record keeping requirements. So we're happy to see NCOIL work on this and thank you, Chair Jordan and Rep. Oliverson for bringing the Model forward. We think it's certainly a step in the right direction. There's by our count 40+ states that have dealt with this in some way, shape or form and this is a really good comprehensive way to address this issue.

Rep. Kerry Wood (CT) stated that as an insurance legislator my question is really to our colleagues here. So, your catalytic converter gets stolen and what I have been hearing is that people are paying $500 and $600 out of pocket to get their cars back online. So, what Model language regarding insurance or what have you done in your districts to kind of help people get their cars up and running? My colleague is an attorney. One of her constituents' catalytic converters was stolen and the insurer deemed it as a total loss. So, we can do all these things to make the penalties tougher and try to go after the illegal industry but on the insurance side how are we helping our constituents get to work as soon as possible without having to pay all this out of pocket if you're experiencing this crime? Mr. Martin stated that I don't think there's a clean answer to that. I think that it's a tough question. The reality is just as you said, which is when the consumer has a catalytic converter stolen they have a couple options to just take it into an automotive dealer and try to get the part replaced at extensive cost, which is probably not really an

option, or to make a claim with insurance and then potentially impact their premiums somewhere down the line because every claim will ultimately find its way back into a premium somewhere down the line. We know that. So there isn't I don't think a really great answer, at least from our perspective and we're focused or the enforcement side of how the insurance industry can make the issue a little bit easier. Those deductibles can be significant, $250 to $500 and then getting it back online still takes many weeks although the insurance industry from my understanding has been pretty good about when a vehicle goes down if the coverages are there providing rental vehicle and other means of getting around, but I don't think from my position I can add much to your question.

Rep. Oliverson stated that Rep. Wood's questions is a really good one. I would say at least from what I'm hearing and what I'm seeing in my home state the real issue right now isn't the ability of the policy to cover that as a loss. I think the sticking point at least in Texas right now is that it takes about literally 15 seconds for them to steal the catalytic converter by sliding under the vehicle, getting it, cutting it off and they're gone. And unfortunately I'm sure everybody's heard this 1,000 times but because of supply chain problems, consumers are finding it difficult to get that catalytic converter replaced in a timely fashion. And so, I can't speak to the individual situation of having the car totaled but I know my office has heard from auto dealers and from consumers alike that the actual getting the vehicle back on the road is a lengthy process, mostly due to lack of supplies because these devices have a certain amount of rare minerals in them that are metals and that's the reason they're stealing them. So I'm just telling you what we've seen so I think it's more on the supply side. One of the other things that we've seen fortunately is that a growing number of auto dealers, particularly cars and trucks in Texas at least, the one that everyone knows about is the large Toyota truck, the Tundra which actually has two catalytic converters. That's sort of the goldmine for a thief and so what the dealers are doing a lot of times is prophylactically before they sell a vehicle they're installing these metal cages on the underside which don't make it impossible to steal but makes it to where somebody goes under the vehicle and sees the cage there and now it's going to take five minutes to remove it so they just move onto the next vehicle so it serves as a bit of a deterrent. And so we're starting to see that happen a lot where dealers are either doing that as part of a dealer charge for the vehicle putting the cage on or they're talking to you when you purchase a vehicle and saying would you like us to add that. It's $150 or $200 for us to get under the vehicle and put this theft deterrent device on so kind of like putting a security system on your car I guess.

Rep. Camille Lilly (IL) stated that I have two questions. One is - is there a study or profile of these bad actors who are taking these catalytic converters? And then two - have you heard that this type of program would be somewhat of a penalty enhancement issue in some states that are trying to get away from that? Mr. Martin stated that I think the short answer at least in my knowledge is no to your first question. I think it's a crime of opportunity based on what we've seen and all types of criminals are just seeing this as a an easy, quick way to make money if it takes less than two minutes to remove a catalytic converter and the rare metals within them can be sold for $500 or $600 per pop. It's a pretty lucrative way of doing things and it doesn't take a high deal of skill so it literally takes a reciprocating saw and you're willingness to go underneath a car and jack it up and remove the catalytic converter, sometimes not even jack it up. So it's just kind of a very low resistance crime. I think what we've found in terms of those who have been caught is that it's a gamut of bad actors. I don't think there's a profile for that

necessarily. It's just a crime of opportunity. For your second question, I don't think we have received direct outreach from legislators saying "hey our legislative body is really against increased enhancements to criminal penalties across the board" but we're aware of it certainly and I think you as a legislator and other legislators are very much aware of various jurisdictions trying to get away from just enhancing penalties without covering the other side of the house and so we're sensitive to that and ultimately it would be a matter of enforcement as well. So, it does give additional tools to law enforcement but they still have to make the decision to dedicate resources towards it and avail themselves of those tools and potential enhancement through sentencing. So I think it's more of expand the toolbox versus dictating, mandating that they enforce that way and so certain jurisdictions would probably take advantage of it and certain jurisdictions would not, I'm sure.

Rep. Forrest Bennett (OK) stated that Rep. Wood's comments made me think about this from a constituent standpoint. We're trying to cut down on the instances of theft but on the other end of it if a catalytic converter is stolen and a claim is filed you know as an insurance agent we always have to decide whether the claim is worth the chance of their rate going up. So, do we have any protections for consumers as far as if their catalytic converter is stolen, an assurance that their auto rates are not going to increase at a time when they're already increasing and I don't know if we've already had this conversation and I just wasn't here for it but that's just something that Rep. Wood's comments sparked for me. Mr. Martin stated that there's nothing in the Model that would address that aspect of the potential order of events or consequences if somebody would make a claim on a stolen catalytic converter. Rep. Matt Lehman (IN), NCOIL Immediate Past President stated that regarding Rep. Bennett's question, when a claim is filed normally this would be a theft claim so it would be a comprehensive claim and comprehensive claims don't normally count against you from a loss standpoint. Frequency could be a problem. If I have a catalytic converter stolen 18 times in a row, there's going to be a problem with my carrier but one claim of I lose my converter, that claim's not going to affect my premium and I say no carrier would really have an adverse effect. The bigger issue goes to the question on coverage and that is, it is a comprehensive claim and there's a lot of people who do not carry physical damage on their vehicle so they're out completely and I don't think there's really a way to fix that. That's their decision. But to your point of is it going to affect a claim, the answer is no.

Rep. Jordan thanked the Committee for speaking and stated that the questions from Reps. Wood and Lilly and others were great. If you have any questions on the topic or if you want to provide any information you can please reach out to me or Rep. Oliverson or NCOIL staff and we look forward to furthering the discussion.

INTRODUCTION AND DISCUSSION ON NCOIL PUBLIC ADJUSTER PROFESSIONAL STANDARDS REFORM MODEL ACT

Rep. Jordan stated that next on the agenda is the introduction and discussion of the NCOIL Public Adjuster Professional Standards Reform Model Act (Model), sponsored by Rep. Michael Meredith (KY) and co-sponsored by Rep. Lehman. You can view that Model on page 327 of your binders and on the website and the app.

Rep. Meredith stated that I appreciate the opportunity to bring this Model forward today and work alongside Rep. Lehman. This is representative of a bill we passed in

Kentucky this year with a couple of minor changes that came from an Indiana bill that passed as well. At this time I will turn it over to Anne Marie Franklin, Gov't Affairs Manager at the Kentucky Farm Bureau, to start the presentation.

Ms. Franklin thanked the Committee for the opportunity to speak and stated that I just want to give you all a little bit of background on why this bill was important to us in Kentucky and a little bit of the background on where it came from. So as most of you know over the last 18 months Kentucky has been hit time and again with natural disasters. It started in December 2021 when the western portion of our state was ravaged by tornadoes. Rep. Meredith's District was impacted, as was Rep. Michael Sarge Pollock's (KY) who is here today. Many of you probably saw on the news the tornado that hit Mayfield, but the damage didn't stop there. It spread from the very western portion of the state all the way up into the south central portion of the state. Many counties were impacted and many insureds were impacted. This happened in the middle of the night and the next day I can say our Governor was boots on the ground immediately. Many of our folks in the General Assembly were out checking on their constituents. We had our Congressmen in town and on the ground the very next morning. But more importantly, our insurers were on the ground. We had independent agents out checking on their people. Our CEO was out checking on our insureds. It was an all in approach from everybody in the state of Kentucky and then that continued on into July of 2022 when Eastern Kentucky was flooded. Again, everybody came out, everybody was helping. Flood insurance is a different story in that part of the state than the coverage that was able to be applied in the western portion of the state. But we were all in again. With that came some new things to Kentucky. Some things that we hadn't really experienced before. Some background, we adopted portions of the National Association of Insurance Commissioners (NAIC) Public Adjuster Model to license public adjusters in the state of Kentucky. There weren't guardrails really put into place. There were no real regulations around some things. We only had 22 residential public adjusters according to our Department of Insurance back in February of 2023.

Since the bill passed in Kentucky, we have gained one licensed residential public adjuster and we work with them all the time at the Kentucky Farm Bureau. I know a lot of other insurance companies work with them as well but the problem wasn't necessarily that we had very few public adjusters. The concern came that we don't have very many, but we got inundated with public adjusters from outside of our state that weren't necessarily familiar with our people and our people weren't familiar with them. We also had a wide range of Western Kentucky, a wide range of Eastern Kentucky, filled with vulnerable consumers who had just lost everything they had. In the east, everything was gone. In the West, everything was gone. So just to kind of cover a little bit about how our statute reads as it defines public adjusters. They are hired by the insured. They are not hired by an insurance company. They don't represent the company, they represent the insured in resolving the claim. They do have a contract that is signed typically. The contract will outline the compensation and things of that nature. Public adjusters are the only adjusters who can receive compensation from an insurance settlement. So, your staff adjusters and independent adjusters represent an insurance company and are paid by an insurance company and they do not receive any funds from the insurance settlement that is paid to the insured to make repairs or rebuild their homes. So some concerns that came from that over the last 18 months, in Western Kentucky, as I mentioned, we were boots on the ground the very next day. It happened in the middle of the night. A lot of folks didn't know what they had lost. A lot of folks didn't know what

they had left and talking about some of these concerns that our insureds had brought to us and our claims staff, we are very fortunate that the Kentucky Farm Bureau has 14 claims offices around the state and a large number of staff adjusters were very much grassroots oriented. People were coming to us with lots of questions around the public adjuster realm.

We started educating folks and talked to the Department of Insurance and they also shared some stories with us of things that had come up and I will share one of those with you today. We had an insured who got up the next morning, was looking at the damages and a vehicle pulled up out front of her home and there was a magnet sticker on the door that said insurance adjuster. That's all it said. And this individual got out and was empathetic to her situation and was talking to her and offered to help her resolve her claim and I think that noble intent was very much there, and I know they'll share with you that that is their intent, and that can be helpful. But in this situation, she was vulnerable. She signed a contract on an iPad that she didn't have time to review. She probably wasn't really in the best mental state to review a contract. When she got her insurance settlement check, 35% of her money was gone and she could no longer rebuild her home because in that contract that public adjuster's compensation was 35% of the total insurance settlement. In that moment I don't know of an insurance company that wasn't paying limits on everything in Western Kentucky following those tornados. Some may say it was justified and it was needed. That insured wasn't truly aware and she didn't receive a copy of that contract to even go back on. There was nothing our Department of Insurance could do, so that's where this came into play and we were very stern regarding charging an unreasonable fee. That insurer felt 35% was unreasonable to file a few papers because she was going to get her limits paid anyway. So that hits the percentage of compensation paid from the claims settlement, the transparency portion. We didn't get a copy of the contract. Her insurance company didn't get a copy of the contract. It's typically, we get a phone call from a public adjuster that says I now represent your insured. You need to make all communications through me and I will represent them in all aspects of the claim.

Again, we do that. We have no problem if our insured has entered into a contract with someone else, we will honor that contract. But we also have a contract with our insured that we will honor too. We have been paid to do that and we have to provide a service and we want to do that. So, actually, while this bill was going through the process, some of our claims staff called and said, "hey, I just got a call from a public adjuster. They're representing one of our insureds. I haven't even heard from our insured to see if a claim is needed. What do I do?" And so we'll reach out to the insured and make sure everything's okay. Double check. Turns out that contract, that public adjuster had forged our insured's signature. So once we were able to obtain a copy of that and our insured, we found they really hadn't entered that contract legally and so we wanted those contracts to be able to be shared with the insurer so that we can honor our contracts with our insured just as the public adjusters are there to honor theirs and to provide the best service that we can. The last point I really want to make is that we have to be able to communicate with our insureds. They came to us and purchased our services. We want to be able to continue that. We are a grassroots organization and work very closely with our insureds. We're very hands on, as I'm sure many other insurance companies are as well. So we added language into our bill in Kentucky that says we can still communicate directly with our insureds and that we would include the public adjuster on that correspondence so they can also stay in the loop. We have no

intention of cutting them out of the process but we had the first contract, so we shouldn't be cut out of the process either. And just to kind of go back, this bill came again from concerns brought to us by our members and our claims staff. We did work with the insurance industry in Kentucky. We worked with the Department of Insurance. In Kentucky they were very supportive of this measure as were then members of the General Assembly and I'll now turn it over to Rep. Meredith.

Rep. Meredith stated that when we brought the bill and what we wanted to bring in this Model is there were three focuses and that was consumer protection, transparency, and preventing conflicts of interest. From a consumer protection standpoint in our bill what we did was we set caps on compensation thresholds and so 15% was the cap on non-catastrophic claims and a 10% cap on catastrophic claims. We had started with a 10% across the board when the bill moved through the House. The final in the Senate ended up with 15%. I know there are a few states that have already adopted laws that have lower fee caps than that and so we don't want to obviously limit them in our language in the Model from that perspective. We also make sure that the contracts that a public adjuster is going to have with the insured is reviewed and approved by the Department of Insurance before those contracts go out so that we know that the consumer's being protected through that contracting process. And we also allow the Insurance Commissioner to use the NAIC database to check the status of the public adjusters who may be coming in from another state to make sure that they are in good standing and don't have enforcement actions or things like that against them. From a transparency standpoint, we make sure that within 72 hours of the contract being signed that the insurance company has the ability to get a copy of that contract and ensure that the insured does still have the opportunity to communicate with the insurance company. Also, and this was from the Indiana language about prohibiting a public adjuster from filing a complaint without the express approval of the insured. And then from a conflict of interest standpoint and preventing conflicts of interest, we made sure in the Model and in the Kentucky legislation that a public adjuster can't have a stake in a company that's working on the home or the automobile whether that be a restoration contractor or a roofing contractor. They can't be a part owner of that or be getting a kick back from them in the process. And so that is what we tried to do when we did our law in Kentucky and what we seek to do in the Model that we bring before you today.

Holly Soffer, General Counsel for the American Association of Public Insurance Adjusters (AAPIA) thanked the Committee for the opportunity to speak and thanked Rep. Meredith who brokered the negotiations over the Kentucky legislation and for the most part, we think it's a really good law. We agree with a lot of the provisions in there which are fair to both parties and provide a lot of consumer protection. We really only have a few issues where we would like to see the Model be optional to allow the individuals states to decide what's best for them on some of those particular issues and then for the most part we think that the Model will really work. So, I'm going to turn it over to Tony DiUlio who is another attorney for AAPIA and then we're going to have Cole Kline speak who is AAPIA's President who's a public adjuster just to give you all a little more information on what a public adjuster does and how a claim works so that you can have more information and education.

Mr. DiUlio thanked the Committee for the opportunity to speak and stated that I'm an attorney that focuses my practice on first party litigation so I'm helping insureds on a daily basis try to make sure that their insurance coverage is appropriately interpreted.

By a show of hands, before reading this Model who actually knew what a public adjuster was and what they do? Who here's actually dealt with that? Alright, there's a good number. It's surprising though, when you're working in property and casualty I ask that question often and people don't have an understanding of what public adjusters actually are or what they help with. So, we wanted to make sure we understood as an organization what they do. Public adjusters are substantive assistance for policyholders when they're dealing with losses and catastrophic losses are a large portion but really the mass majority of what public adjusters deal with are everyday claims. Plumbing losses when a pipe breaks into the home. Hail damage from a storm that comes by. A wind that damages shingles on your roof and your siding. Dealing with those types of claims are really what public adjusters do on a day to day basis and AAPIA represents all of those from the small claims adjusters that are dealing with $10,000 or $15,000 claims and helping policyholders to the large loss million dollar commercial claims as well. We are helping ensure compliance with policy conditions. You've got to remember that an insurance policy is just a contract, a very complicated contract, and very confusing for policyholders. So when you have a public adjuster they help understanding with that homeowner to know, "hey, this is what your policy covers, this is what it does, and I'm going to help represent you." Because when you have these losses and this is something we can all agree with, the policyholders are often in a state that they don't know what to do, they are confused. They are overwhelmed by damage to what is often their only major asset. So public adjusters step in and say I don't want you to have to worry about that. We're here to help you. They provide that professional knowledge and assistance in that stressful time. Public adjusters do a ton on these claims. Now, I put a key fact out that I need to make sure I point out. Between 2016 and 2018 the average property damage claim was just $13,000. So we are not dealing with an industry that is overwhelmed with million dollar losses. We're dealing with much smaller claims – 92% of all insurance claims are under $25,000 and that's going to be important that we're talking about these fee issues because the reality is when you have a fee that is too low, you leave homeowners and consumers with no ability, no protection to have any assistance at all.

There is certainly an argument to be made and we'd support it of saying, look, if someone's coming in and charging an exorbitant fee on an extremely large loss, the insurance departments can review that. Most of these insurance departments have a reasonableness requirement for public adjuster fees and that can be reviewed without any other language within those provisions but when you have those fees you've got to recognize what it represents. You've got public adjusters who understand the policy language first and foremost. Consumers don't. If you talk to your constituents, you're going to realize they have no idea what their insurance policy covers. That's why you need a public adjuster. They help identify damages. They outline repair methods, present a loss for inspection so that the homeowner doesn't need to be there. They step into those shoes, to be the assistance for the property owner. They advise the insureds on duties like mitigating their damages realizing "Hey, you can't just sit back and let this get worse. Let me make sure you know what you need to do to protect your interests and comply with the policy." They coordinate those mitigation efforts, bringing in mitigation companies to help protect that property and document the claim through the entire process and communicate with the carrier. They are the representatives of the insureds. Just as a brief background, AAPIA represents all of those adjusters. The small guys to the big guys. Also invited here today is the National Association of Public Insurance Adjusters (NAPIA). They represent the large loss public adjusters across the

country. They apologize that they couldn't make it. They had a plane issue getting out here and weren't able to make it. I'm going to skip through these slides as you guys kind of know who we are. I even put those nice little QR codes in there if anyone reviews these later you can feel free to take a look. But what really this comes down to is how does a public adjuster day to day help these insureds? And I want to pass it over to Mr. Kline to discuss exactly what he does just by way of some examples so that you can see first hand how they're able to help with these claims.

Mr. Kline thanked the Committee for the opportunity to speak and stated that I'd like to talk to you about just what public adjusters do on a day to day basis with residential properties or average size losses that we handle every day and as well, commercial property losses and what those look like. An important point is insurance companies only pay for damage that is covered by the policy. No claim is ever overpaid because a public adjuster's involved. Insurance companies pay more on claims that are increased because a public adjuster's involved because they present the claim properly or find damage that just wasn't presented prior. So this is a loss that gives you a real example of where a public adjuster can really provide value. This is a loss where a vehicle impacted the side of a home and the initial offer for settlement from the insurance company was around $23,000. The carrier in this specific claim offered to patch a portion of the brick on this exterior. With further documentation and investigation of property, we learned that the building had just older building materials. Instead of sheathing, underneath the brick they had a product all the Celotex. This particular adjuster that worked this claim found that and most involved didn't know what Celotex was. It's just a product that's no longer is used anymore and the way the brick is tied into the side of the structure it wraps around the entire structure. So, with proper investigation and documentation presentation from a public adjuster we were able to present the claim and the insured was able to be made whole which brought the claim from an initial settlement offer of $23,000 to $92,000 where the insured wasn't able to repair their property before they hired the public adjuster and gained their assistance. It's a really complex process. This homeowner also was a construction professional and they didn't know the difference between sheathing and Celotex material or the variety of other building components. So we performed a study of 129 claims in 2022 and the average residential roof increase after hiring a public adjuster was about $57,000. The average number of days to work that claim was over a year – 377 days.

The average residential increase on a fire insurance claim was $119,000 and the average number of days from the time they hired the public adjuster to reach a final settlement with the insurance carrier was just under a year, 332 days. And of those 129 claims, the average residential water damage increase was $52,000 and average timeline of 254 days. Of those 129 claims, if a 15% fee cap was in place, 43 of those policyholders would not have received help and so the average starting amount of those 34 claims was just above $300,000 and after working with a public adjuster had an average ending amount of $30,000 and an average number of days from hiring the public adjuster to completion of the claim of 320 days. So, to give you a couple other examples. We recently had an insured who received an estimate after they had a fire and the insurer included drywall in their estimate but the policyholder had plaster over metal lap as well as the adjuster detached and reset base shoe in the house but because the base shoe was made of a just a lesser product, they weren't able to do so. The homeowner didn't know what plaster was, how it was repaired and attached to the wall or what was behind the plaster. And with the help of a public adjuster, we were able

to fix the errors that the insurer made and was able to help the homeowner navigate the claim. A lot of these issues were not due to inaccuracies or intentional fault of the insurance company but just the skill set of the insurance company adjuster a lot of times, especially in storm situations there are just newer adjusters that are entered into the field.

Ms. Soffer then stated that for the most part we think the Model really works. There are uniform procedures for licensing and definitions of terms that help as you go from state to state. One just quick point, this is very minor, the Model requires the $50,000 bond. Most states have $20,000 and what we've suggested recently is that public adjusters form entities like limited liability companies (LLCs) or corporations and those also need the license in most states. They should require a license in every state. We're 100% in favor of that but maybe just put the $50,000 on the company and then allow the individuals to only have a $20,000 bond. This isn't really clear as to whether it would apply to the individuals or the company. We're really okay with it either way, but we think the company should have the $50,000 so just maybe tighten that language a little bit in the final version. Next, the contract issues. This Model requires the public adjuster to have their contract pre approved by the Insurance Commissioner and the reason we wanted this optional is that it won't work in a lot of states. Every state has different rules as to what should be in the contract. Some make it really easy and just put out a form and they say you must use this form. Texas, Pennsylvania, and California have an optional form that makes it really easy on the public adjusters. The Department decides ahead of time what the contract should look like and that's it and they don't have to worry about it. Requiring individual approval as the Kentucky Department of Insurance is learning because I've been talking to them on the phone almost every day for the past two weeks. because one thing I do is write contracts for public adjusters. It's a lot of work. It's a lot of manpower. And a lot of the Departments just don't have the budget for it and I've talked to them and they just refuse to do it. So we thought if you could just make that part optional so either put in certain required language or a form contract but requiring pre approval should just be optional because I don't think that the Insurance Commissioners are all going to want to have to do that so we would just stick in optional in front of certain provisions and we'll get to some of the others.

The contractor issue has been brought up and is another issue that varies tremendously by state. Some states have a complete prohibition on a public adjuster being a contractor. Some allow it with required disclosure. Some say you can do it and there are no restrictions. It's moving in the direction of more restrictions. The problem we have with this language is that it's not clear enough. So one business model that some public adjusters use is that they're hired by contractors to do the adjusting on a claim, especially a lot of commercial claims. Contractors are not public adjusters and I know all of you and all of us are in favor of people having to be licensed to be a public adjuster so we don't want unlicensed contractors to be adjusting claims. So very often they will say we have this repair job, it's an insurance claim. We would like to hire a public adjuster on behalf of the insured and we will pay the public adjuster. That's the model in a lot of states so we don't think this language is clear enough so we can talk after this about tightening up that language to allow that and some other things. The really important issue that we wanted to talk about is the fee caps. Again, fees vary by state. There are only a handful of states that have caps on fees. Some are 20%, some are 33%. There are a few that are 10%. We are okay with the fee cap on the catastrophic losses for 10%. Those are big storms with widespread damage and I know that Ms. Franklin

talked a lot about the aftermath of a catastrophe. We're completely on board with that. It's just on those regular small claims that we talked about, public adjusters can't afford to help people on claims that are small if they're fee is limited to 15%. As Mr. Kline said, they're just going to walk away from those claims and those people are left without any professional representation and we've talked to you about the value that public adjusters bring. And again, different states have different situations with regards to different weather patterns and the different needs for public adjusters and different laws so we would like to either remove this or just see it as optional and let each state decide what they want to do with regard to public adjuster fees and do what works in their individual state in order to protect the consumers.

Jon Schnautz, Ass't VP of State Affairs at NAMIC thanked the Committee for the opportunity to speak and stated that NAMIC does think the time is right for another look at a national public adjuster Model. As many of you heard yesterday, there is an existing NAIC model but we think there are some good opportunities here and have appreciated the conversation with Rep. Meredith about areas where we think this Model might be strengthened. I think the context that he laid out in the bill in Kentucky is important. So in Kentucky, they were writing on a canvas there where there was very little restriction. I think the example Ms. Franklin gave of a 35% commission on a policy that was going to be paid limits regardless is a pretty good example of how little Kentucky had on the books before his bill. Not every state is that way. Texas was mentioned. Texas has had a comprehensive public adjuster statute for 20 years. It predates the NAIC model. In our opinion it is stronger than the NAIC model. And a couple of factors that I'll point out. So we do think it's important to look at the context of the Kentucky bill. A few specifics. So the fee issue has come up. I want to address that specifically. Texas since 2002 has had an across the board 10% limit on public adjuster fees. It applies to catastrophic and non catastrophic claims. We have no shortage of public adjusters. The last time I looked at the licensure count, we have more than 1,400. In fact, we have a state public adjuster trade association which most states don't have. We work with them often on legislation. So, I think the idea that that has prevented public adjusters from helping people is proven otherwise in Texas.

We also have a form contract. It is the only contract that a public adjuster can use. That's a very easy way to simplify the department approval process is have one contract and that's it. You don't have to worry about reviewing. A few other specific provisions. There is a prohibition in the Model very appropriately on public adjusters giving legal advice. They should not be doing that hard stop. The way the language from the Kentucky bill is phrased it has a little bit of wiggle room that maybe we're only talking about bodily injury claims and that shouldn't be the case. Public adjusters are not lawyers unless they happen to be lawyers so we want to clarify that provision. Finally, I want to address a specific provision in the Model that hasn't come up yet that we think is potentially problematic and that is Section 3(1)(b) that creates a circumstance in which a public adjuster can be compensated by the policyholder prior to a written contract being in place and it references this happening in an emergency situation. That really raises a red flag for us. We think it needs a second look or a third one or however many looks to change it because frankly that provision is directly contrary to some things both in the NAIC model and Texas law where public adjusters can't even solicit during a loss producing event, much less collect money. The NAIC model has an optional provision and the Texas law has a provision that prevents them collecting money pre-settlement. This provision isn't even pre settlement. It's pre contract and that we think is a potential

abuse and ought to be looked at. There's some other good provisions we think from the Texas law that might be put in. We've talked about some of these with Rep. Meredith. Prohibitions or controls on referral fees – that's a common area for abuse. And then finally the Model we think should cover entities who are holding themselves out to be public adjusters but are not actually licensed and there's a provision in the Texas law that says if someone is doing that the policyholder can void the contract so we want that in place just to make sure we don't reward people who don't actually get licensed.

Rep. Jordan stated that in the interest of time I'm going to make a few comments and then we'll go to Del. Steve Westfall (WV) and then I'm going to go to Rep. Meredith and then Rep. Lehman to close. We've had this issue in Louisiana. In Louisiana we don't allow for contingency fee contracts at all. Two of the things I saw on the slide disturbed me and I can tell you is part of the issue that we've had. When you're interpreting contracts and you're talking about understanding policy language and advising on duties, in Louisiana that would be considered the unauthorized practice of law so we don't allow that either. So those are two of the big issues that we've had with that. I'm not necessarily asking for responses. I'm just telling you those are some of the issues that we had. Ms. Soffer stated that ties into her earlier remarks about how there are differences in difference state's laws and how some of the Model's provisions won't work in Louisiana.

Del. Westfall asked if he could be added as co-sponsor of the Model as he plans to run the Model in West Virginia in January. Rep. Jordan stated that is up to Rep. Meredith. Rep. Meredith replied yes to Del. Westfall and then stated the issue of fee caps keeps coming up and it's been talked about over and over again. I think it's really important that the fee cap is a low fee cap. I know what they're saying but you got to understand any of this contingency money is coming out of the claim that is being paid for the repair on a piece of property or on an automobile or whatever it may be and whatever less money that insured is getting is the money they don't have to restore their loss and so I think that fee cap is extremely important.

Mr. DiUlio stated that I understand the concept but the concern we have is when an insured is owed let's say $20,000 on a claim but the carrier for whatever reason might miss something and the insured is paid $3,000. Isn't it better to have a professional come in to assist them to make sure they get the additional $17,000 on that claim that they are owed even if it's above 15% on the contingency fee. Otherwise we are leaving potentially 92% of insureds who have claims without any way to get professional assistance in the event that things are missed and we are really as much as you are concerned about protecting the consumer here. This isn't about public adjusters, it's about protecting that consumer and giving them an option.

Ms. Soffer stated that the fee cap works in states like Texas and New York that have the fee caps but sometimes there are other provisions in the law. For instance in Texas, a lot of public adjusters will do what's like an over and above fee. They'll charge 25% on what they recover as long as it doesn't exceed 10% of the claim and actually on small claims, and I'm familiar with the Texas Association of Public Insurance Adjusters (TAPIA) as we work with them, what happens is the public adjusters don't take the claim at all and then they get a referral fee from a contractor because they're not the public adjuster. We think that shouldn't be allowed and it really doesn't help the homeowner in

the end because they're not having professional representation because the public adjuster would walk away from those really small claims which are the majority of claims.

Rep. Lehman thanked Rep. Meredith for bringing this Model forward and stated that I want to kind of take a 30,000 foot view as we wrap this up and that is, I think that first of all, thank you to the industry for being here and giving your opinion. I think what I heard when we did this in Indiana is even this industry wants to get the bad actors out. Mr. DiUlio, Mr. Kline and Ms. Soffer replied yes. Rep. Lehman stated that when you talked about confusion, what we have seen as an independent agent and what I've seen over my career of 30 years has been the confusion begins when they signed these contracts. So again bad actors have to be out. I think the philosophy at NCOIL has been we try to build a strong foundation that you can take back to your states and then implement where you think it best fits your constituency. So, I'm looking forward to continue to build on this foundation and I think there are issues around like the bond amount and you know the Department review and even fees that maybe is going to be unique to different states based on different pieces. We'll continue to work on that. I think within this Model there's issues around when payments can be paid and not taking all of my money up front. The big issue we had in Indiana and with the department and the NAIC was complaints. I brought this up at an NAIC meeting and everybody looked at me like they didn't want to talk about it but the reality was when they finally spoke, they said we're getting multiple complaints from the adjusters, not from the insureds and we have to respond to those. And so in this Model it talks about that it has to be written consent there for complaints. My only concern there is does it just get put into the contract? So, when I signed this contract and it says I have a right to file a complaint now I never have to get your consent in the future. So I think those are just some things I think we'll continue to work on because I think at the end of the day, we all want the same thing and that is to get the bad actors out because they created quite the havoc in this industry.

Rep. Jordan thanked everyone for speaking and stated that responses to the comments from Reps. Meredith and Lehman can be made to them after this meeting. If you have any comments in the future you can certainly reach out to me, Rep. Lehman, Rep. Meredith and now Del. Westfall, or the NCOIL staff. Again we apologize on time. Mr. DiUlio stated and we of course encourage everyone to reach out to us as questions arise. We are here to be a resource. We are in agreement with most of this, transparency is a good thing for everybody, and we all want to protect the consumer.

CONSIDERATION OF RE-ADOPTION OF MODEL LAWS

Rep. Jordan stated that last on our agenda is the consideration of the readoption of existing NCOIL Model Laws. Per NCOIL bylaws all Model Laws must be readopted every five years or else they sunset. Those Models appear in your binders starting on page 321 and are: The Model State Uniform Building Code, Consumer Protection Towing Model Act, Model Act Regarding Auto Airbag Fraud, Model Act Regarding Disclosure of Rental Damage Waivers, Model Anti-Runners Fraud Bill and the Property & Casualty Insurance Domestic Violence Model Act.

Hearing no questions or comments, Rep. Jordan stated that he will entertain a Motion to re-adopt the Models for the full five years except for the Model State Uniform Building Code because we still have some work to do on that one. Upon a Motion made by Rep.

Lehman and seconded by Rep. Carl Anderson (SC), the Committee voted without objection to readopt the Models for five years.

Rep. Jordan then returned to the Model State Uniform Building Code and, hearing no questions or comments, he said he will entertain a Motion to readopt that Model until the Committee's meeting in November rather than the full five years as amendments to that Model continue to be worked on. Upon a Motion made by Rep. Anderson and seconded by Del. Westfall the Committee voted without objection to readopt that Model until the Committee's November meeting.

ANY OTHER BUSINESS

Del. Westfall stated that in November if possible I think we need to re-look at the NCOIL Delivery Network Company (DNC) Insurance Model Act that was adopted last November. I was co-sponsor of that Model with former Kentucky Representative Bart Rowland being prime sponsor. There has been some language that I think was agreed to by different parties but there's only one state that has passed that so far, I think North Dakota. We tried to in West Virginia and I think Kentucky tried also and there's a stumbling block on the delivery part for the bigger carriers. I think there's language out there now that both sides agree to and if it's possible I would like to offer an amendment to the Model in November and if possible have an interim Zoom meeting of this Committee in advance of November. Rep. Jordan stated that an interim meeting will be set up to discuss that amendment.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Anderson and seconded by Rep. Lehman, the Committee adjourned at 10:45 AM.

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
PROPERTY & CASUALTY INSURANCE COMMITTEE
INTERIM COMMITTEE MEETING – SEPTEMBER 22, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Property & Casualty Insurance Committee held an interim meeting via Zoom on Friday, September 22, 2023 at 12:00 P.M. (EST)

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

Other members of the Committee present were:

Rep. Tammy Nuccio (CT)
Rep. Rita Mayfield (IL)
Rep. Matt Lehman (IN)
Rep. Mike Meredith (KY)
Rep. Rachel Roberts (KY)
Rep. David LaBoeuf (MA)
Sen. Paul Utke (MN)
Asm. Jarett Gandolfo (NY)
Sen. Bob Hackett (OH)
Rep. Forrest Bennett (OK)
Rep. Jim Dunnigan (UT)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Deborah Feguson, DDS (AR)
Rep. Elaine David (TN)
Asm. David Weprin (NY)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Manager, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

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

INTRODUCTORY REMARKS: CHAIR JORDAN

Rep. Jordan thanked everyone for joining the meeting and stated that we're going to begin with some new business which is the discussion of some proposed amendments to the NCOIL Delivery Network Company (DNC) Insurance Model Act. Then we'll continue with discussing the NCOIL Public Adjuster Professional Standards Reform Model Act, and then proposed amendments to the NCOIL Model State Uniform Building Code. There won't be any votes on any of these items discussed today. As you know, these interim meetings are extremely helpful in maintaining an open dialogue and ensuring that we're able to complete our agenda in an efficient timeline. One last thing before we get started. The latest version of the models that were distributed for the

meeting are not necessarily what will be discussed or considered at our committee meeting in November. We're likely to make more changes between now and the time for the 30 day materials deadline which is a few weeks away. And then we can also make more changes between then and the November meeting.

DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL DELIVERY NETWORK COMPANY (DNC) INSURANCE MODEL ACT

Rep. Jordan stated that NCOIL adopted this Model this past November and we really don't like to re-open Models for discussion so soon after adoption but it's come to our attention that some clarifying amendments might need to be made. You can review those amendments in the materials for this meeting. So, we'll go ahead and we'll hear from the interested parties first and I'm going to start with Brad Nail, representing Lyft, who led the interested persons discussion group on this Model last year and has been initiating many of the discussions this time as well.

Mr. Nail thanked the Committee for the opportunity to speak and stated that as was mentioned, the Model passed last year. It was run in a few States and I think the stakeholders identified some possible changes to make to help the Model move along in States better in upcoming sessions. And in the materials that were distributed for this meeting were some suggested revisions that were generally agreed to. There are three areas for continued discussion and that's where I think today's meeting could be particularly helpful. We can get a sense of direction from the stakeholders and the Committee members what direction you want to take and hopefully prepare language to address everything for the November meeting.

The three areas for continued discussion are further refinement of the delivery available definition, a different approach to the delivery service definition, and then whether or not to address independent contractor or worker classification issues in the Model. I'll just go over quickly the amendments in the material that you have and much of this is pretty technical in nature. You can see it starts really on page two of the Model with a technical correction of the placement of the word “and” at the top of that page and then a drafting note that clarifies that the insurance requirements are intended to apply to vehicles that are required to carry insurance in your state. That is something that we know varies from state to state - how you define what a vehicle is and when it's required to carry insurance. And we're not trying to apply insurance requirements to something that's not otherwise required to be insured like a bicycle or something like that.

Then we get to the delivery available period definition and the modification was made to make the insurance requirements apply to the period when a driver is eligible to receive work requests. The thinking is that the term “eligible” better captures the status of the driver under various business models used by the DNCs. And then under subsections G and H on that same page a technical change is proposed to better clarify that the location of the delivery may be different from the location of the customer who is placing the order. And the final technical correction is on page five where there's a change to a cross reference that got messed up in the printing of the model. So, these have been distributed and we solicited feedback and I think they are generally agreed on. We did get the suggestion for a further refinement of the delivery available period definition that I think needs additional discussion and the suggestion was instead of simply changing the

definition to read “eligible” that it be changed to read “eligible and available.” This was discussed among the stakeholders but has not yet been agreed to.
The second area for discussion is a proposed change to the delivery service period definition. Keep in mind that the delivery companies operate using different business models and that makes it a little trickier here. And some of the DNCs have suggested narrowing this delivery service period definition to limit the time when they're required to provide coverage, particularly among the DNCs that use scheduled delivery. They schedule folks for specific time periods as opposed to true on demand delivery when someone just turns an app on and is looking for work that they've not already been assigned. So, those DNC's don't want to cover the time when that driver is driving to their first pickup, as they view that more in line with commuting as opposed to work that they would insure. So the suggestion was circulated but not agreed to for a bifurcated approach that separately defines on demand DNCs from scheduled delivery DNCs. So that's an area for discussion and I think you will probably be able to hear from some of the stakeholders who have positions on that. And the third area is just whether or not to try to address the employment status and the independent contractor status of drivers who sign up and work on the DNC platforms. So, that lays out the suggested changes in the material that was distributed and those additional areas for discussion.

Jordan Bailey, Senior Legislative Policy Advisor at DoorDash, thanked the Committee for the opportunity to speak and stated that I just wanted to share from our perspective that we are fine with the technical changes that are being proposed and have been circulated as part of the materials. But I really do hope that there can be a broader conversation about the delivery available period definition and some of our concerns. I think separate from the amendments that Mr. Nail directly mentioned, we have also had conversations with several members of this Committee about some refinements to that definition to address our concerns around kind of the potential for fraud or folks just to leave the platform open and the challenges that creates for our model. Would the insurance coverage during the delivery available period apply? So we would love to work more on some potential guardrails to prevent kind of misuse of coverage during that period as it pertains to our model between now and potentially the meeting in November.

CJ Stolle, Senior Manager of Public Policy at Amazon, thanked the Committee for the opportunity to speak and thanked Mr. Nail for his work for trying to help us get through this process. I will say we are one of the different models where most of our deliveries are done in prescheduled blocks, where our delivery partners can select the date time and location that works best for them and it is a little bit different than your typical on demand drivers. So, while we do believe that drivers should have access to insurance coverage that protects them, we do recognize that different models work very differently and a one-size fits-all approach won't work necessarily for this legislation. We have shared some language to close that potential technical gap that exists for models like ours that are schedule ahead. We hope that we can continue to have this conversation and be able to clarify that the delivery available period is applicable to those orders that are truly on demand services.

Jon Schnautz, Assistant Vice President of State Affairs at the National Association of Mutual Insurance Companies (NAMIC), thanked the Committee for the opportunity to speak and stated that NAMIC has been engaged on this from the beginning trying to work toward a Model that everybody involved can support. I want to focus on the couple

issues that have been mentioned. On delivery available, we understand the concerns from some of the DNCs that you don't want to create a situation where somebody registers for a shift three days in advance and is covered by the DNC's coverage for the three days in between. I don't think that was ever the intention of delivery available. We are supportive of the change that some of the DNCs had suggested to go from the word available to the word "eligible." We are also willing to vet with our members the idea of "available and eligible." We do want more of an understanding of what that adds that isn't already there in the term eligible but we're open to that.

But the bigger conversation that I want to mention is what Mr. Nail alluded to on the delivery service period. This to us is going to be a more difficult issue to get a compromise on. So, as we understand it what some of the DNC providers want here is that the primary coverage obligation would not be on them for someone going to a facility to pick up packages that they then deliver. And just to remind everybody the context of this Model is specifically about people using their personal vehicles to make deliveries which is generally a commercial activity. From our perspective driving to a facility to pick up packages that I'm going to spend the rest of the day delivering is just as much commercial activity as actually delivering them. So, we think that obligation ought to be there. More pointedly, if the Model does not put that obligation on the DNC there are already many private passenger auto policies that exclude coverage for that period. So, unless we thread that needle, there could be a coverage gap at that point which we think would be a problem. All that said, we are very willing to continue working for something that accommodates everyone. I guess for us though that period in which you go to pick things up that you're then going to deliver is as much commercial activity as the rest of this and we think appropriately ought to be covered through specific coverage that individual needs rather than put that on every driver's private passenger auto coverage, when they may in fact have no need or desire for it.

Rep. Matt Lehman (IN), NCOIL Immediate Past President, stated that I know there's a lot of issues out there, and I really appreciate where we're going with some of these discussions. I really want to address driving to the first pickup. I'm going to take you all the way back to when we did the Transportation Network Company (TNC) Model. The reason we even got down this path was there was a gap between that standard insurance and when someone was in your car and it was that in route piece that we had to fill the gap. Well, we did that with the TNC and DNCs ended up having the same gap and so I think if we have some discussion of removing that in route coverage then we're right back to where we started which is we're having a gap. So, I look forward to the discussion. We passed this in Indiana this past session. I know Amazon was at the table and I understand they're concerned along with others like them but I think it's two things, one is making sure no one's getting insurance three days in advance and at the same time once I leave to pick up my standard auto policy will cease to cover me and we don't want to have that gap.

Rep. Forrest Bennett (OK) stated that I'm also interested in the conversation around that as I'm someone who used to do Postmates while I was campaigning the first time that I was running for office. Some of those initial drives can be quite a ways. I live in the fourth largest city by land mass in the country in Oklahoma City and I'd turn my app on and my first job would be picking up something up somewhere that is 30 minutes away. But my view was when I turned that app on that was when I started work. So, that's just

an employee side of that or a worker side of that but that's the part of the conversation I'm really interested in hearing about.

Sen. Bob Hackett (OH) stated that I realize it's a different scenario than the ride sharing problem but we were able to solve the ride sharing problem. The problem a lot of times is that commercial auto coverage is so expensive and so how we solved the ride sharing thing was we were able to go to the big insurance companies and have them create an endorsement or a rider that was very cost effective and then they could look at what claims would have come into play. And one of the TNC companies decided they'll cover the whole process because you're right there was a gap in coverage and they covered the other part of the coverage. But they wanted the people to put the claims in on the personal auto and it was business activity but the commercial auto didn't work. So, is this different? Do drivers have a commercial auto policy during this process? Or is it very similar to the ride sharing issue that we got resolved?

Mr. Nail stated that I think it's more analogous to the ride share issue. It's a personal auto policy and then the companies are carrying commercial policies that cover drivers on a non-owned auto policy so it's more analogous to that as opposed to drivers carrying their own commercial policy. Sen. Hackett stated that it's very expensive for the drivers to carry their own commercial auto. The model of the delivery won't work if they have to have a commercial a policy.

Rep. Jordan stated that I'm listening to this and I'm a little bit concerned because we did just recently pass this Model. I thought this effort was going to be sort of a technical cleanup but as I listen, and maybe I'm misinterpreting what I'm hearing, but this almost seems like more substantive changes are being sought and it's almost like we want to relitigate the Model and I'm not sure that that was necessarily the intent. Does somebody want to comment on that? Mr. Nail stated that I think the changes that have been circulated are more along the lines of cleanup. The areas for additional discussion that we've been having here are more substantive.

Rep. Jordan said to please just keep that in mind as we move forward. We'll continue the discussion on this issue during the meeting in November and please be sure to submit any thoughts or comments to me or to the NCOIL staff.

CONTINUED DISCUSSION ON NCOIL PUBLIC ADJUSTER PROFESSIONAL STANDARDS REFORM MODEL ACT

Rep. Jordan stated that next on our agenda is the continued discussion on the NCOIL Public Adjuster Professional Standards Reform Model Act (Model). I'll turn things over to the sponsor of the Model, Rep. Mike Meridith (KY)

Rep. Meredith stated that we've had some ongoing conversations since the initial presentation on this back at our July meeting in Minneapolis. And we've had some positive discussions. This Model that we brought before you is based on largely a bill that we passed in Kentucky and we've made some changes since July and so I just wanted to go through those a little bit. Certainly, this is not our final product but I want to do everything we can to be prepared for moving forward at the November meeting when we are in Columbus so I'm looking forward to a little bit more discussion today.

Rep. Jordan then recognized the co-sponsors of the Model, Rep. Lehman and Del. Steve Westfall (WV), for remarks.

Rep. Lehman stated that I do appreciate the work Rep. Meredith has done on this. We passed similar legislation in Indiana last year and it's an issue where the time is now to address this. It goes down really to making sure we don't get rid of an industry that can be needed in certain cases and at the same time making sure we're dealing with those who have abused this situation. And think there's evidence of that. So, I appreciate Rep. Meredith bringing this and look forward to the continued discussion.

Del. Westfall stated that he agrees with Rep. Lehman and I think we just need some safeguards on this. We're not trying to stop it in its entirety but put some safeguards on it some with some guidelines. I think we're getting there and I appreciate everybody's work and look forward to today's discussion as well as the discussion in November.

Rep. Meredith stated that I don't want to get too deep in the weeds as far as the changes that are before you but I do want to kind of outline them quickly. Most I think would be considered clarifying the intent of what we were already working on. The first thing you'll see is we did add a few definitions in the beginning of the Model just to clarify what we're talking about through the entirety of the Model. We also removed references to independent and staff adjusters. That was something that was really kind of conforming to our language in Kentucky and we had agreed to remove that even prior to the meeting in Minneapolis. In section four on page nine we removed the provision that permits a public adjuster to be compensated for services provided to an insured prior to the execution of a written contract in emergency circumstances. That was again something pretty specific to Kentucky. We have administrative regulations that dictate what those emergency situations are and so we had heard from some folks from other states that it could be concerning if those guardrails along with those administrative regulations weren't there.

In section five on pages 13 and 14 we added some provisions dealing with requiring the public adjuster to use the terms of the insurance policy to resolve a claim. Again, that was just clarifying as the policy is going to govern the claim anyway but we just wanted to clarify that. And then prohibiting solicitation during the actual progress of a natural disaster, and clarifying language with conflicts of interest and non-licensed public adjusters not being able to charge for the service if they are not licensed. In section seven on page 16, we added some language regarding compensation and fee caps and that's a drafting note just to clarify that if states have tighter compensation or fee caps that we would not be suggesting raising those. In section eight on page 19 we added language that clarifies that contracts for services entered into by an insured with a person who is in violation of the Act is null and void.

And I think that is the crux of the major changes. Before we hear feedback on the changes I do want to note we did take into account the discussion and the information brought before us by the public adjusters at the July meeting and I want to just outline a couple of the things that they raised at that meeting. Lowering the amount of the surety bond required for licensure. I see that as a consumer protection piece and certainly we can continue to discuss that but I saw it as a consumer protection piece of the Model. Making optional the provision of the Model that deals with pre-filing and approving contracts by the Department of Insurance or the Insurance Commissioner. Again, we

know that we have a highly regulated industry and the Department of Insurance is able to review policies and rates on policies on the insurance side and we thought it would be fair for them to be able to review those things on the adjuster side too.

Making optional the provision of the Model that prohibits public adjusters from acting as contractors or having a financial interest in a contractor. I think it's important with these contracts that the public understands that the public adjuster is working on behalf of the insured and not on behalf of some other conflict of interest that might be out there, whether that's a roofing contractor that they have a part in or whether they're a contractor themselves. And so I think it's imperative that we ensure that they're working on behalf of the insured and not somebody else in the progress of the claim. And then they also ask not to set forth fee caps but rather leave that to the states and I know NCOIL doesn't normally address fee caps in a lot of things that they do but I find it very important in this Model. And I suggest strongly that we keep language in there with the fee caps and I say that simply because any amount of money that comes out of that claim is money that the insured will not have to be able to do repairs that are needed to their home or auto in this situation. And so I think it's very important that we understand that and don't have some large amount of compensation coming out of that because they're either going to have to dip into a huge amount of their savings or go borrow money to finish that.

Holly Soffer, Counsel for the American Association for Public Insurance Adjusters (AAPIA), thanked the Committee for the opportunity to speak and stated that I'll keep it really brief. Rep. Meredith I completely understand your concerns. You did a great job summarizing our concerns and I understand where you're coming from with the fees. But we still believe that the fee cap should be optional because especially with small claims we understand that whatever portion is paid to the public adjuster comes out of the eventual recovery and the homeowner in that scenario would have less money to make the repairs. But if you look at all the information we provided and the statistics, those funds wouldn't be available at all but for the public adjuster. On many of these cases the original offer and even final offer from the carrier was so much lower than the amount that the public adjuster was able to obtain when they use their expertise to present the damage that the homeowner is so much farther ahead it more than pays for the public adjuster. So, we still feel that sometimes with the cap of 15% on those smaller losses it deprives the homeowner of any professional representation because the public adjusters can't afford to do those smaller claims and then some claims they are sometimes undervalued by that small amount of money.

And that's where I just wanted to make sure that it's clarified that regardless of what the number is for the fee cap I know that back in Kentucky the Department of Insurance has recently put out an advisory bulletin that the cap on fees only applies to funds received after date of contract. And I just wanted to make sure that the language in this Model is very clear on if there is to be a cap where the cap would apply. In other words is it like states that already have fee caps like Texas? And others where it's the public adjusters can charge a higher amount on what's called like an over and above but not to exceed x% of the total amount? Or is that cap on the over and above which it seems to be interpreted as being the same as Kentucky which has of course the same language. But it can be interpreted in different ways when it's not clear and we can send some emails out with some suggestions on that.

And then with regard to the contract approval, we understand the concern but sometimes when the states have to approve contracts they don't have the time to do it and it can create very long delays. So, if we have to have contract approval maybe we can have some timeframes in there that a contract has to be approved within x amount of days because I know in California and Ohio and states that are understaffed and overworked it can take up to two months to approve a public adjuster contract so it's a real disadvantage to people trying to move from state to state or get a license in a certain state if it's going to take them more than two months to get their contract approved. And I know that Kentucky has recently addressed this. They're drafting a regulation with some timeframes in there but without those timeframes and requiring contract approval I think that it could create problems.

Tony DiUlio, an attorney with the AAPIA, thanked the Committee for the opportunity to speak and stated that with regard to the other issues that were brought up with the public adjuster financial interest with contractors - one of the things I think we can all agree with is we want to make sure that the people who are assisting homeowners in claims are licensed professionals. There are states that have in essence made their entire model public adjusters who work with contractors and I would simply suggest that a disclosure might be able to do that trick as well rather than prohibiting it in its entirety. I completely agree with Rep. Meredith that we don't want there to be any confusion as to the conflicts or who's working for who but restricting a person as to what types of income they can have through multiple areas of business could also be resolved through a disclosure so the property owner can just make that informed decision. They'll want to try and streamline the process through a public adjuster who works with a contractor. As long as that disclosure is made and is clear that should I think resolve everybody's concerns while also leaving options for the property owner to kind of make it a one-stop shop when it comes to their claim.

Again, I think all of us agree that the main goal here is protecting the insureds. We all want to make sure that they are in a position to be able to best repair their property. And I want to hit on that fee cap issue as well. The language that was added to the Model, while it indicates that it's not intended to increase caps for other states, it doesn't make any indication from the states that have higher fee caps in places like Georgia where it's one third, that there's no intent that they reduce their fee cap either. Again, this comes down to our position earlier where it really should be left up to the individual states because when you've got an insured with $10,000 worth of damage and a carrier comes out and says we're only giving you $1,000 you reach the same exact conclusion that you're concerned about with the public adjuster in that they don't have enough money to do the job and if they don't have enough money to do the job they need a professional to step in and a public adjuster can do that but they can't if it's a $10,000 loss and there's $9,000 on the table if there's a fee cap like this.

So we are simply asking that we protect those insureds because they make up the mass majority of insurance claims across this country. Over I think 92% of claims are around $22,000 or less so you're in essence telling all of those people if they're shortchanged by their carrier, or if their carrier just makes a mistake and they need a professional to come in and fix that they're going to be left without an option if this were to be accepted. So, we want to simply address that problem so that those people who make up the mass majority of insureds with claims can get that assistance. Again, I thank you for your time and I would love to hear any questions about this or concerns when it comes to

addressing these people who have the lower value claims kind of what the hope is with this Model to be able to still help them.

Cole Kline, President of the AAPIA thanked the Committee for the opportunity to speak and stated that I have just one valuable piece of information I wanted to add. We did a study of 129 claims in 2022 and of those residential roof claims it took on average 377 days from the time the public adjuster was contacted to reach a settlement on those claims. So just a significant amount of time especially for these smaller but average size claims. It just takes a substantial amount of time effort and work on part of the public adjuster to help these policyholders.

Eric DeCampos, Director of Gov't Affairs at the National Insurance Crime Bureau (NICB), thanked the Committee for the opportunity to speak and stated that I just wanted to go back to a comment that was made regarding putting disclaimers for any conflict of interests. So, from NICB's perspective we do have some concerns with this idea just because from an insurance fraud investigation standpoint, we have seen cases where disclaimers can easily be hidden or obscured when individuals are signing contracts. So, I think there would need to be a deeper discussion on that idea regarding fleshing out how exactly that can be implemented and what guardrails can be put in place to ensure that a consumer is not only educated but is fully aware that there is this interest that does exist between a public adjustor and a contractor. I'm happy to take part in those conversations with anybody who's interested in that but did want to express our concerns with this idea. Ms. Soffer stated that we would certainly love to work with you on those disclaimers because there are situations where in some states where the business model is for the contractor to actually hire the public adjuster to help them because we don't want contractors adjusting claims because they don't have a license. So, we want the two parties to be able to work together where there's no common financial ownership or interest. One is just hiring the other or referring the claim to the other. So, we can certainly work with any appropriate disclosure on that.

Mr. Schnautz stated first of all thank you, Rep. Meredith. We think the changes that were incorporated into the Model are improvements. I also want to add many of those changes are closely modeled on the Texas statute which has been in effect more or less for 20 years. I do want to clarify Texas does have a written contract requirement on a form approved by the Commissioner, and a 10% across the board fee cap. None of those issues have restricted public adjusters from operating in that state as we have a very robust market for them and I would just encourage the committee and NCOIL to keep the Model strong. Mr. DiUlio stated that I just want to make sure it's clear, it's not that we're concerned about the public adjusters being able to stay in business. We're concerned about the insureds who have these smaller claims and can't get assistance. So, I want to make sure that it's clear this isn't just about protecting a public adjuster's right to a free and open market, but about protecting insureds who will be limited in what they can do if a cap like that were put across the board on all claims.

Hearing no other comments from interested persons or legislators, Rep. Jordan stated that I'll just follow up briefly to say I know we had this issue in Louisiana and when it comes to charging a percentage we certainly don't allow it. We consider that engaging in the unauthorized practice of law. Our Supreme Court looks at it the same way. I can't speak for what other states would want to do. I can tell you in Louisiana that it would be something that would be very difficult to get passed and it would receive lots of

opposition. But we do want to keep the Model strong and so I hope that we can continue our discussions with it.

CONTINUED DISCUSSION ON PROPOSED AMENDMENTS TO NCOIL MODEL STATE UNIFORM BUILDING CODE

Rep. Jordan stated that we'll move to the last item which is a continued discussion on proposed amendments to the NCOIL Model State Uniform Building Code and with that I'll turn things over to the sponsor of the amendments, Rep. Jim Dunnigan (UT).
Rep. Dunnigan stated that since the Committee met in July, I've have been able to have some very valuable discussions on this issue and I'm glad to work on these amendments which generally speaking where we started out kind of was to incentivize homeowners and renters to take steps to strengthen their residences from natural disasters by providing them with insurance discounts if certain standards were met. In my home state of Utah, we've been dealing with some very horrific wildfires along with much of the western United States. So, I'm really interested to see if we can find a public policy that ultimately strengthens homes and neighborhoods. However, in the discussions with various stakeholders I've had since introducing these amendments I'm not convinced that what I've been working on is really going to move the needle so to speak. If a person's homeowners policy is $3,000 and they get a 10% discount of $300, that's unlikely to motivate them to redo their roof and put a more fire resistance roof on it. I'm told that Oklahoma has had a similar type of law where they provide a discount on insurance since 2018 and the take up rate has been very minimal. I would encourage you to look at the chat feature here on Zoom that talks about the destruction of the homes in Hawaii as a result of the wildfires.

You probably heard about the wildfires that took place on Maui Lahaina Town. I was actually in Hawaii when that happened and I found it very interesting. If you can take a minute and look at the image or the photo all the houses there and the structures were completely torched except for one that came through virtually unscathed. And the reason is as part of a restoration the homeowner or the building owner had put on a metal roof and cleared away all the shrubs immediately adjacent to the building and then put in some pavers. He didn't do it to fireproof it. He did that to remove the vegetation to keep termites away. But it protected him. I mean it's a stark contrast showing what can be done if people move vegetation away and have a more fire resistant roof. I want to invite suggestions and I've had several given to me about what can we do that would actually move the needle. And so I I'm interested and I'm open to other policy choices that this organization could endorse and support. I've heard of promising things done in Alabama and Louisiana with some grants and I want to keep working on this but I want to shift the direction a little bit and try to find something that'll actually end up with a product that will be worthwhile.

Rep. Jordan stated that before we open this up to discussion I do want to tell you a little bit about Louisiana since you mentioned what we are doing and we're following the model in Alabama because in speaking with them it was difficult to get people to participate in a program or upgrading their roofs to a fortified roof without some type of grant. So, what we've done this last session we set aside $30 million for $10,000 grants and that program application opens up on October 2nd. And we've been advertising it and we hope it's going to be very successful. I can tell you in Alabama they've been doing it for a while and once they started offering the grants there was a significant

uptake in that so I'm hoping that if you want to look at something like that I think it'll be very beneficial to you.

Matt Overturf, Regional VP, Ohio Valley/Mid-Atlantic Region at NAMIC, thanked the Committee for the opportunity to speak and stated that we appreciate Rep. Dunnigan's comments. I know we've had several conversations on this issue since July and we've been working through coming up with some alternative ideas. You've hit on a couple of those but I'll just kind of go through our list and look forward to continuing to work with you on some language around some of these ideas. So, in no particular order, obviously the readoption of the building code model is important but also looking for ways to improve and strengthen building code requirements would be one. Funding mechanisms such as grants for mitigation efforts which Rep. Jordan just touched on is something that we find would be successful. In addition to that, state tax incentives is another one that has come up that has really incentivized folks to take on some of these efforts. And another one that's out there is catastrophe savings accounts. I know there's been some effort at the federal level but like most things at the federal level it moves pretty slow so, that could be something that we could look at on this end.

In addition, potentially maybe outside of this Model but maybe an NCOIL Resolution that would support changes to the Federal Emergency Management Agency's (FEMA's) Building Resilient Infrastructure and Communities (BRIC) program. NAMIC joined 50 other organizations at the end of August and sent a letter to FEMA outlining some changes that they could make to the BRIC program to make it more accessible to states and communities across the country so that could be something there as well. And then finally, if discounts is something that is going to continue to be part of the conversation, doing those in a voluntary manner is important and we also find it important to include an anti-rebating safe harbor with that piece. That would not only cover discounts but other services and resources that insurers may offer to their policyholders for disaster mitigation. And in that line there may also be an opportunity to have a conversation around a transparency component with that as to what insurers offer to mitigate against disasters.

Amy Bach, Executive Director of United Policyholders, thanked the Committee for the opportunity to speak and stated that my organization is a national 501(c)(3) insurance education and advocacy for policyholders group and we've had the pleasure to be at quite a few NCOIL meetings over the years and I just want to share that we are based in California so we know a lot about what's been going on here in the wildfire context and trying to speed up wildfire risk reduction and get us closer to where the hurricane prone states have been, the states that have very robust fortified home programs, catastrophe savings accounts, that sort of thing. But we also keep an eye on things nationally. I was at a conference last week and in Washington D.C. where a lot of these similar conversations were going on and I'm also part of the National Association of Insurance Commissioners (NAIC) consumer representative program and with all these conversations I would recommend that we look at Alabama and see what they've been doing. I think people certainly at the conference last week a lot there were reinsurers, insurers, environmental groups, and public officials from the state and federal level. And everyone seemed to kind of think that Alabama is a shining example of how to do things right in terms of funding risk reduction and having insurers incentivize risk reduction and reward it.

And I know there's a tension between mandating that insurers give a specific discount that insurers may feel isn't necessarily warranted by the data. At the same time what I have heard in a lot of conversations in other forums is that states that didn't mandate a discount and just left it to the insurers – they wish they had mandated it because it's just a much slower adoption. And I think we all feel the pressure those of us who are concerned about the health of the property and casualty ecosystem feel like it's really imperative that we figure out how to give property owners as much help and as much clarity on what's effective in risk reduction and as much rewards as we can in the insurance context. And Rep. Jordan it's good to see you and I remember Louisiana Insurance Cmsr. Jim Donelon saying we did all this work to fortify our levies after Hurricane Katrina and the insurers are still questioning things. And I get that insurers like to see a lot of data on the efficacy of risk reduction before they will have their rates and underwriting reflect reduced risk but we've got to keep moving forward here.

Hearing no other comments or questions from interested parties or legislators, Rep. Jordan stated that again, Alabama is the model. I would also suggest for everyone to go to the Insurance Institute for Business and Home Safety (IBHS). They are in South Carolina and they do a lot of research in this area and in fact, Alabama and Louisiana have both relied on them heavily for some of the research that they've done in this area. So, I would tell you to take a look at the great work that they've done as well.

ANY OTHER BUSINESS

Rep. Lehman stated that I brought an issue forward in Indiana last session regarding litigation funding. If you're familiar with this process a third party will fund a lawsuit in support of the plaintiff and in exchange they will get part of the settlement or other end result. That has been around for some time and I would say it was kind of a small industry helping people get through paying their mortgage and some food money. It's turned into really now a much more larger industry and you're seeing private equity is entering this and foreign money is coming in and I was on a panel during our Summer NCOIL meeting in Minneapolis and I went up to my room and I got on a panel and started talking about how are we going to get our hands around this? It's become a national issue especially in the area of these kind of nuclear verdicts that are coming out. And so I do think it's time because of this kind of interest on a national scale I think it's time for NCOIL to kind of re-engage and be a part of this. I've never had the intent of prohibiting this practice. I think we just have to put some strong parameters around it.

We had this issue at NCOIL several years ago. Some of you may recall. We never got a lot of traction. I don't think it was as big an issue maybe then as it has become today. But with the issue as it's progressed I think we need to get back involved. I've relayed this interest to the NCOIL staff and we've put it on as a general session in November in Columbus. But I want that to be a jumping off point to develop a model law that I want to sponsor and lead to discussion next year. Like I said we did pass some of this in Indiana this year. We didn't go probably as far as I would have liked but we're starting to have that discussion. So I look forward to working with everyone on that and anyone who has interest can reach out to me or the NCOIL staff.

ADJOURNMENT
Hearing no further business, upon a Motion made by Rep. Lehman and seconded by Rep. Dunnigan, the Committee adjourned at 1:00 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Proposed Amendments to NCOIL Model State Uniform Building Code

Proposed Amendments sponsored by Rep. Jim Dunnigan (UT) and co-sponsored by Rep. Matthew Gambill (GA) will be referenced during the NCOIL Property & Casualty Committee on November 17, 2023

SECTION 1.

A. Beginning January 1, 20XX, property insurance companies shall provide a premium discount or insurance rate reduction to any owner who builds or locates a new insurable property in the State of XXXXXXXXX if the insurable property is certified as being constructed in accordance with the standards set forth in subsection B of this section. Insurance companies shall be required to offer such a premium discount or rate reduction only when the insurer determines they are actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property in this state shall be certified as constructed in accordance with the FORTIFIED Home High Wind and Hail Standards as may from time to time be adopted by the Institute for Business and Home Safety or a successor entity. An insurable property shall be certified as conforming to the FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards provided in subsection B of this section, receipts from contractors and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any

such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction required by this section shall submit a rating plan certified by their actuary as actuarially justified providing for the premium discount or rate reduction described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply any applicable premium discount, rate reduction or other adjustment to the wind and hail premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

SECTION 2.

A. Beginning January 1, 20XX, property insurance companies shall provide a premium discount or insurance rate reduction to any owner who retrofits an insurable property in the State of XXXXXXXXX if the insurable property is certified as being retrofitted in accordance with the standards set forth in subsection B of this section. Insurance companies shall be required to offer a premium discount or rate reduction only when the insurer has deemed the adjustments to be actuarially justified and there is sufficient and credible evidence of cost savings, which can be attributed to the construction standards set forth in subsection B of this section. In addition, insurance companies may also offer additional adjustments in deductible, other risk differentials, or a combination thereof, collectively referred to as other adjustments.

B. To obtain the premium discount, rate reduction, or other adjustment provided in this section, an insurable property shall be retrofitted to the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety (IBHS) or a successor entity. Wind-Zone-3-HUD-Code manufactured homes installed on a permanent foundation and retrofitted as defined in the FORTIFIED Home High Wind and Hail Standards, as may from time to time be adopted by the Institute for Business and Home Safety or a successor entity, shall be eligible for

the premium discount or rate reduction provided in this section. An insurable property shall be certified as conforming to FORTIFIED Home High Wind and Hail Standards only after evaluation and certification by an evaluator certified pursuant to the FORTIFIED Home High Wind and Hail Standards.

C. An owner of insurable property claiming a premium discount, rate reduction, or other adjustment pursuant to this section shall maintain sufficient certification records and construction records including, but not limited to, a certification of compliance with the FORTIFIED Home High Wind and Hail Standards as provided in subsection B of this section, receipts from contractors, and receipts for materials. The records shall be subject to audit by the Insurance Commissioner, or his or her representatives, and copies of any such records shall be presented to the insurer or potential insurer of a property owner before the premium discount, rate reduction, or other adjustment becomes effective for the insurable property.

D. Insurers that write policies that are subject to the premium discount or rate reduction required by this section shall submit rating plans certified by their actuary as actuarially justified providing for the premium discounts or rate reductions described in this section. A premium discount, rate reduction, or other adjustment shall only apply to policies that provide wind or hail coverage and to that portion of the premium for wind or hail coverage. A premium discount, rate reduction, or other adjustment shall apply exclusively to the wind and hail premium applicable to improved insurable property. If an insurer already offers an actuarially justified hail resistance discount, that discount shall be deemed as having met the requirements of this act as it pertains to hail-related discounts or rate reductions and no additional hail-related discount or rate reduction shall be required. If an insurer already offers an actuarially justified discount for IBHS FORTIFIED Home standards, that discount shall be deemed as having met the requirements of this act as it pertains to wind-related discounts or rate reductions and no additional wind-related discount or rate reduction shall be required. Insurers shall apply the premium discount, rate reduction, or other adjustment to the wind premium at the policy renewal that follows the submission of the certification to the insurer. At the time of a policy renewal for which a premium discount, rate reduction, or other adjustment has previously been made, the insurer may request documentation or recertification that the fortified standards as described in subsection C of this section continue to be met. In addition to the requirements of this section, an insurer may voluntarily offer any other mitigation adjustment that the insurer deems appropriate.

SECTION 3.

For the purposes of this act, the term "insurable property" includes single-family residential property. Insurable property also includes modular homes satisfying the codes, standards or techniques as provided in Section 1 or 2 of this act. Manufactured homes or mobile homes are excluded, except as expressly provided in subsection B of Section 2 of this act.

SECTION 4.

This act shall only apply to new insurance policies written, or existing policies renewed, on or after January 1, 20XX.

SECTION 5.

The Insurance Commissioner shall promulgate such rules as are necessary to implement and administer this act.

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NATIONAL COUNCIL OF INSURANCE LEGISLATORS (NCOIL)

Model State Uniform Building Code

Readopted by the NCOIL Executive Committee on July 15, 2012, and by the Property-Casualty Insurance Committee on July 13, 2012. First adopted by the Executive Committee on March 3, 2007, and by the P-C Insurance Committee on March 2, 2007. Re-adopted by the NCOIL Property & Casualty Insurance Committee on July 12, 2018 and the NCOIL Executive Committee on July 15, 2018
Sponsored by Rep. George Keiser (ND)

**To be considered for re-adoption during the Property & Casualty Insurance Committee meeting on November 17, 2023.*

****Proposed amendments sponsored by Rep. Jim Dunnigan (UT)***

Section 1: Purpose

A. This Act provides for the adoption, updating, amendment, interpretation, and enforcement of a single, unified state building code that applies to the design, construction, erection, alteration, modification, repair, or demolition of public or private buildings, structures, or facilities in this state to provide effective and reasonable protection for public safety, health, and general welfare at reasonable costs, and establishes a Building Code Commission to effect those ends.

B. This Act establishes statewide building standards that would take effect one (1) year after enactment. For hurricane, flood, and seismic exposure areas in the state, the Act requires that such high-hazard areas implement those standards no later than 90 days following enactment.

C. This Act is intended to permit the fullest use of modern technical methods, devices, and improvements; encourage the use of standardized construction practices, methods, equipment, materials, and techniques; and eliminate restrictive, obsolete, conflicting, and unnecessary building regulations.

D. This Act provides that local governments shall have the authority to enforce the [insert state] Uniform Building Code.

Section 2: State Building Code Commission

A. A Building Code Commission shall be established in the [insert appropriate state agency] to perform the following functions in establishing and administering the state's Uniform Building Code program:

1. review, modify, update, and promulgate the building codes referenced below in accordance with provisions of this Act and the Administrative Procedures Act of this state

2. promulgate rules and regulations to modify portions of the [insert state] Uniform Building Code as provided by this Act

3. review and update the [insert state] Uniform Building Code at least every three (3) years

4. establish qualifications for personnel responsible for inspection and enforcement of the [insert state] Uniform Building Code

5. adopt rules and regulations prescribing minimum standards for administration and enforcement of the [insert state] Uniform Building Code

6. assist counties and municipalities in establishing programs to ensure consistent, effective, and efficient administration and enforcement of the [insert state] Uniform Building Code

7. develop, and in conjunction with counties and municipalities, disseminate training and education programs for code officials and contractors and programs to raise homeowners' awareness of steps that they may take to enhance the safety, comfort, value, and livability of buildings

8. review all requests from municipalities or counties for variation from the [insert state] Uniform Building Code to determine which variations, if any, are justified by local conditions and may be enacted after a finding on the record that modification does not diminish structural integrity or stability to affect the public health, safety, and welfare

9. provide interpretations of contested provisions of the [insert state] Uniform Building Code

10. in conjunction with appropriate state, municipal, or county government agencies, resolve requirements of those agencies that conflict with the application or enforcement of the state Uniform Building Code

Section 3: Commission Membership

A. The Building Code Commission shall consist of 16 members appointed by the governor, subject to Senate confirmation, who each will serve for a period of four (4) years. Members shall be appointed within 15 days of the effective date of this Act. Initial appointments shall be staggered, with six (6) appointments for a two (2) year period; six (6) appointments for a three (3) year period; and three (3) appointments for a four (4) year period. Vacancies shall be filled for the remainder of an unexpired term.

B. The Commission shall consist of:

1. an architect licensed in this state

2. a structural engineer licensed in this state

3. a mechanical or electrical engineer licensed in this state

4. a general contractor doing business in this state

5. a residential contractor doing business in this state

6. a municipal administrator, manager, or elected official

7. a county administrator, manager, or elected official

8. a representative of the State Fire Marshall

9. a certified code enforcement official

10. a representative of the plumbing industry doing business in this state

11. a representative of the electrical industry doing business in this state

12. a representative of the mechanical or gas industry doing business in this state

13. a representative of the manufactured housing industry

14. a disabled person

15. a representative of the property-casualty insurance industry

16. a representative of the general public

Section 4: Commission Administration

A. The Commission shall:

1. convene within 45 days of the effective date of this Act

2. elect from its members a chairman

3. meet at least four (4) times a year

a. at the call of the chair

b. at the request of a majority of its membership

c. at the request of the [insert appropriate state agency]

d. or at such times as may be prescribed by the Commission's rules

B. Members shall be notified in writing of the time and place of a regular or special meeting at least seven (7) days in advance of the meeting. A majority of members of the Commission shall constitute a quorum.

C. The Commission and its members shall be immune from personal liability for actions taken in good faith in the discharge of their responsibilities. The state shall hold the Commission and its members harmless from all costs, damages, and attorney fees arising from claims and suits against them with respect to matter to which immunity applies.

D. Members of the Commission shall receive per diem or other compensation for their duties on the Commission, as determined by state policy.

Section 5: State Uniform Building Code

A. The Commission, pursuant to the State Administrative Procedures Act, shall adopt a State Uniform Building Code to take effect within one (1) year of the effective date of this Act.

B. The State Uniform Building Code shall contain or incorporate all laws and rules that pertain to and govern the design, construction, erection, alteration, modification, repair, and demolition of public and private buildings, structures, and facilities and the enforcement of such laws and rules, except as otherwise provided in this Section.

C. The provisions of this Act shall not apply to structures that are constructed on a farm, other than residences or structures attached to them.

D. The Commission shall adopt a State Uniform Building Code by reference to the latest editions of the following nationally recognized codes and the standards for the regulation of construction within this State: building, residential, existing buildings, gas, plumbing, mechanical, electrical, fire, and energy codes as promulgated, published, or made available by the International Code Council, Inc. and the National Electrical Code as published by the National Fire Protection Association. The appendices of the codes

provided in this Section may be adopted as needed, but the specific appendix or appendices must be referenced by name or letter designation at the time of adoption.

E. The Commission may modify the selected model codes and standards as needed to accommodate the specific needs of this state provided that modifications do not diminish structural integrity or stability to affect the public health, safety, and welfare.

F. Counties and municipalities, upon review and approval by the Commission, may adopt amendments to the technical provisions of the State Uniform Building Code that apply solely within their jurisdictions and that provide for more stringent requirements than those specified in the State Uniform Building Code.

G. The Commission shall review and update the State Uniform Building Code ~~at~~ to maintain a code version that is no older than four (4) years old~~least every three (3) years~~.

H. To the extent that federal regulations preempt state and local laws, nothing in this chapter shall conflict with the federal Department of Housing and Urban Development (HUD) regulations regarding manufactured housing construction and installation.

Section 6: State Building Code Provisions Addressing Catastrophic Hazards—Wind, Flood, and Seismic

A. Wind and flood mitigation requirements prescribed by the ~~2006 or later~~ most current version of the International Building Code and ~~2006 or later~~ most current version of the International Residential Code are adopted by this Act and shall apply within [insert appropriate areas of state] and seismic requirements by the 2006 or later most current version of the International Building Code and the ~~2006 or later~~ most current version of the International Residential Code shall apply within [insert appropriate areas of state].

B. Wind, flood, and seismic code provisions shall be enforced no later than 90 days from the effective date of this Act. If counties or municipalities are unable to enforce the provisions of this Section, the [insert appropriate state agency] shall enforce the provisions.

C. The [state agency] may establish contract agreements with counties, municipalities, and third party providers in order to provide enforcement of this Section.

Section 7: Enforcement

A. Notwithstanding any other law to the contrary, all counties and municipalities in this state shall enforce only the State Uniform Building Code as provided for in this Act, including enforcing any more stringent county or municipal standards as authorized under Section 5(F).

B. The Commission shall promulgate rules and regulations prescribing minimum standards for administration and enforcement of the State Uniform Building Code.

C. Such rules and regulations shall address the nature and quality of enforcement and shall include, but not be limited to, the frequency of inspections; number and qualifications of staff, including qualifications required for inspectors; required minimum fees for administration and enforcement; adequacy of inspections; adequacy of means for insuring compliance with the Uniform Code; and procedures whereby any provision or requirement of the State Uniform Building Code may be varied or modified, subject to requirements of this Act.

D. Municipalities and counties may establish agreements with other governmental entities of the state to issue permits and enforce building codes in order to provide the services required by this Act.

E. The Commission may assist in arranging for municipalities, counties, or consultants to provide the services required by this Act to other municipalities or counties if a written request from the governing body of such municipality or county seeking assistance is submitted to the Commission.

Section 8: Penalties

Should any building or structure be maintained, erected, constructed, reconstructed, or its purpose altered, so that it becomes in violation of the State Uniform Building Code, either the county or municipal enforcement officer or the [insert appropriate state agency] may, in addition to other remedies, institute any appropriate action or proceeding in order to:

A. prevent the unlawful maintenance, erection, construction, reconstruction, or alteration of the building/structure's purpose, or to prevent overcrowding

B. restrain, correct, or abate the violation, or

C. prevent the occupancy or use of the building, structure, or land until the violation is corrected

Section 9: Effective Date

This Act shall take effect upon enactment.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Public Adjuster Professional Standards Reform Model Act

***Sponsored by Rep. Michael Meredith (KY)**
***Co-sponsored by Rep. Matt Lehman (IN) – NCOIL Immediate Past President and Del. Steve Westfall (WV)**

***Draft as of ~~June~~September 18~~20~~, 2023. To be discussed during the Property & Casualty Insurance Committee meeting on November~~July~~ 17, 2023.**

Table of Contents

Section 1. Title

This Act shall be known and cited as the "[State] Public Adjuster Professional Standards Reform Act."

Drafting Note: This Model Act is primarily intended to amend each state's statutory code that sets forth licensing and other professional standards for public adjusters.

Section 2. Definitions

(1) "Person" includes an individual, firm, company, association, organization, partnership, limited liability company, or corporation.

(2) "Public insurance adjuster" or "public adjuster" means:

(A) a person who, for direct, indirect, or any other compensation:

(i) acts on behalf of an insured in negotiating for or effecting the settlement of a claim or claims for loss or damage under any policy of insurance covering real or personal property; or

(ii) on behalf of any other public insurance adjuster, investigates, settles, or adjusts or advises or assists an insured with a claim or claims for loss or damage under any policy of insurance covering real or personal property; or

(B) a person who advertises, solicits business, or holds himself or herself out to the public as an adjuster of claims for loss or damage under any policy of insurance covering real or personal property.

Section 3~~2~~. Application for License

(1) Except as provided in this section and xxxxx, no person shall in this state act as or hold himself, herself, or itself out to be ~~an independent, staff, or~~ public adjuster unless then licensed by the department as an ~~independent, staff,~~ or public adjuster.

(2) (a) An individual applying for a resident ~~independent, staff, or~~ public adjuster license shall make an application to the commissioner on the appropriate uniform individual application and in a format prescribed by the commissioner.

(b) An applicant under paragraph (a) of this subsection shall declare under penalty of suspension, revocation, or refusal of the license that the statements made in the application are true, correct, and complete to the best of the individual's knowledge and belief.

(c) Before approving an application submitted under paragraph (a) of this subsection, the commissioner shall find that the individual to be licensed:

1. Is at least eighteen (18) years of age;

2. Is eligible to designate [State] as the individual's home state;

3. Is trustworthy, reliable, and of good reputation, evidence of which shall be determined through an investigation by the commissioner;

4. Has not committed any act that is a ground for probation, suspension, revocation, or refusal of a license as set forth in xxxxxx;

5. Has successfully passed the examination for the adjuster license and the applicable line of authority for which the individual has applied;

6. Has paid the fees established by the commissioner pursuant to xxxxx; and

7. Is financially responsible to exercise the license.

(3) (a) To demonstrate financial responsibility, a person applying for a public adjuster license shall obtain a bond or irrevocable letter of credit prior to issuance of a license and shall maintain the bond or letter of credit for the duration of the license with the following limits:

1. A surety bond executed and issued by an insurer authorized to issue surety bonds in [State], which bond shall:

a. Be in the minimum amount of fifty thousand dollars ($50,000);

b. Be in favor of the state of [xxxxxx];

c. Specifically authorize recovery of any person in [State] who sustained damages as the result of the public adjuster's erroneous acts, failure to act, conviction of fraud, or conviction for unfair trade practices in his or her capacity as a public adjuster; and

d. Not be terminated unless written notice is given to the licensee at least thirty (30) days prior to the termination; or

2. An irrevocable letter of credit issued by a qualified financial institution, which letter of credit shall:

a. Be in the minimum amount of fifty thousand dollars ($50,000);

b. Be subject to lawful levy of execution on behalf of any person to whom the public adjuster has been found to be legally liable as the result of erroneous acts, failure to act, conviction of fraud, or conviction for unfair practices in his or her capacity as a public adjuster; and

c. Not be terminated unless written notice is given to the licensee at least thirty (30) days prior to the termination.

(b) The commissioner may ask for evidence of financial responsibility at any time the commissioner deems relevant.

(c) If the evidence of financial responsibility terminates or becomes impaired, the public adjuster license shall:

1. Automatically terminate; and

2. Be promptly surrendered to the commissioner without demand.

(4) (a) A business entity applying for a resident independent or public adjuster license shall make an application to the commissioner on the appropriate uniform business entity application and in a format prescribed by the commissioner.

(b) An applicant under paragraph (a) of this subsection shall declare under penalty of suspension, revocation, or refusal of the license that the statements made in the application are true, correct, and complete to the best of the business entity's knowledge and belief.

(c) Before approving an application submitted under paragraph (a) of this subsection, the commissioner shall find that the business entity:

1. Is eligible to designate [State] as its home state;

2. Has designated a licensed independent or public adjuster responsible for the business entity's compliance with the insurance laws and regulations of [State];

3. Has not committed an act that is a ground for probation, suspension, revocation, or refusal of an independent or public adjuster's license as set forth in xxxx; and

4. Has paid the fees established by the commissioner pursuant to xxxxxx.

(5) For applications made under this section, the commissioner may:

(a) Require additional information or submissions from applicants; and

(b) Obtain any documents or information reasonably necessary to verify the information contained in an application.

(6) Unless denied licensure pursuant to xxxxx, a person or business entity who has met the requirements of subsections (2) to (5) of this section shall be issued an ~~independent, staff, or~~ public adjuster license.

~~(7) An independent or staff adjuster may qualify for a license in one (1) or more of the following lines of authority:~~

~~(a) Property and casualty;~~

~~(b) Workers' compensation; or~~

~~(c) Crop.~~

~~(8) Notwithstanding any other provision of this subtitle, an individual who is employed by an insurer to investigate suspected fraudulent insurance claims, but who does not adjust losses or determine claims payments, shall not be required to be licensed as a staff adjuster.~~

(7~~9~~) A public adjuster may qualify for a license in one (1) or more of the following lines of authority:

(a) Property and casualty; or

(b) Crop.

~~(10) Notwithstanding any other provision of this subtitle, a license as an independent adjuster shall not be required of the following:~~

~~(a) An individual who is sent into [State] on behalf of an insurer for the sole purpose of investigating or making adjustment of a particular loss resulting from a catastrophe, or for the adjustment of a series of losses resulting from a catastrophe common to all losses;~~

~~(b) An attorney licensed to practice law in [State], when acting in his or her professional capacity as an attorney;~~

~~(c) A person employed solely to obtain facts surrounding a claim or to furnish technical assistance to a licensed independent adjuster;~~

~~(d) An individual who is employed to investigate suspected fraudulent insurance claims, but who does not adjust losses or determine claims payments;~~

~~(e) A person who:~~

~~1. Solely performs executive, administrative, managerial, or clerical duties, or any combination thereof; and~~

~~2. Does not investigate, negotiate, or settle claims with policyholders, claimants, or their legal representatives;~~

~~(f) A licensed health care provider or its employee who provides managed care services if the services do not include the determination of compensability;~~

~~(g) A health maintenance organization or any of its employees or an employee of any organization providing managed care services if the services do not include the determination of compensability;~~

~~(h) A person who settles only reinsurance or subrogation claims;~~

~~(i) An officer, director, manager, or employee of an authorized insurer, surplus lines insurer, or risk retention group, or an attorney-in-fact of a reciprocal insurer;~~

~~(j) A United States manager of the United States branch of an alien insurer;~~

~~(k) A person who investigates, negotiates, or settles claims arising under a life, accident and health, or disability insurance policy or annuity contract;~~

~~(l) An individual employee, under a self-insured arrangement, who adjusts claims on behalf of the individual's employer;~~

~~(m) A licensed agent, attorney-in-fact of a reciprocal insurer, or managing general agent of the insurer, to whom claim authority has been granted by an insurer; or~~

~~(n) 1. A person who:~~

~~a. Is an employee of a licensed independent adjuster, is an employee of an affiliate that is a licensed independent adjuster, or is supervised by a licensed independent adjuster, if there are no more than twenty-five (25) persons under the supervision of one (1) licensed individual independent adjuster or licensed agent who is exempt from licensure pursuant to paragraph (m) of this subsection;~~

~~b. Collects claim information from insureds or claimants;~~

~~c. Enters data into an automated claims adjudication system; and~~

~~d. Furnishes claim information to insureds or claimants from the results of the automated claims adjudication system.~~

~~2. For purposes of this paragraph, "automated claims adjudication system" means a preprogrammed computer system designed for the collection, data entry, calculation, and system-generated final resolution of consumer electronic products insurance claims that complies with claim settlement practices pursuant to xxxxx.~~

(8~~11~~) Notwithstanding any other provision of this subtitle, a license as a public adjuster shall not be required of the following:

(a) An attorney licensed to practice law in [State], when acting in his or her professional capacity as an attorney;

(b) A person who negotiates or settles claims arising under a life or health insurance policy or an annuity contract;

(c) A person employed only for the purpose of obtaining facts surrounding a loss or furnishing technical assistance to a licensed public adjuster, including photographers, estimators, private investigators, engineers, and handwriting experts;

(d) A licensed health care provider or its employee who prepares or files a health claim form on behalf of a patient; or

(e) An employee or agent of an insurer adjusting claims relating to food spoilage with respect to residential property insurance in which the amount of coverage for the applicable type of loss is contractually limited to one thousand dollars ($1,000) or less.

~~(12) Notwithstanding any other provision of this subtitle, a license as a staff adjuster shall not be required of an employee or agent of an insurer adjusting claims relating to food spoilage with respect to residential property insurance in which the amount of coverage for the applicable type of loss is contractually limited to one thousand dollars ($1,000) or less.~~

(9~~13~~) For purposes of this section, except as otherwise provided in subsection (10~~5~~) of this section, "home state" means any state or territory of the United States or the District of Columbia in which a~~n independent, staff, or~~ public adjuster:

(a) Maintains his, her, or its principal place of residence or business; and

(b) Is licensed to act as a resident ~~independent, staff, or~~ public adjuster.

~~(14) Temporary registration for emergency independent or staff adjusters shall be issued by the commissioner in the event of a catastrophe declared in [State] in the following manner:~~

~~(a) An insurer shall notify the commissioner by submitting an application for temporary emergency registration of each individual not already licensed in the state where the catastrophe has been declared, who will act as an emergency independent adjuster on behalf of the insurer;~~

~~(b) A person who is otherwise qualified to adjust claims, but who is not already licensed in the state, may act as an emergency independent or staff adjuster and adjust claims if, within five (5) days of deployment to adjust claims arising from the catastrophe, the insurer notifies the commissioner by providing the following information, in a format prescribed by the commissioner:~~

~~1. The name of the individual;~~

~~2. The Social Security number of the individual;~~

~~3. The name of the insurer that the independent or staff adjuster will represent;~~

~~4. The catastrophe or loss control number;~~

~~5. The catastrophe event name and date; and~~

~~6. Any other information the commissioner deems necessary; and~~

~~(c) An emergency independent or staff adjuster's registration shall remain in force for a period not to exceed ninety (90) days, unless extended by the commissioner.~~

(10~~5~~) (a) As used in this subsection, "home state" has the same meaning as in subsection (13) of this section, except that for purposes of this subsection the term includes any state or territory of the United States or the District of Columbia in which an applicant under this subsection is licensed to act as a resident ~~independent, staff, or~~ public adjuster if the state or territory of the applicant's principal place of residence does not issue an ~~independent, staff, or~~ public adjuster license.

(b) Unless refused licensure in accordance with xxxxx, a nonresident person shall receive a nonresident ~~independent, staff, or~~ public adjuster license if:

1. The person is currently licensed in good standing as an ~~independent, staff, or~~ public adjuster in his, her, or its home state;

2. The person has submitted the proper request for licensure and has paid the fees required by xxxxx;

3. The person has submitted, in a form or format prescribed by the commissioner, the uniform individual application; and

4. The person's designated home state issues nonresident ~~independent, staff, or~~ public adjuster licenses to persons of [State] on the same basis.

(c) The commissioner may:

1. Verify an applicant's licensing status through any appropriate database, including the database maintained by the National Association of Insurance Commissioners, its affiliates, or subsidiaries; or

2. Request certification of an applicant's good standing.

(d) As a condition to the continuation of a nonresident adjuster license, the licensee shall maintain a resident adjuster license in his, her, or its home state.

(e) A nonresident adjuster license issued under this subsection shall terminate and be surrendered immediately to the commissioner if the licensee's resident adjuster license terminates for any reason, unless:

1. The termination is due to the licensee being issued a new resident ~~independent, staff, or~~ public adjuster license in his, her, or its new home state; and

2. The new resident state or territory has reciprocity with [State].

Section 4~~3~~. Public Adjuster and Insured Contract Requirements

(1) (a) Except as provided in paragraph (b) of this subsection, a public adjuster shall not provide services to an insured until a written contract with the insured has been executed on a form that has been pre-filed with and approved by the commissioner.

~~(b) The commissioner may approve a form that allows a public adjuster to be compensated for services provided to an insured prior to the execution of a written contract in emergency circumstances.~~

(b~~c~~) A contract between a public adjuster and an insured in violation of paragraph (a) of this subsection shall not be enforceable in this state.

(c~~d~~) A form pre-filed with the commissioner by a public adjuster for approval under paragraph (a) of this subsection shall be subject to disapproval by the commissioner at any time if the form is found to:

1. Violate any provision of this chapter;

2. Contain or incorporate by reference any inconsistent, ambiguous, or misleading clauses; or

3. Contain any title, heading, or other indication of its provisions which is:

a. Misleading; or

b. Printed in a size of typeface or manner of reproduction so as to be substantially illegible.

(de) A contract between a public adjuster and an insured that was executed on a form that was pre-filed with and approved by the commissioner under paragraph (a) of this subsection prior to a disapproval of the form under paragraph (d) of this subsection shall be enforceable to the extent allowed by:

1. Ordinary principles of contract; and

2. Any applicable state or federal laws implicated by the contract.

(2) A public adjuster shall ensure that all contracts between the public adjuster and the insured for services are in writing and contain the following terms:

(a) The legible full name of the adjuster signing the contract, as specified in the department's licensing records;

(b) The adjuster's permanent home state business address and phone number;

(c) The license number issued to the adjuster by the department;

(d) A title of "Public Adjuster Contract";

(e) The insured's full name, street address, insurer name, and policy number, if known or upon notification;

(f) A description of the loss or damage and its location, if applicable;

(g) A description of services to be provided to the insured;

(h) The signatures of the adjuster and the insured;

(i) The date the contract was signed by:

1. The adjuster; and

2. The insured;

(j) Attestation language stating that the adjuster has a letter of credit or a surety bond as required by xxxxx;

(k) The full salary, fee, commission, compensation, or other consideration the adjuster is to receive for services, including but not limited to:

1. If the compensation is based on a percentage of the insurance settlement, the exact percentage, which shall be in accordance with Section xxx of this Act;

2. The initial expenses to be reimbursed to the adjuster from the proceeds of the claim payment, specified by type, with dollar estimates; and

3. Any additional expenses, if first approved by the insured;

(l) A statement that the public adjuster may not render services or perform acts that constitute the practice of law.

(m) A statement that the adjuster shall not act on behalf of or aid any person in negotiating or settling a claim relating to bodily injury, death, or noneconomic damages;

(n~~m~~) The process for rescinding the contract, including the date by which rescission of the contract by the adjuster or the insured may occur; and

(o~~n~~) A statement that clearly states in substance the following: "Complaints regarding this contract or regarding the public adjuster may be filed with the consumer protection division of the [State] Department of Insurance."

(3) (a) Compensation provisions in a contract between a public adjuster and an insured shall not be redacted in any copy of the contract provided to the commissioner.

(b) A redaction prohibited under paragraph (a) of this subsection shall constitute an omission of material fact in violation of xxxx and xxxx.

(4) A contract between a public adjuster and an insured shall not contain any contract term that:

(a) Allows the adjuster's percentage fee to be collected when money is due from an insurer, but not paid;

(b) Allows the adjuster to collect the entire fee from the first check issued by an insurer, rather than as a percentage of each check issued by an insurer;

(c) Requires an insured to authorize an insurer to issue a check only in the name of the adjuster;

(d) Imposes collection costs or late fees;

(e) Allows the adjuster's rate of compensation to be increased based on the fact that a claim is litigated; or

(f) Precludes the adjuster from pursuing civil remedies.

(5) Prior to the signing of a contract with an insured, a public adjuster shall provide the insured with a separate disclosure document regarding the claim process that states the following:

"Property insurance policies obligate the insured to present a claim to his or her insurance company for consideration. Three (3) types of adjusters may be involved in the claim process as follows:

1. "Staff adjuster" means an insurance adjuster who is an employee of an insurance company, who represents the interest of the insurance company, and who is paid by the insurance company. A staff adjuster shall not charge a fee to the insured;

2. "Independent adjuster" means an insurance adjuster who is hired on a contract basis by an insurance company to represent the insurance company's interest in the settlement of the claims and who is paid by the insurance company. An independent adjuster shall not charge a fee to the insured; and

3. "Public adjuster" means an insurance adjuster who does not work for any insurance company. A public adjuster works for the insured to assist in the preparation, presentation, and settlement of the claim, and the insured hires a public adjuster by signing a contract agreeing to pay him or her a fee or commission based on a percentage of the settlement or another method of payment.

The insured is not required to hire a public adjuster to help the insured meet his or her obligations under the policy, but has the right to hire a public adjuster. The insured has the right to initiate direct communications with the insured's attorney, the insurer, the insurer's adjuster, the insurer's attorney, and any other person regarding the settlement of the insured's claim. The public adjuster shall not be a representative or employee of the insurer. The salary, fee, commission, or other consideration paid to the public adjuster is the obligation of the insured, not the insurer."

(6) (a) A contract between a public adjuster and an insured shall be executed in duplicate to provide an original contract to:

1. The public adjuster; and

2. The insured.

(b) A public adjuster's original contract shall be available at all times for inspection by the commissioner without notice.

(7) Within seventy-two (72) hours of entering into a contract with an insured, a public adjuster shall provide the insurer:

(a) A notification letter that:

1. Has been signed by the insured; and

2. Authorizes the public adjuster to represent the insured's interest; and

(b) A copy of the contract.

(8) (a) The insured shall have the right to rescind a contract with a public adjuster within three (3) business days after the date the contract was signed.

(b) A rescission of a public adjuster contract shall be:

1. In writing;

2. Mailed or delivered to the public adjuster at the address in the contract; and

3. Postmarked or received within the three (3) business day period.

(9) If an insured exercises the right to rescind a contract under subsection (8) of this section, anything of value given by the insured under the contract to the public adjuster shall be returned to the insured within fifteen (15) business days following receipt by the public adjuster of the rescission notice.

Section 5~~4~~. Insured's rights -Written notice requirement -Duties of public adjuster

(1) A public adjuster shall give an insured written notice of the insured's rights under this section and Sections 2 and 4 of this Act.

(2) A public adjuster shall prepare each claim for an insured represented by the public adjuster in accordance with the terms and conditions of the contract of insurance under which recovery is sought.

(3~~2~~) A public adjuster shall ensure that:

(a) Prompt notice of a claim is provided to the insurer;

(b) The property that is subject to a claim is available for inspection of the loss or damage by the insurer; and

(c) The insurer is given the opportunity to interview the insured directly about the loss or damage and claim.

(4~~3~~) A public adjuster shall not restrict or prevent an insurer or its adjuster, or an attorney, investigator, or other person acting on behalf of the insurer, from:

(a) Having reasonable access, at reasonable times, to:

1. The insured or claimant; or

2. The insured property that is the subject of a claim;

(b) Obtaining necessary information to investigate and respond to a claim; or

(c) Corresponding directly with the insured regarding the claim, except a public adjuster shall be copied on any correspondence with the insured relating to the claim.

(5~~4~~) (a) A public adjuster shall not act or fail to reasonably act in any manner that obstructs or prevents the insurer or its adjuster from timely conducting an inspection of any part of the insured property for which there is a claim for loss or damage.

(b) Except as provided in paragraph (c) of this subsection, a public adjuster representing an insured may be present for the insurer's inspection.

(c) If the unavailability of a public adjuster, after a reasonable request by the insurer, otherwise delays the insurer's timely inspection of the property, the insured shall allow the insurer to have access to the property without the participation or presence of the public adjuster in order to facilitate the insurer's prompt inspection of the loss or damage.

(6~~5~~) A public adjuster shall provide the insured, the insurer, and the commissioner with a written disclosure concerning any direct or indirect financial interest that the adjuster has with any other party who is involved in any aspect of the claim.

(7~~6~~) A public adjuster shall not:

(a) Participate, directly or indirectly, in the reconstruction, repair, or restoration of damaged property that is the subject of a claim adjusted by the adjuster;

(b) Engage in any activities that may be reasonably construed as a conflict of interest, including, directly or indirectly, soliciting or accepting any remuneration of any kind or nature;

(c) Solicit or attempt to solicit a client for employment during the progress of a loss-producing natural disaster occurrence.

(~~d~~e) Have a financial interest in any salvage, repair, or any other business entity that obtains business in connection with any claim that the public adjuster has a contract to adjust; or

(e~~d~~) 1. Use claim information obtained in the course of any claim investigation for commercial purposes.

2. As used in subparagraph 1. of this paragraph, "commercial purposes" includes marketing or advertising used for the benefit of the public adjuster.

(f~~e~~) File a complaint with the commissioner on behalf of an insured alleging an unfair claim settlement practice unless the insured has given written consent for the public adjuster to file the complaint on the insured's behalf.

(g) Pay, allow, or give, or offer to pay, allow, or give, directly or indirectly, to a person who is not a licensed public insurance adjuster a fee, commission, or other valuable consideration for the referral of an insured to the public insurance adjuster for purposes of the insured entering a contract with that public insurance adjuster or for any other purpose.

(h) Accept a fee, commission, or other valuable consideration of any nature, regardless of form or amount, in exchange for the referral by a licensed public insurance adjuster of an insured to any third-party individual or firm, including an attorney, appraiser, umpire, construction company, contractor, or salvage company.

Section 6~~5~~. Requirements for Funds Received or Held by Public Adjuster

(1) All funds received or held by a public adjuster on behalf of an insured toward the settlement of a claim shall be:

(a) Handled in a fiduciary capacity; and

(b) Deposited into one (1) or more separate noninterest-bearing fiduciary trust accounts in a financial institution licensed to do business in this state no later than the close of the second business day from the receipt of the funds.

(2) The funds referenced in subsection (1) of this section shall:

(a) Be held separately from any personal or nonbusiness funds;

(b) Not be commingled or combined with other funds;

(c) Be reasonably ascertainable from the books of accounts and records of the public adjuster; and

(d) Be disbursed within thirty (30) calendar days of any invoice received by the public adjuster upon approval of the insured or the claimant that the work has been satisfactorily completed.

(3) A public adjuster shall maintain an accurate record and itemization of any funds deposited into an account under subsection (1) of this section in accordance with xxxxxx.

Section 7~~6~~. Fees and Commissions for Public Adjuster

(1) Except as provided in subsection (2) of this section:

(a) Any fee charged to an insured by a public adjuster shall be:

1. Based only on the amount of the insurance settlement proceeds actually received by the insured; and

2. Collected by the public adjuster after the insured has received the insurance settlement proceeds from the insurer;

(b) A public adjuster may receive a commission for services provided under this subtitle consisting of:

1. An hourly fee;

2. A flat rate;

3. A percentage of the total amount paid by the insurer to resolve a claim; or

4. Another method of compensation; and

(c) A public adjuster:

1. Shall not charge an unreasonable fee; and

2. May charge a reasonable fee that does not exceed, inclusive of all compensation the public adjuster is paid on a claim:

a. For non-catastrophic claims, fifteen percent (15%) of the total insurance recovery of the insured; and

b. For catastrophic claims, ten percent (10%) of the total insurance recovery of the insured.

Drafting Note: The fee caps included in this model are the maximum fees the model allows. States may, and some states do, impose lower caps, and the intent of this model is not to replace any lower caps.

(2) If an insurer, not later than seventy-two (72) hours after the date on which a loss or damage is reported to the insurer, either pays or commits in writing to pay the policy limit of the insurance policy to the insured, a public adjuster shall:

(a) Not receive a commission consisting of a percentage of the total amount paid by the insurer to resolve a claim;

(b) Inform the insured that the claim settlement amount may not be increased by the insurer; and

(c) Be entitled only to reasonable compensation from the insured for services provided by the adjuster on behalf of the insured, based on the time spent on the claim and expenses incurred by the adjuster prior to when the claim was paid or the insured received a written commitment to pay from the insurer.

Section 8~~7~~. Penalties

(1) The commissioner may place on probation, suspend, or may impose conditions upon the continuance of a license for not more than twenty-four (24) months, revoke, or refuse to issue or renew any license issued under this Act, or may levy a civil penalty in accordance with xxxxxx, or any combination of actions for any one (1) or more of the following causes:

(a) Providing incorrect, misleading, incomplete, or materially untrue information in a license application;

(b) Violating any insurance laws, or violating any administrative regulations, subpoena, or order of the commissioner or of another state's insurance commissioner;

(c) Obtaining or attempting to obtain a license through misrepresentation or fraud;

(d) Improperly withholding, misappropriating, or converting any moneys or properties received in the course of doing insurance or the business of life settlements;

(e) Intentionally misrepresenting the terms of an actual or proposed insurance contract, life settlement contract, or application for insurance;

(f) Having been convicted of or having pled guilty or nolo contendere to any felony;

(g) Having admitted or been found to have committed any unfair insurance trade practice, insurance fraud, or fraudulent life settlement act;

(h) Using fraudulent, coercive, or dishonest practices; or demonstrating incompetence, untrustworthiness, or financial irresponsibility; or being a source of injury or loss to the public in the conduct of business in this state or elsewhere;

(i) Having an insurance license, life settlement license, or its equivalent, denied, suspended, or revoked in any other state, province, district, or territory;

(j) Surrendering or otherwise terminating any license issued by this state or by any other jurisdiction, under threat of disciplinary action, denial, or refusal of the issuance of or renewal of any other license issued by this state or by any other jurisdiction; or revocation or suspension of any other license held by the licensee issued by this state or by any other jurisdiction;

(k) Forging another's name to an application for insurance, to any other document related to an insurance transaction, or to any document related to the business of life settlements;

(l) Cheating, including improperly using notes or any other reference material to complete an examination for license;

(m) Knowingly accepting insurance from an individual or business entity who is not licensed, but who is required to be licensed under this subtitle;

(n) Failing to comply with an administrative or court order imposing a child support obligation;

(o) Failing to pay state income tax or to comply with any administrative or court order directing payment of state income tax;

(p) Having been convicted of a misdemeanor for which restitution is ordered in excess of three hundred dollars ($300), or of any misdemeanor involving dishonesty, breach of trust, or moral turpitude;

(q) Failing to no longer meet the requirements for initial licensure; or

(r) Any other cause for which issuance of the license could have been refused, had it then existed and been known to the commissioner.

(2) (a) For any public adjuster or apprentice adjuster supervised by a public adjuster under xxxxx, the commissioner may deny, suspend, or revoke the adjuster's license or impose a fine not to exceed five thousand dollars ($5,000) per act against the adjuster, or both, for any of the following causes:

1. Violating any provision of this chapter;

2. Violating any administrative regulation or order of the commissioner;

3. Receiving payment or anything of value as a result of an unfair or deceptive practice;

4. Receiving or accepting any fee, kickback, or other thing of value pursuant to any agreement or understanding, oral or otherwise, from anyone other than an insured;

5. Entering into a split-fee arrangement with another person who is not a public adjuster; or

6. Being otherwise paid or accepting payment for public adjuster services that have not been performed.

(b) The sanctions and penalties under this subsection shall be in addition to any other remedies, penalties, or sanctions available to the commissioner against a public adjuster or an apprentice adjuster supervised by a public adjuster under xxxxx under this section or any other law.

(3) The license of a business entity may be suspended, revoked, or refused for any cause relating to an individual designated in or registered under the license if the commissioner finds that:

(a) An individual licensee's violation was known or should have been known by one (1) or more of the partners, officers, or managers acting on behalf of the business entity; and

(b) The violation was not reported to the department nor corrective action taken.

(4) The applicant or licensee may make written request for a hearing in accordance with xxxx.

(5) The commissioner shall retain the authority to enforce the provisions and penalties of this chapter against any individual or business entity who is under investigation for or charged with a violation of this chapter, even if the individual's or business entity's license has been surrendered or has lapsed by operation of law.

(6) The sanctions and penalties applicable to licenses and licensees under subsection (1) of this section shall also be applicable to registrations and registrants under xxxxxx.

(7) Any contract for services regulated by this Act that is entered into by an insured with a person who is in violation of the public adjuster licensure requirements of this state shall be voided. If a contract is voided under this section, the insured is not liable for the payment of any past services rendered, or future services to be rendered, by the violating person under that contract or otherwise.

Section 9~~8~~. Rules

Pursuant to xxxxx, the commissioner may promulgate administrative regulations necessary for or as an aid to the effectuation of any provision of this Act.

Section 10~~9~~. Effective Date

This Act shall take effect xxxxxx.

616 Fifth Avenue, Suite 106
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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Catalytic Converter Theft Prevention Model Act

Draft as of June 20, 2023. To be ~~introduced and~~ discussed during the Property & Casualty Insurance Committee on November 17~~July 22~~, 2023.

Rep. Tom Oliverson, M.D. (TX) – NCOIL Vice President; Rep. Edmond Jordan (LA) --- Joint Sponsors

Section 1. Title

This Act shall be known and cited as the [State] Catalytic Converter Theft Prevention Act.

Section 2. Definitions

(1) "Catalytic converter" means an exhaust emission control device that reduces toxic gas and pollutants from internal combustion engines.

(2) "Used catalytic converter" means a catalytic converter that has been detached from a motor vehicle as a single item and not as part of a scrapped motor vehicle, or any nonferrous part thereof; but does not include a catalytic converter that has been tested, certified, and labeled for reuse in accordance with the Clean Air Act, Chapter 85 of Title 42 of the United States Code, and all applicable regulations thereunder.

(3) "Covered Activity" means the die or pin stamping of the full vehicle identification number onto the outside of a catalytic converter in a conspicuous manner on motor vehicles in a typed font and covered by applying a coat of high-visibility, high-heat theft deterrence paint.

(4) "Department" means the Department of [XXXX].

(5) "[Law Enforcement] Department" means the Department of [XXXX].

(6) “Eligible Entity” means:

i. State and local law enforcement agencies;

ii. Licensed auto dealers;

iii. Licensed auto repair shops and vehicle service centers; and

iv. Nonprofit organizations established to

(a) assist federal, state, or local law enforcement agencies in the investigation or prosecution of vehicle-related crimes; or

(b) detect, prevent, and deter insurance crime and fraud.

(7) “Person” means any individual, or any corporation, limited liability company, partnership, association, or other group existing under or authorized by the laws of either [State] or the United States.

Section 3. Catalytic Converter Theft

Any person who steals or knowingly and unlawfully takes, carries away, or conceals a catalytic converter from another person’s motor vehicle shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

Section 4. Aggravated Offenses

(a) Any person convicted for an offense committed under Section 3 two or more times previously, upon any subsequent convictions, shall be guilty of a Class [X] felony and shall be sentenced to at least [XX] years in prison or fined under this Section not more than [XX] dollars. Any sentence imposed under this Section must run consecutive to any sentence imposed under Section 3.

(b) Any person convicted for an offense committed under Section 3 while armed shall be sentenced to at least [XX] years in prison or fined under this Section not more than [XX] dollars.

Section 5. Receipt of Stolen Catalytic Converters

(a) Any person who buys, receives, possesses, or obtains control of a stolen catalytic converter, knowing or having reason to believe that the catalytic converter was stolen shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

(b) For the purposes of this Section, the term "stolen property" includes property that is not in fact stolen if the person who buys, receives, possesses, or obtains control of the property had reason to believe that the property was stolen.

Section 4. Limitations on Sales of Used Catalytic Converter

(a) It shall be unlawful for any person engaged in a transaction involving the sale, transfer, purchase, or acquisition of a used catalytic converter to violate subsections (b) through (f) of this Section. Any person who violates this Section shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

(b) Any person who sells or otherwise transfers to another for consideration a used catalytic converter shall be a registered [secondary metals recycler/core recycler/scrap metal dealer/junk yard]; licensed new or used motor vehicle dealer; licensed automotive repair service; motor vehicle manufacturer; licensed automotive dismantler and parts recycler; or licensed distributor of catalytic converters.

(c) Any person identified in subsection (b) of this Section must provide the purchaser or transferee with the following information:

1. a copy of the person's driver's license or nondriver identification card;

2. motor vehicle registration information from the motor vehicle from which the used catalytic converter was taken, including:

i. the make and model of the vehicle;

ii. the vehicle identification number of the vehicle; and

iii. the person's ownership interest in the vehicle;

3. any identifying information of the used catalytic converter, including a part number or other identification number; and

4. the name of the person who removed the catalytic converter or for whom the removal was completed.

(d) Any person described in subsection (b) of this Section must maintain the records described in subsection (c) of this Section for [xx] years.

(e) Any transaction involving the sale, transfer, purchase, or acquisition of a used catalytic converter shall not be by cash. Payment by check may be made payable only to a person described in subsection (b) of this Section.

(f) Any person described in subsection (b) of this Section shall not enter into a transaction described under this Section with any person younger than eighteen years of age.

(g) Any transaction under this Section shall not be between the hours of 9:00 p.m. and 6:00 a.m.

(h) Each used catalytic converter involved in any transaction under this Section shall constitute a separate violation of this Section.

(i) Any person involved in any transaction under this Section shall not provide false, fraudulent, altered, or counterfeit information or documentation as required under this Section. Each instance of false, fraudulent, altered, or counterfeit information or documentation shall constitute a separate violation of this Section.

(j) Any used catalytic converter possessed in violation of this section shall be considered contraband, and is subject to seizure and forfeiture as provided pursuant to [state law § xxx].

Section 5. Recordkeeping Requirements for [Secondary Metals Recycler/Core Recycler/Scrap Metal Dealer/Junk Yard]

(a) Any person registered as [a secondary metals recycler/core recycler/scrap metal dealer/junk yard] under [state law § xxx] involved in any transaction for the sale, transfer, purchase or acquisition of a used catalytic converter shall maintain a record of all such transactions for not less than [XX] years and be made available to any law enforcement officer or state official during usual and customary business hours.

(b) The records required in subsection 5(a) of this Section shall include the following information:

1. the records required under Section 4 of this Chapter;

2. the name and address of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard secondary metals recycler];

3. the name or identification of the employee of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard] executing the transaction;

4. the date and time of the transaction;

5. the weight, quantity, or volume and a description, to include any and all part or identification numbers, of all used catalytic converters involved in a transaction;

6. the amount of consideration in exchange for the transaction;

7. a signed statement from the seller in the transaction stating that he or she is the rightful owner or is authorized to sell the used catalytic converter being sold; and

8. a digital photograph or video recording of the person delivering the used catalytic converter or receiving consideration for the used catalytic converter delivered in which the person's facial features are clearly visible and a photograph or video recording of the used catalytic converter as delivered or sold is identifiable. The time and date shall be digitally recorded on the photograph or video recording.

(c) Any transaction for the sale, transfer, purchase or acquisition of a used catalytic converter must occur at a fixed business address of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard], as registered with the Department of [XXXX], that is a party to the transaction.

(d) Before each transaction, the [secondary metals recycler/core recycler/scrap metal dealer/junk yard] recycler, including any agent, employee, or representative thereof, shall:

1. verify, by obtaining the applicable documentation, that the person selling or transferring the used catalytic converter acquired it legally and has the right to sell or transfer it;

2. retain a record of the applicable verification and other information required under this Section; and

3. note in the business records of the [secondary metals recycler/core recycler/scrap metal dealer/junk yard] any obvious markings on the used catalytic converter, such as paint, labels, or engravings, that would aid in the identification of the catalytic converter.

(e) Any person who violates this Section shall be guilty of a Class [X] felony and shall be sentenced to not more than [XX] years in prison or fined under this Section not more than [XX] dollars, or both.

Section 5. Vehicle Identification Number Stamping Grant Program

(a) Not later than one year after the date of enactment of this Act, the [Law Enforcement] Department shall establish a program to provide grants to eligible entities to carry out covered activities, excluding wages, related to catalytic converters.

(b) To be eligible for a grant under this section, an eligible entity shall submit an application at such time, in such manner, and containing such information as the [Law Enforcement] Department may require.

(c) Any covered activity shall be carried out at no cost to the owner of the vehicle being stamped.

(d) In awarding grants under this section, the [Law Enforcement] Department shall prioritize eligible entities operating in the areas with the highest need for covered activities, including the areas with the highest rates of catalytic converter theft, as determined by the [Law Enforcement] Department.

(e) The [Law Enforcement] Department shall create a restricted account known as the "Vehicle Identification Number Stamping Grant Program Fund" which shall be funded by money received through enforcement actions pursuant to this Chapter; and shall be used to disburse grants to eligible entities.

Section 5. Preemption

This Act shall take precedence over any and all local ordinances governing catalytic converter transactions. If any municipal or county ordinance, rule or regulation conflicts with the provisions of this Act, the provisions of this act shall preempt the municipal or county ordinance, rule or regulation.

Section 6. Enactment

This Act shall take effect and be in force from and after [XXXX].

616 Fifth Avenue, Suite 106
Belmar, NJ 07719
732-201-4133
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)

Adopted by the NCOIL Property & Casualty Insurance Committee on November 18, 2022 and the NCOIL Executive Committee on November 19, 2022.

Proposed amendments sponsored by Rep. Michael Sarge Pollock (KY) and Del. Steve Westfall (WV)

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; and

(2) owned, leased, or otherwise authorized for use by the Delivery Network Driver~~; and~~.

Drafting Note: The term "vehicle" in the definition above is intended to apply to vehicles for which state law requires liability insurance. The term may be modified in states to reflect this intent.

(f) "Delivery Available Period" means the period when a Delivery Network Driver:

(1) is operating a Personal Vehicle~~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~~ has logged on to a Digital Network and is eligible to receive requests to provide Delivery Services from a Delivery Network Company, 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, or to different locations at the direction of a Customer.

(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 Customer, or the last location so designated in a series of deliveries; or (iii) 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 that insures the driver 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.

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 broker 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) 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 the Driver was operating during the Delivery Available Period or the Delivery Service Period at the time of the accident.

(h) 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 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. 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) 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 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).

BUDGET COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
BUDGET COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 19, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Budget Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Wednesday July 19, 2023 at 9:30 AM.

NCOIL Treasurer, Assemblywoman Pam Hunter (NY), presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Rep. Rachel Roberts (KY)
Sen. Paul Utke (MN)
Sen. Jerry Klein (ND)
Rep. Forrest Bennett (OK)
Rep. Tom Oliverson, M.D. (TX)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

MINUTES

Upon a Motion made by Rep. Rachel Roberts (KY), and seconded by Rep. Forrest Bennett (OK), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's November 18, 2022 meeting in New Orleans, LA.

2024 BUDGET PLANNING DISCUSSION

Asw. Pam Hunter (NY), NCOIL Treasurer and Chair of the Committee, stated that the Committee is here today to discuss and plan for NCOIL's 2024 budget. Before going through the proposed budget, Asw. Hunter 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 Columbus in November to formally adopt the 2024 budget and send it to the Executive Committee for final consideration at the conclusion of the Annual Meeting.

Asw. Hunter noted that in addition to a copy of the proposed budget, a document showing the organization's 2023 financials as of June 30, and a document showing the organization's year-end financials for 2022 and 2021 have been distributed. Asw. Hunter stated that NCOIL is in the midst of having another strong year and the numbers in the proposed 2024 budget represent an expectation that things will remain positive for the organization. Asw. Hunter then turned things over to Cmsr. Tom Considine, NCOIL CEO, to go through the proposed budget and entertain any questions.

Cmsr. Considine stated that starting with dues - 30 states paid in 2021 and 29 states paid last year. Based on current commitments we have received this year, 32 states are projected to pay dues in 2024. The reason why the total amount anticipated does not read $640,000 ($20,000 times 32) is because some states split dues payments between Chambers and there are a few states that, for the past several years, have only had one Chamber pay. As of today, 15 states have paid their 2023 dues, and most states operate on a July 1 fiscal year, so the majority of dues payments typically arrive after this meeting. And since the June 30th financials document was distributed, more dues payments have been received putting us at $270,000 year to date, which is $50,000 ahead of where we were last year at this time.

Rep. Roberts asked which states are expected to pay dues this year that did not pay last year. Will Melofchik, NCOIL General Counsel, stated that Georgia and Rhode Island did not pay last year but have paid this year, and Illinois is expected to pay as well.

Rep. Deborah Ferguson, DDS (AR), NCOIL President, then noted how the dues structure changed in 2020, going from $10,000 to $20,000 and introducing the legislator stipend program. Rep. Ferguson then asked Cmsr. Considine to explain the relationship between NCOIL and NCOIL Support Services, LLC for those who may not be aware. Cmsr. Considine stated that when he came on as NCOIL CEO in 2016, leadership agreed that it would be best for an LLC to be formed which would handle everything related to NCOIL. Accordingly, Cmsr. Considine formed an LLC and then once a month, money from NCOIL is transferred to the LCC to pay for things like rent, utilities, office supplies, and payroll. In terms of payroll, Cmsr. Considine and all other staff are technically employees of the LLC, not NCOIL. Everyone has agreed that this process is more efficient than the prior process where purchases for small things like paper and staples needed to be sent to the NCOIL President for approval. Rep. Ferguson stated that during her time as NCOIL President she has experienced firsthand the connection between NCOIL and the LLC and stated that everything is a very good and transparent process and that it has been a part of NCOIL doing very well financially the past several years. NCOIL is now in a position to take money from reserves and put that in certificates of deposit (CDs).

Cmsr. Considine then moved to Corporate & Institutional Partners (CIP) revenue: the proposed amount is $450,000 which simultaneously represents: a significant increase in last year's budgeted amount; the reality of a thriving CIP program; but an amount significantly lower than what we actually received in CIP revenue last year: $554,000. The reason for that decrease is explained in note 2 of the proposed budget: at the recommendation of the auditor, a reclassification of revenue allotted for conference registration discounts to realize it where it occurred. So, $100,000 that would have been previously been CIP revenue is distributed in the aggregate among the conferences. As of June 30, we have received approximately $400,000 in CIP dues, but again, that doesn't include some dues that were reclassified as Spring Meeting revenue.

Rep. Ferguson stated that the CIP program has been and is very successful and she urged the Committee members to encourage new members to join and also to thank current members for their support. The program has actually been so successful that last year it was decided that it would be best to put a pause on accepting new members until this year. Cmsr. Considine stated that the reason for that was to try and not have CIP revenue exceed state dues revenue. Cmsr. Considine stated that as the CIP

continues to grow, he is very comfortable with the scenario of as long as nothing changes in terms of the way the CIP program has been operating, and it 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 had last year to achieve good financial balance.

Asw. Hunter asked if there are other ways for companies and associations to be involved at NCOIL besides joining the CIP program. Cmsr. Considine replied yes and noted that the Insurance Legislators Foundation (ILF) Scholarship Fund was struggling for a while and Rep. Tom Oliverson, M.D. (TX), NCOIL Vice President, had a good idea to have a golf outing for legislators, companies, and associations to participate in and the proceeds of that go towards the Scholarship Fund. Also, in an effort to further build up the Scholarship Fund, we have asked certain CIP members to make a payment to the Scholarship Fund in an amount equal to and in lieu of their CIP dues, with those members still retaining all CIP benefits. We expect to continue that practice going forward but only on an as-needed basis.

Asw. Hunter then noted the upward difference in CIP revenue from the 2023 proposed budget to what the actual number is today. Cmsr. Considine stated that proposed budgets for CIP dues and other revenue items are typically used as a conservative, flexible tool that the Committee generally understands will be exceeded. Asw. Hunter then asked how much more CIP revenue may come in for this year. Cmsr. Considine stated that we typically don't get many new members joining past July, but some members will pay this year to cover their 2024 membership.

Cmsr. Considine then moved to meeting support & revenue. The 2024 numbers are similar to those from last year but with some adjustments based on things such as the location of the conferences and anticipated conference sponsorship levels.

Moving to the Industry Education Council (IEC) NCOL grant, this amount reflects what the IEC has been contributing this year, and there is no reason to believe it will increase or decrease. Rep. Oliverson asked if there were any plans for the IEC to disband or reorganize going forward. Cmsr. Considine stated that there were some discussions of that nature the past couple of years but those discussions have subsided. Cmsr. Considine stated that the new $2,000 level of the CIP was developed to serve as somewhat of a bridge for any IEC members in case the IEC did disband since IEC dues are $1,500. Asw. Hunter asked for more details about that $2,000 CIP level. Cmsr. Considine stated that it is limited to entities with less than 20 employees or annual revenues of less than $4,500,000. Rep. Ferguson stated it's important for all supporters of NCOIL to be treated the same and noted that the IEC has been loyal to NCOIL. Cmsr. Considine agreed but stated that it's an unfortunate reality that the IEC has been struggling with membership since the CIP program was formed.

Cmsr. Considine then moved to discuss interim calls. The number of $5,000 mirrors what we budgeted for last year and is almost exactly what we did end up receiving in interim call revenue. We will be having a couple of interim calls following the Minneapolis meeting which should get us near the $5,000 mark for this year.

Lastly, for interest income, the amount is increased from years past to reflect the positive activity of our CD's which are new this year.

Overall, the total support & revenue number comes in at $1,705,000 which reflects consistency as well as continued growth.

Moving to the expense side – CIP expenses are expected to be similar to this year. Additionally, as some of you know, last month we had the annual CIP Planning Meeting in Park City, Utah, and last year we had it in Napa, California. It seems that the consensus going forward is to have that meeting in locations that are outside the typical NCOIL conference cycle, which is nice, but it does result in an increase in CIP expenses.

Moving to the stipend program – as note 3 in the proposed budget states, the budgeted amount for the legislator stipend program assumes a complete consumption of $9,000 for all fully contributing states. We have noted a steady upward trend in stipend usage year to year.

Moving to the retainer and incentive payment. For the retainer, as note 4 in your document shows, the number continues to reflect 100% of the retainer being paid from NCOIL, not the ILF. Additionally, it contains the annual contractual increase of 3%, which NCOIL Support Services waived in 2021. 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 the overall NCOIL performance results increase, so does the incentive payment to staff.

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.

Moving to future location deposits – that number is based on how future contracts read, and they all largely mirror past contracts.

Moving to IEC Discount Givebacks – that involves discounts IEC members receive on NCOIL conference registrations so we track that lost revenue as an expense. We expect that number to track last year.

Moving to travel – we generally budget for something close to $20,000. The number of $22,000 is the same as the amount for last year and it looks like we're on track this year to have similar travel expenses.

Moving to Professional Fees. Prior budgets had two lines, one labeled "Audit Fees" and the other labeled "Accounting Fees." Last year, it was agreed that the lines should be merged and titled as "Professional Fees." The amount of $37,000 reflects: NCOIL bearing a greater portion of the audit expenses and the ILF a lesser share; standard accounting fees; and the anticipated fees for a new researcher 1099 position focusing on Model Law passage.

Moving to Miscellaneous – that number remains the same.

Lastly, the D&O insurance amount has decreased.

Overall, the proposed budget has support and revenue at $1,705,000 and expenses at $1,614,270.95 for an excess of $90,729.05 which reflects conservatism, consistency and continued growth.

Rep. Ferguson asked whether Wi-Fi was purchased for this conference for attendees to access. Cmsr. Considine replied yes and it was approximately $20,000. To help with that expense, we slightly raised the industry registration fee for the conference.

Rep. Forrest Bennett (OK) asked for more information on the new 1099 position. Cmsr. Considine stated that someone will research and compile a list showing which states have adopted certain NCOIL Model Laws.

Rep. Ferguson then brought up the issue of future NCOIL conferences and CIP meetings being in states that aren't dues paying NCOIL Contributing States. Rep. Ferguson stated that she feels strongly that the organization shouldn't meet in states that aren't Contributing States. Asw. Hunter and Rep. Oliverson agreed.

The Committee then held a brief discussion on the National Conference of State Legislatures (NCSL) having a committee that deals with insurance and how NCOIL should, if at all, be engaged there[5].

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Roberts and seconded by Rep. Bennett, the Committee adjourned at 10:00 AM

[5] In a post-adjournment discussion, the group decided to make this item an agenda item for the Officers' Meeting to be scheduled in Washington in October.

GENERAL SESSION MATERIALS – Whose Claim is This Anyway? Examining a Legislative Framework for Litigation Funding

Indiana's litigation financing framework will be referenced throughout the general session - https://iga.in.gov/laws/2023/ic/titles/24#24-12-4 – particularly the recently enacted change to that framework, IN HB 1124

JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
JOINT STATE-FEDERAL RELATIONS & INTERNATIONAL INSURANCE ISSUES COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
JULY 20, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Joint State-Federal Relations & International Insurance Issues Committee met at the Minneapolis Marriott City Center Hotel in Minneapolis, MN on Thursday, July 20, 2023 at 11:30 AM.

Representative Brenda Carter (MI), Vice Chair of the Committee, presided.

Other members of the Committee present were:

Rep. Deborah Ferguson, DDS (AR)
Sen. Paul Utke (MN)
Rep. Nelly Nicol (MT)
Sen. Jerry Klein (ND)
Sen. Pam Helming (NY)
Rep. Ellyn Hefner (OK)
Sen. Bob Hackett (OH)

Other legislators present were:

Rep. Dafna Michaelson Jenet (CO)
Rep. Stephen Meskers (CT)
Rep. Tammy Nuccio (CT)
Rep. Cara Pavalock-D'Amato (CT)
Rep. Kerry Wood (CT)
Rep. Linda Chaney (FL)
Rep. Brian Lohse (IA)
Rep. Rod Furniss (ID)
Rep. Camille Lilly (IL)
Sen. Michael Fagg (KS)
Sen. Beverly Gossage (KS)
Rep. David LeBoeuf (MA)
Sen. Pamela Beidle (MD)
Rep. Mike McFall (MI)
Sen. Lana Theis (MI)
Sen. Michael Webber (MI)
Sen. Gary Dahms (MN)
Rep. Liz Reyer (MN)
Sen. Walter Michel (MS)
Sen. Vickie Sawyer (NC)
Asm. Erik Dilan (NY)
Asw. Pam Hunter (NY)
Asm. David Weprin (NY)
Rep. Tim Barhorst (OH)
Sen. George Lang (OK)
Rep. Bob Peterson (OH)
Rep. Forrest Bennett (OK)
Rep. Carl Anderson (SC)
Sen. Mary Felzkowski (WI)
Del. John Paul Hott (WV)

Also in attendance were:

Commissioner Tom Considine, NCOIL CEO
Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a Motion made by Sen. Jerry Klein (ND) and seconded by Sen. Pam Helming (NY), the Committee voted without objection by way of a voice vote to waive the quorum requirement.
MINUTES

Upon a Motion made by Sen. Klein and seconded by Sen. Bob Hackett (OH), the Committee voted without objection by way of a voice vote to adopt the minutes of the Committee's March 10, 2023 meeting in San Diego, CA.

PRESENTATION ON RECENT FEDERAL HEALTHCARE REFORM PROPOSALS

Joey Mattingly, PharmD, Ph.D., MBA, Associate Professor & Vice Chair for Research, Department of Pharmacotherapy, University of Utah, thanked the Committee for the opportunity to speak and stated that I'm a pharmacist and health economist at the University of Utah. I also own my own research analytics firm. Real quickly I want to share a conflicts of interest review as I think it's important to know where my salary and everything is paid from so you understand where my conflicts are as we talk about this policy. I have research funding from the Food and Drug Administration (FDA) and my wife is a full time employee of the FDA. Also in the past 12 months, I received consulting fees from both the Arnold Foundation and the Pharmaceutical Research & Manufacturers of America (PhRMA). And then I've been an unpaid consultant to the Centers for Medicare & Medicaid Services (CMS) for the implementation of the Inflation Reduction Act (IRA). In all my presentations on health policy I always start with the basics and it's not to insult anyone, it's just so we're all using the same language. And then I'm going to jump into some federal legislation. I kind of categorize this as a Pharmacy Benefit Manager (PBM) focus as well as drug pricing focus and things really like copay capping and whatnot. And then I want to hit on a couple myth busting if you will and some myths that are full myths and partial myths, I guess I'll say. So I start every presentation, as I said with some basics and I start with the premium equation. Everything we talk about in healthcare policy and health insurance should come back to this and a lot of members and the people in this room fully understand this. That on the left hand side if we're talking about estimating and calculating a premium. On the right hand side we have things like the administrative costs of administering a plan and profit. We have things like coinsurance, co-payments. What I always tell with my students is look at the direction of the signs. Right, we think about the math. So, you see a negative sign in front of the C? That means that it's an inverse relationship with the premium. So as we increase co-payment, coinsurance we can keep premiums down. If we reduce co-payment, co insurance, we may have put pressure on the premium.

Similarly, if the price of something goes up that we're paying for it's a positive relationship to the premium and both can go up. And then same as we increase the units of healthcare dispense, so it might be more patients treated or patients receiving more medication, the premium goes up. We've always got to start here and every health policy, in my opinion, should be evaluated through this lens. Similarly, we have a drug supply chain. It really should be simplified and I try to simplify it and I do a basic supply chain first. We have a drug manufacturer, a manufacturer sells to the wholesale distributor, a wholesale distributor distributes drugs to the pharmacies, pharmacies distribute medications to patients. And not to get into all the acronyms this morning, although I had to learn a lot of new insurance acronyms attending my first NCOIL meeting but we got a lot of acronyms in drug pricing as well. Things like wholesale

acquisition costs (WAC), average wholesale price (AWP), usual and customary. When we add an insurance company or third party payer to the mix, it gets way more complicated, right? So this is where we start seeing legislation trying to address some of these relationships. So instead of just a fee from the manufacturer going to the wholesaler, we have to consider potential rebates and discounts that may go back to the payer for formulary replacement. We also recognize that there's a relationship between the payer or PBM and the pharmacy distributor and how that pharmacy is reimbursed. And again so me as academic when I'm trying to estimate these things sometimes it's hard for me to evaluate when we talk about transparency, what's the actual price being paid? And then as we start talking about things like vertical integration, that's become a hot topic in the PBM space. A pharmacy, not to pick on CVS, it's just one of the big ones, thinking about a payer PBM that may also own a pharmacy, then how does that change the equation?

So I like to start there to get some of those things out of the way. Again, I feel like those three slides can earn you a Ph.D. so I'm trying to trying to bring it all down to just the basics. So let's talk about some of the federal legislation on the horizon. So if we talk about PBM focused legislation, several of the states in this room are well further ahead than the federal government in my opinion. The states have really pushed the issue on regulation and PBM reform. I will the one thing I found interesting about this and you look at the current bills, so the PBM Transparency Act, the PBM Reform Act, and the Patient Act, led by Senators Cantwell and Grassley, Sanders and Cassidy, McMorris Rodgers and Palone, I think the thing that I've been watching is just how bipartisan it is. Recently I've been thanking my friends in the PBM industry for helping unite the country. With that said, as you go into what are some of the provisions, there are similar provisions across these bills as we're thinking about what has the chance of passing. With all of these bills they have these similar things that we all tend to agree on. We want to pass through drug rebates. So any manufacturer rebates that are coming from branded pharmaceuticals, we want to pass those on to the plans or to the ultimate payer. We want to prohibit things like spread pricing. From a PBM perspective, they don't refer to that as spread pricing. It's risk mitigation pricing. It's a differential pricing. It's basically like if I buy a cell phone, I don't pay the cost of the cell phone, I pay the price that the cell phone company is charging me. And you can call it a spread if you want, it's their gross margin. So there's challenges here in terms of I think we've seen cases of you hear this one drug, this spread price is $10 but over here it's $100. What's the difference? The product or service is the same. Why is this spread such a big deal? Also, you hear things like clawbacks or direct and indirect remuneration (DIR) fees. This is an area that seems to be where there's a lot of traction as well. The contract with pharmacies typically have situations where if you earn $100 on a claim for reimbursement on that claim at the end of the year anywhere from 3% to 10% may be due back to the PBM.

As I share with my friends in the pharmacy business, if you get rid of the DIR fees, do you think your total reimbursement will be higher or lower? And the response is overwhelmingly, “Oh yeah, we'll probably just get less money upfront.” So I think the challenge is okay, DIR is kind of a bad guy right now but just because you get rid of DIR doesn't necessarily mean pharmacies are going to make more money. And then additionally, part of the bills we also see annual reporting. It's a little mix on whether it will go to Federal Trade Commission (FTC) or the Government Accountability Office (GAO) and then the reports go to Congress. So the final bills will be interesting in terms

of what they will ultimately look like. I want to touch on a couple of different things on drug price focus legislation. So we have the SMART Prices Act with Senator Klobuchar leading and as of earlier this week, I did not see any Republican co-sponsors and I don't really expect any because this bill is expanding the drug price negotiation program in the IRA. That's very partisan right now and I don't know where you land on the IRA and what it's doing with drug price negotiation but it doesn't seem to me that there's a lot of support in expanding it just yet. That may change in a new Congress. I don't know. In terms of the Expanding Access to Low Cost Generics Act, Senators Smith and Braun have introduced that bill to reduce the practice of parking. Parking is when a brand manufacturer essentially is agreeing not to sue the first generic company that's coming to market. So I'm just kind of working on that deal to delay that release of the generic. I think that's something that seems to be bipartisan that folks can get around. And then another bill that Senators Warnock and Kennedy are behind is the Affordable Insulin Now Act, which is taking that $35 cap that we saw with the IRA and trying to get that to private plans.

And this is where it's like I don't know how many degrees I need to figure this stuff out but figuring out how are we actually going to pay for that? If we cap a price what's it going to do back to the premium? What's it going to do to the ultimate price we're paying for it if it's not actually lowering the price of insulin? So that's why I want to jump into myths. The first myth is about PBMs. When I see the term middleman, I immediately think you're either biased or you don't know what a PBM does. And that's just how it is. So when I saw the FTC headline “deepens its inquiry on prescription drug middleman” I said, “oh well, either the FTC is biased right now or it doesn't fully understand what a PBM does.” To lump them into a pejorative term like middleman is totally ignoring the service that they've done and developed over 70 years. I think the first PBM's were developed in the early 1960s or late 1950s and they have evolved on services that we asked for. The second myth is that vertical integration is always bad. It's always like “oh vertical integration this terrible thing.” Does anybody own an iPhone or an Apple product? This company has built a multi trillion dollar company off of a vertical integration model. Vertical integration in itself may or may not be a bad thing. It's just we need to evaluate when vertical integration may or may not hurt consumers. So the real question should be when is vertical integration bad? So maybe it's not a myth. Maybe it's a partial myth. The third myth is that PBM's are not transparent. This seems to be a big kick about we just need more transparency. I showed you a supply chain earlier with the manufacturer, wholesaler, pharmacy, PBM. If we're asking for transparency from the PBM, PBM's are responding to requests for proposals (RFP). They're responding to what payers and employers want. I believe that they're transparent with their customer - they're saying, “Okay, we responded to what you want, so put it in the RFP if you want it”. I think PBM's will respond to that. So, I think they are transparent with the agreements that they make. What's probably challenging is, as a general public, it's so convoluted in terms of what we're paying for what we're getting.

And I've always been frustrated about how many degrees do I need to understand my benefits? I don't know if I can get another degree to understand this anymore. And it’s still confusing when I go to the pharmacy or even in October when it's sign up period for your new plan. So maybe those are things that we need to work on and how we talk about transparency. And then what's the role of transparency for the other members of the supply chain? Pharmacies, wholesalers, and whatnot. Now we also have some drug price myths. I'll cover these and then go ahead and pass on to the next speaker.

Myth one, and this might be controversial, maybe it's a partial myth - the U.S. pays too much for prescription drugs. I've done analysis on brand and generic drugs and the biggest misnomer is that we pay the most for drugs. For generics we pay the lowest of our comparative countries - Organisation for Economic Co-operation and Development (OECD) countries. We have for many, many years. But what we've done in this country, we've made a trade off since the 1960s that if you bring a new drug to market we grant you a monopoly for a period of time, and then you charge us monopoly prices. You charge us very high prices when you have a branded product. So we see these huge prices for the brand drugs. That is true. So both are true. So we have to be careful when we throw out things like drug prices because on the generic side we're seeing drug shortages. Drug shortages may be a function of a supply chain that's not supported. Myth two is that co-payment caps lower prices. They do not lower prices. They lower the price to the patient that's exposed to it. I explain copayments and premiums to my students as the co-payment is a tax on the person using the insurance. Or the sick. The premium is the tax on the whole population. I think you have to explain it that way. And so if you're not doing something to lower the actual price, then the co-payment cap isn't necessarily lowering prices. And the third myth is that price transparency will lower prescription drug costs. I'm sorry, this is also a myth. If you have a rare disorder that can only be cured by a certain drug, your demand for that drug is inelastic. It does not change. And you will pay whatever it takes to get that drug. If you are having a heart attack and you get into the ambulance and the EMT pulls out an iPad and starts giving you prices for the nearest hospitals your decision making is not going to change a whole lot. Get me to the first hospital that can fix my heart. So my point is some drugs actually do have elastic demands and price transparency can help but some drugs it's not going to matter.

David Root, VP of Gov't Affairs at Prime Therapeutics, thanked the Committee for the opportunity to speak and stated that I feel compelled to say that in 15 years of working in the PBM business I have not witnessed a more balanced presentation of how the program works so let me take a moment to say thank you to Dr. Mattingly. I can assure you that I have never met him but I think we will be talking again soon. I think it's really important to take what you heard here a moment ago and try to derive some questions and hopefully you'll have some questions for us. I was asked to sort of talk about the legislative state of play at the federal level. So let's go ahead and walk through that a little bit and see how that comports with what we've just heard. So here are the issues that are in play through a variety of bills. I just want to read them off to you. A ban on spread pricing, FTC regulation of PBM's, mandatory rebate pas through, public reporting of drug pricing codifications, delinking of PBM's compensation to the list price, expanding FTC studies of PBM's, PBM's required to be fiduciaries, formulary tiering, pharmacy DIR fees which is an interesting prospect in itself because CMS fixed that last year and it takes effect next year so it's been addressed, yet we have five bills in Congress right now readdressing it. And we have Employee Retirement Income Security Act of 1974 (ERISA) preemption, step therapy restrictions, issues around biosimilars, rebates for highly rebated drugs, particularly insulin, and cost sharing for insulin. Those are the issues. Now, what are the rules? The rules are that you need 60 votes in the Senate to pass anything so even if the House bill comes over they have to get 60 votes to pass and right now, the House hasn't been able to organize itself to make those things happen around any particular piece of legislation and the Senate has multiple committees of jurisdiction that are vying for their version of healthcare reform.

Now, which one's going to come out we don't know and how they're going to get there, it's going to be hard to tell. There are 14 days left between now and the August recess and they come back and next year starts and is an election year. Is there enough time to do this? Only Senator Schumer, who's in charge of the Senate, will be able to determine that and then once they figure out the time, they have to be able to get to the number 60. We all want lower drug prices. The problem is that list of issues I just read don't represent lower drug prices. As we just heard in the previous statement, there are consequences for every action, so I love the equation. You take an equation everybody remembers from chemistry class. If you do one you have to do the same thing on either side of the equation. If you lower the out of pocket cost, you're going to have to raise the premium because none of those issues address the overarching issue and the overarching issue is that the manufacturers are the ones and the only ones that set the list price and have the ability during the course of any given year, to raise the list price as they see fit. And we have proof of that now as we've seen over the years, the three major insulin manufacturers have finally come out publicly and said we're going to lower the cost of insulin to between $35 and $50 depending on which manufacturer it is. Well come on in guys, join the water. We've been in that pool for the last five to six years. For the last five or six years the majority of the PBM membership whether they are employer groups or plans have not paid more than between $35 and $50. The highest in the $55 category usually being the people in the high deductible health plan space but we've been able to even mitigate that. The people that are exposed to the list price are the insured. That is a problem, but that exposure is to a price that is not set by the PBMs and it is an exposure that is not addressed in any of those issues in any of those bills. There have been 11 hearings in Congress so far. Not a single one of those hearings has addressed the single question of why does that drug cost so much? Why is that the list price for a new drug? There's this wonderful category I like to call the "me too drug." So, you take a category like multiple sclerosis (MS) and there are a ton of drugs in the MS category, they all have roughly the same value in that they treat MS in the same way with roughly the same level of side effects and the same potential amount of side effects. But there's a new drug and the only difference between that new drug and the other 19 drugs in that class is that the new drug costs 20% more than the last one that entered the class.

And so the PBM's job is to come along and negotiate with the manufacturer and say, "we want a better price. Your drug is no more efficacious than the other drugs. Give us a better price and we'll prefer that product and we'll help drive our members, the individuals and the benefit sponsors, to the lowest possible cost for the healthcare, the lowest possible cost for the product." That's the role that the PBM's play in the supply chain. We force pharmacies, we force community pharmacies to compete on price and service which is directly extended to the member at the counter. And we force manufacturers to compete on price and efficacy which is again towards the benefit of the consumer. All of this legislation is being driven by those two entities because they don't want to be forced to compete. They don't like it, and I understand that. But the bottom line is if we don't force them to compete, they continue to drive healthcare costs up and up and up with the manufacturers driving it up with launch prices and ever increasing price structures for existing drugs. And you take the pharmacy's, it's a simple question - if I take my benefit to a pharmacy today and it costs me $20 at that pharmacy and a state passes a piece of legislation and I now go back to that pharmacy a month later and I get the same product and it now costs me $30 for that product, how has that lowered my healthcare costs? It hasn't. It's just transferred more of that healthcare dollar away

from the consumer and away from the health plan and giving it to the community pharmacy. Now, there may be people here that share the attitude that we need to protect community pharmacies and we need to do this and that and that's your right to talk about that. But I'll suggest that you need to be very careful. That's a slippery slope. If you're going to protect that group, then what are you going to do for the used automobile salesman? Or what are you going to do for the hardware store because Walmart came to town? Or the food store because ALDI came to town? So you need to really think about the consequences as you go through those actions and you need to ask yourself, “are we really lowering the cost of healthcare or are we just transferring money?” And more often than not we're not lowering the cost of healthcare, we're just shifting money from one entity to another and it's away from the consumers.

Rep. Stephen Meskers (CT) stated that I'm going to start off with an observation and then the question. The last comment you made was that we're transferring money around and I would challenge you on that’s probably an inaccurate assessment. But that's what we're doing now with the entire PBM and pharmaceutical money. We're transferring the money of my constituents into the pockets of pharmaceutical companies and into PBMs. And in the U.S. we’re paying three or four times what they’re paying in the OECD countries for pharmaceuticals which tells me that our pricing mechanism is broken and that if I have to look at a PBM model and I spent enough time on Wall Street to know that if I can’t figure out the model, someone’s got their hand in my pocket. So, if the model is broken, the question is how do we fix it? The most logical model for me is to use a negotiated price and the negotiated price for our pharmaceutical industry versus the OECD countries is a premium to make sure research, development and technology stays in the U.S. So I don't know if that's a 20% premium over Switzerland or England or Holland, or you name the countries in the OECD, and a premium to keep the development here. But the U.S. should no longer be subsidizing cheap European and international drug prices at the expense of our constituents. And the question is, how do we get more transparency where I'm not paying four times what my Canadian colleagues are paying for drugs? Because I'm subsidizing the world? And that's research and development, stock buybacks, executive compensation, etc. I'm not against any of those but I'm not sure why I'm footing the entire bill for that in the industry and I don't think PBMs solved the problem. And all of the bills I see before Congress, I feel like they chase me down a rabbit hole that gets me nowhere in terms of generating the fundamental problem. I thought what we did at the national level in the Infrastructure Act to require some negotiated drug prices was the first salvo in saying transparency in pricing. And I'm not sure if any of the rest of this gets to that point. And so, I guess the question is, shouldn't we be negotiating our drug prices at some premium to keep the industry here? And isn’t that the best way to improve the model?

Mr. Root stated that's exactly what the PBMs do is negotiate those drug prices. If you feel as though we're subsidizing the rest of the world, that's a question to ask of manufacturers. And in some respect, I don't disagree with you. We are. If you look at a manufacturer bringing new drugs to the world market, they have a very specific way in which they bring that drug to market across the globe all designed to be able to increase its price when they get to our market and North America and a few other industrialized countries. So we are subsidizing that. You’re asking that question frankly to the wrong person. We would agree with you that we need a better way to make them accountable for those drug prices and to get them to be more realistic because I think what you’re actually saying is that for the most part a lot of these new launch prices are not realistic.

Not only are they not realistic, but they're not sustainable. But without our ability to leverage the lives because that's what a PBM does, it leverages lives and we go to the manufacturer and say you've created this great new product. That's fine. We've got 140 million lives and we want to be able to have those lives have access to your product but we can only do that if you give us a better price because your list price isn't going to cut it.

Rep. Meskers stated that I guess that's the observation I'm making is that the PBM is trying to negotiate a drug price in a market that lacks both negotiating strength and strategy from the point of view of the fact that we're paying three and four times what OECD countries are paying. So if it was effective, and it's not an attack on PBM's, it's the structural problem. If we don't negotiate drug prices at the national level we're always chasing some hope in the future for rational drug pricing in the U.S. and everyone else is benefiting and that's the observation. Mr. Root stated that's a fair observation and I would argue that from my perspective, I would say that the PBM negotiations do work. I would say in the interest of honesty, there's one place where they don't and that is where we have no leverage and that is orphan drug status - the rare orphan drug disease where there's one drug in the class, there's no competition and we therefore don't have the ability to leverage the two competitors against each other to get a better price. So in that respect, we do fall down as an industry. That is a place where we don't negotiate very well, not because we can't but because there just isn't any leverage to drive that market competition.

Sen. Pam Beidle (MD) stated that my question is about the independent pharmacies for Mr. Root. I am a little confused by your comments about the independent pharmacies. What my pharmacists are telling me is they have no cost of distribution. They're actually losing money when they distribute and sell certain drugs. So how do we answer them about lack of cost to actually do the distribution of the drugs? Mr. Root stated that a great question. The first answer to that is to be intellectually honest and say that yes, they are losing money on some of the drugs that they dispense. Our reimbursement to them is designed to be two things. It's designed to be a total basket of reimbursement so cherry picking an individual drug where you might have lost $100, 50 cents or even $250 serves an illustration, but does not actually represent the whole. The second issue is that our reimbursement incentivizes them to be judicious purchasers of those products. Generic drugs, especially generic drugs, are available in the marketplace from a variety of different sellers, wholesalers and manufacturers. We try to incentivize through our reimbursement to make those pharmacies buy those products at the cheapest possible place so that our members can then have that savings. And when they don't, it becomes a problem for that pharmacy. When they are not buying that drug at the most judicious location or in the best possible way, that is causing a problem for them but our reimbursement is specifically designed to do both of those things because both of those things put downward pressure on the price of the product for the consumer when at the counter.

Dr. Mattingly stated that we're studying pharmacy closures in the U.S. at the University of Utah. The independent pharmacy closures situation is quite complex. In a period of where pharmacies net grew in the country from like 68,000 to 69,000 over about a 10 year period, still we had about 12% of pharmacies would close in any given year. So there's a lot of churn. Also in my former life, I was a district manager for the Kroger company, which had a $4 list. For every drug on that list, if I got $4 from a patient, the

drug may cost pennies, but the operational cost to put that prescription together and pay the pharmacist and pay the overhead and all the technicians was typically $6 or $7. Every single product that left that pharmacy was at a loss. Pharmacies have selectively done this on purpose because when a patient comes in with their generic blood pressure medication they might also have a more expensive product that I make $200 on and so that's probably more just cutting to it. Pharmacists, my own people, have sold at a loss strategically and now we're saying that differentially, when your patient population changes like maybe a certain drug goes generic and then it goes to that low price all of a sudden that used to be a big money maker for you. It's not. And so I think what we're seeing is that as patients change, as communities change, the pharmacy that's been there for 75 years is now covering a patient population that's not profitable to them anymore and then those pharmacies without any carrot or anything else close. And that's why I think it's complex and also part of during my time as a district manager we had a pharmacy in a small town in Southern Illinois that closed. It was devastating for the community. So again it's complex. The problem is when we start talking in aggregate and who's making what, the nuances gets lost.

Rep. Forrest Bennett (OK) thanked the speakers for their presentations and stated that I enjoyed hearing you talk about wanting to lower the cost of drugs and I have been educated well on PBM's and this whole chain. I think on behalf of my constituents and consumers, I would love to see us lower drug prices significantly and my general question is, my colleague from Connecticut was much more detailed, but I struggle to understand how anyone in this chain is actively invested in lowering the cost. Because your bottom lines depend on it. A PBM negotiating a lower price still needs that initial price to be very high in order for them to make a profit. So I would love to know where you see the spots in this chain that are ripe for reform, that will actually lower drug prices as opposed to what you said, which is true, which is moving money around. Dr. Mattingly stated that you're absolutely right. Every part of what you just said is accurate. If our reimbursement to pharmacies, if our payment of drugs is a function of the drug price, every contract in that supply chain is a function of that drug price. And if you're making 3% or 4% on that product, you'd rather have it be a $1,000 product than a $20 product. So I applaud you for calling that out. So if you disaggregate that then the question is okay then do we pay a cost for the drug and then how do we figure out what is the value of the pharmacist service? What is the value of the wholesaler maintaining a cold supply chain to make sure the insulin is not sitting in a hot factory somewhere? How do we disaggregate that? And it's messy, but I'm willing to jump into it because I think what you're getting at is really important. But one thing I have to keep going back to is our drug prices aren't always high and if we're not willing to address patent law, if we're not willing to address that, then we're not touching that piece and I don't know what else to say besides we'll just leave it there and we'll just keep dancing around this issue of we're going to incentivize the innovation and then we're going to reward that company for billions of dollars. And some will say, "well, what's your marketing cost? What's your research and development (R&D) cost?" It's not the R&D cost of that drug, the billions of dollars that go to that drug company fund the R&D for the other 20 drugs in their pipeline. And they have to pay for the failures too. So I hate it because I'm an economist that also is calling it out that I want it to be lower, but also if I get a disease that's not cured yet I'd like there to be a product in a few years for that to be there. So unless we're willing to have that conversation, I don't know how to answer it.

Mr. Root stated that was a great question and actually very insightful. Patent reform we would argue is critical. That is something that would begin to lower the price. The pay for delay program that manufacturers engage in with generic manufacturers that actually pay them to not bring their generic to market so they can keep their branded product, their monopolized branded product in the market a year longer. And when we say maybe a year longer, let's make sure we understand what the dollars are. One drug, Humira, made $4 billion last year. So when we talk about just 12 more months, 12 more months can be a lot of money. A lot of money. And they're willing to do that. We need to see FDA reform. We need to see them reforming the citizens petition which is another form of pay for delay that the manufacturers engage in. I think it was just at the beginning of this year or in the middle of last year, one manufacturer, in order to extend the life of their monopoly, sold the patent rights to their product to an Indian tribe. Because they were going to get out of the federal monopoly law and be able to continue to be the sole proprietor for that product for another period of time. That was overturned but they tried it. Those things have a direct impact on the list price of the product. They will lower that price. And we know, as I said before, that the manufacturers have the ability to do it. The three top insulin manufacturers just did it and so starting I think in September of this year, you're going to see $35 insulin. And further to that point, within the PBM space, every PBM has figured out a way to get that insulin preferred on their formulary and get that $35 insulin to their members. So the idea that we won't go after the low cost product, that's not true. The one comment I would have to your question that I would say is not really accurate - our contracts with payers are performance contracts and performance in the PBM space as it relates to payers means getting them the lowest net cost for the drug. So we have to deal with the high list prices that the manufacturers set because only they can set them but we use market tools and market leverage to ultimately get those prices lower so that's the lower price that the benefits sponsor and the consumer actually pay. So our contracts are driven, we profit, we make money when we provide the lowest net cost for each of the products. Not when we provide the highest. Think about that. If you were going to put out an RFP to build a road would you award it to the person who added a $1 million cost to the building of that road? Or would you award it to the company that took $1 million out of the cost of building that road? That's what we do. We do not add costs to the system. We reduce the initial cost of the product. Do we make a profit when we do that? Do we make money when we do that? Yes, we do. We're a business. If we did this and it didn't make money we wouldn't be a business, we'd be a charity.

Sen. Bob Hackett (OH) stated that in Ohio, our big companies are really called the Business Roundtable and when you look at the rebate, that rebate between the companies is never disclosed. We've been trying to get that rebate. The state of Ohio won't give the amount of the rebate. So the PBM's do a tremendous job for the big companies but when you saw that federal legislation that's pending that all the rebate would go through, for the smaller and mid-sized companies, they are not giving them the same rebate that they give major companies. So the PBM is keeping that rebate because they're getting that rebate from the drug manufacturer because it's based on the volume of that. So the question is, will that legislation be the solution? How do we get out of that problem? Because the big companies don't want to change the system, they love the PBM system because PMB's negotiate for them and they get huge rebates. But the smaller guy doesn't. The mid size doesn't and the PBM pockets that. And I realize once again their costs are higher. So how do you react to the rebates that the PBM keeps?

Mr. Root stated that's a great question and it draws a level of specificity. When a PBM negotiates rebates, they negotiate the rebates with the drug manufacturers for their entire book of business which includes the large companies and the small companies. Each company gets their portion of the rebate as it's allotted to the total slice. So if you're 13% of the total rebate aggregation, you're going to get 13% of the rebates that are negotiated. That's how that works. Many of those mid-sized to small companies are also working through a health plan and so we're taking all of those lives and we're negotiating that and their contract is not with the PBM. Their contract is with the health plan and their portion of that rebate is negotiated with that health plan. If they don't like that negotiation, we encourage them to go with another health plan or reinvigorate their negotiation or go direct to a PBM. If you're a mid-sized company, you can go directly to a PBM without going through an insurer but a lot of them go through insurers because the insurers are able to do a lot more for them and they're able to aggregate a lot more if there are other benefit issues. So they actually are getting that. The PBM's aren't keeping that rebate. You can't just keep money and not claim it and hide it. That's not how it works, especially with for profit PBMs they have financial disclosures. Every dollar has to be accounted for. Sen. Hackett asked so why does the federal legislation say that all the rebate should pass back to the plans? It doesn't now. Mr. Root stated that it does that now. We don't have a problem with that legislation, the fact that you have legislation that says that 100% of the rebates have to pass through to the benefit sponsor. The only question with 100% of the rebates passing through the benefits sponsor is a lot of those smaller mid-sized companies that don't have the cash available to pay for the quality benefit that they offer their employees, will offset payment for that by allowing the PBM to keep 2% of the rebates that they collect for them. And that is a form of payment for them. So if you take that away in the legislation and say 100% of the rebates have to go back to the plan sponsor, we're fine with that. But then that means, as Sen. Mitt Romney said in the last hearing, that you're now eliminating a flexibility option for that mid-size employer to offer benefits for their employees.

Rep. Linda Chaney (FL) stated that I sponsored a PBM bill in Florida so I got pretty deep in the weeds on this stuff and the one question I never got answered meeting with the Pharmaceutical Care Management Association (PCMA) and PBM's like yourself is they constantly said that they are not a middleman and that they provide a service to reduce drug costs for the consumer. Yet, drug prices have gone up 180% and three PBMs control 80% of the market, and are number five and six on the Fortune 100 list. So how can you say that you are not a middleman because you don't manufacture. You don't warehouse, you don't touch the product. You're basically pushing paper, negotiating that appears to be for the benefit of your profits, not the discount to consumers based on how drug prices have increased and how your value as a company has increased. So my first question is what is a PBM if you're not a middleman? And your purpose is to reduce cost to the consumer, yet there's no evidence of that. Help me with that. Mr. Root stated that I would go back to the presentation that we heard earlier from Dr. Mattingly and say that we are a middleman, I don't shy away from that. But I don't use that term with the derogatory intention. We are in the middle between the consumer and the manufacturer and the pharmacies. So yes, we are in the middle and we aggregate those lives and we negotiate with manufacturers and pharmacies to create networks and create prices for those drugs that ideally are sustainable. I might ask that question another way. So looking around this room, there is not a single state that's represented in this room either up here or behind us that hasn't passed some version of the bills that

we just listed off and many of the states have had these versions on the books and many of them in the past few years. And I agree with you, prices haven't gone down. I agree. This year alone, the manufacturers in the first quarter of the year did what they always do, the top 25 manufacturers came out with the top 200 drugs that they raised the price of between 9% and 15% across the board. I agree with you. But that has nothing to do with us. We take that raise, we take that price and we negotiate with the manufactures with the lives that we have to ultimately have payers and consumers pay a lower price other than what they've said is the list price. So I think we do our job well. If you want to look at it try looking at modeling a world where there isn't anyone between your pocketbook and PhRMA.

Rep. Chaney stated that so with the rebates that you require the drug manufacturer to add on top of the cost of the drug that goes to the PBM how is that reducing drug costs for the consumer? Mr. Root stated that well, first of all, we don't require the rebate. The rebate is offered to the PBM price. Rep. Chaney asked isn't that required to be on the formulary though? Mr. Root replied no, we do not and the case of point will be the three insulin drugs. Those three insulin drugs will not have rebates. They'll be $35, they'll be the lowest net cost and they'll be the preferred product in those classes. So again, the manufacturers offer us the rebates in order to gain that favor. Rebates were a construct of the manufacturers, not the PBM's. They wanted to be able to create that level of preference on the formulary. Rep. Chaney stated that one of the biggest battles I had with the bill was specialty drugs, which there's not a definition for specialty drugs. Best we can tell, specialty drug means that it's a high price drug with a high profit. So our bill defines specialty drugs. But if the PBM again is focused on lowering drug prices, why fight so hard to protect the margins in the specialty drugs? Mr. Root stated that because the cynical way that specialty drugs were defined is not really accurate. So there are some definitions for specialty drugs. CMS has a specialty drug definition that talks about price, it talks about storage, it talks about the issues that center around the utilization of the drug. And so a drug on a specialty drug list is dependent upon all of those things. What kind of administration does it require? There is a price component to it. The shipping. The access to the product. And then ultimately it's a product of the decision between the benefit sponsor. There are different benefit sponsors in this room, represented by the various state health plans where you will have a drug on one state health plan that will not be considered a specialty drug, but that same drug on another state health plan will be considered a specialty drug. And that is not a product of the PBM. That is a product of the health plans' decision in how they created their formulary. So we administered that formulary.

Rep. Carter stated that we have to move on to handle the other topics on the agenda. This conversation has been very beneficial. I am going to follow up personally with you both.

OVERVIEW OF MINNESOTA'S "BASIC HEALTH PROGRAM"

Rep. Carter stated that next on our agenda is a presentation on Minnesota's basic health program which will focus on which states have them and what has and has not worked for these states. In your binder on page 51 is some background information that you might want to look at for this presentation. This is also on the conference app and website.

Julie Marquardt, Acting Assistant Commissioner and State Medicaid Director at the Minnesota Department of Human Services, thanked the Committee for the opportunity to speak and stated that I am going to speak to our basic health program in Minnesota. Its name is MinnesotaCare and that would be the name that all Minnesotans know it by. Mmost Minnesotans don't know it's a basic health program. Just to go back to the history of MinnesotaCare. The program itself predates any federal opportunities for having basic health programs. The program was originally established in 1992. It was established as a subsidized program. It was for families who are making too much to qualify for the state's Medicaid program but were really still struggling to afford health coverage. It had bipartisan support. It was established under a Republican governor with bipartisan legislative support and it has enjoyed quite a large amount of bipartisan support since then. It is a statewide program. It is offered in all 87 counties in Minnesota. If you don't know Minnesota, there's kind of seven counties that are considered our metropolitan area and then there are 80 counties that are often referred to as Greater Minnesota. More than 50% are in Greater Minnesota that are served by this program so it has a large reach across our entire state. In 1995, CMS, which had a different name at the time, still allowed states to operate under a waiver and so we were able to bring this program under a waiver. So instead of having all state funds we were to finally get some federal Medicaid matching funds. It didn't cover all the population but we were able to receive some federal funding to help support the program. Ultimately it was a program that covered children and families that otherwise could not get coverage but it expanded eventually over time to include adults without any children.

As I mentioned, today it operates as a basic health program under federal law. We established our program in 2015. We were the first to establish our program, New York also established their program in 2015 but we launched ours a little bit ahead of theirs. It is a state and federal program. It is not part of our Medicaid program. It operates under a different authority and I just give for reference the section of the Affordable Care Act (ACA) that authorized this and it allows states to purchase coverage directly for people. The way that it's funded is by pooling the premium tax credits and cost sharing reduction subsidies that they would have otherwise received had they gone through the exchange. As I mentioned there's two states, Minnesota and New York who operate basic health programs. And I mentioned for now, because Oregon is a state that is looking to expand and include a basic health program and I know that work is underway and that study is underway. There have been other states that have studied it. I don't know that there's any state other than Oregon that's getting close but there have been states who have been interested in setting up basic health programs. So, going back to the population today, it serves more than 100,000 Minnesotans. It is mostly adults over 18. Many of them are parents whose children may be on our Medicaid program. The income level they are making between 133% and 200% of the federal poverty guidelines and just to give a context that's somebody making no more than $27,180 annually and for a family of four they are not making more than $55,500 annually. The coverage that we offer under our MinnesotaCare program is comprehensive. It has additional benefits that are not typically available under most of the individual market plans. We do have to cover the essential health benefits that are offered in the market plans but we also have dental for adults and children. We have eyeglasses coverage and we have a broader array of behavioral health benefits than the typical exchange product would. This program offers low cost sharing. We have a 94% actuarial value and certain populations are exempt from any cost sharing. So that would include, for instance, children under 21, American Indians or Alaskan natives are all people who are exempt from cost sharing under the

program. The way that the services are offered is through our managed care organizations that are contracted with our department. This is required under the basic health plan regulations. You have to offer it in kind of a managed care construct. Also, within the regulations we have to offer at least two health plan choices to individuals on our Minnesota year program. We have nine health plans that are currently contracted with us and Minnesota has a broad array of health plans that do business in this state. We have five licensed private health maintenance organizations (HMO's.) We have one licensed county owned HMO which is Hennepin County, our largest county. And then there are three county based purchasing organizations that offer a county based purchasing plan and that exists in 33 rural counties. And so there is a wide array of options for people to choose from. We leverage our Medicaid contracts and we negotiate this as part of those offerings but this is operating as a separate program but it includes the same organizations that we contract with in our Medicaid program. As I said, the financing comes from the state and federal government. For the federal funds as I said, it's 95% of the tax credits that would otherwise be available to those individuals. With state funds the state has a healthcare access fund, which is funds that are derived essentially from a state tax on hospitals and other providers. We also have to use state funds to pay the administrative costs to operate the program. So those tax credits that we draw down from the federal government cannot be used to pay for any of the administration that we have to operate the program in our state.

So our healthcare access funds, which are derived from those tax sources are what we use to fund our administration and then there are enrollee premiums. That's the third source of financing for the program and that is based on a sliding scale and ranges from $0 to $80. And I have January of 2024 there because during the Public Health Emergency we charged no premiums and our legislature last session extended that through our resumption of renewals for Medicaid because MinnesotaCare when we kept continuous coverage, MinnesotaCare was included in that continuous coverage. So we are restarting renewals for our MinnesotaCare program this year too but we will not be charging premiums until January of 2024. So there is a lot of learnings that continuously go on with our program and a lot of it is just to understand the marketplace and the populations and that has changed over time. It's changed a lot since 1992 and it's changed a lot since 2015 and really figuring out how does the basic health plan fit into our marketplace, really understanding who are the uninsured populations. What does your Medicaid program coverage look like? Each state has different Medicaid programs that cover different populations with different benefits. So, really understanding who's left out there when you've put together your individual market, your Medicaid program and what are you trying to accomplish with it? And then financial considerations and relationships - knowing that you have to cover administrative costs. How are you going to do that? What is the impact of bringing a basic health plan into that continuum on the individual market? What does that do to your Medicaid program? And trying to understand that and mitigate any unintended consequences if you can. Then there's a whole question about benefit design. What benefits are you going to offer? There's the 10 essential health benefits that you have to offer but when Minnesota stood our program up, I would say it is more like a Medicaid benefit. We kind of leverage our Medicaid benefits and our rates but other New York perhaps has leveraged more of a commercial in their marketplace versus using some other metric. You could use Medicare as a metric.

Essentially, you have to provide those essential health benefits, and then you have to market to a benchmark plan and there are a variety of options for benchmarking. The one that Minnesota happens to use is the Federal Employees Program and then you have to determine cost sharing and 94% actuarial value is the lowest that you can go. So Minnesota has adopted the highest amount of cost sharing that we can apply but that's a consideration of also, we have some benefits that don't have cost sharing that apply to them as well so anyone who accesses certain benefits will not have cost sharing that applies and many of those are in the behavioral health spectrum of care. With anything, there are opportunities. So there are economies of scale. In Minnesota, we leverage our Medicaid program. In other states, they may consider leveraging their marketplace infrastructure but one way or another, you need to be able to negotiate rates with health plans. You need to have an infrastructure where you can do benefit design, where you have policy development. But that can exist in other places than a Medicaid program. Minnesota used our Medicaid program infrastructure to really leverage our operations for our basic health program. But we operate the MinnesotaCare program out of our department. So unlike our Medicaid program, which is kind of distributed to the seven counties, eligibility occurs there. For the MinnesotaCare program it's centralized at our department and that was just a decision that was made for efficiency, to make the administration cheaper to operate. As I said, we leveraged our purchasing power with our health plans and negotiate with those nine health plans both for their business in Medicaid alongside their participation in MinnesotaCare.

And then policy development. Whenever new benefits come on to our Medicaid program we have to think about what does that mean for MinnesotaCare? Are we going to include coverage in MinnesotaCare? If we make rate changes in our Medicaid program is that going to impact the cost of our MinnesotaCare program? And if it is then we have to factor that in and so sometimes we do make strategic different decisions about things to cover because understanding the populations, the MinnesotaCare population is not the same as our Medicaid population. So it's not an automatic that everything we cover in Medicaid is covered in our MinnesotaCare program. It is not. Then, as I said, we aligned our programs so that people who move from one program to another as families incomes change, they see the same health plans that are available and in a perfect world, we would align Medicaid, our basic health program and the individual market so someone can move across and find the same health plan available to them. That would be ideal. We have a lot of overlap. We're fortunate in that way that people do find those options between Medicaid and our basic health program. There is a tremendous amount of overlap so that is something we're very fortunate to have. There are opportunities to expand to other populations. Once you have a program stood up, Minnesota has used the program to expand to some of our undocumented residents in Minnesota. We offer under MinnesotaCare with state funding and premium payment and cost sharing to people who are covered under Deferred Action for Childhood Arrivals (DACA), for instance.

There is also a great amount of conversation in our state around public options and does the basic health program fit into that? We don't have that today, that is not something that's offered, but there is a lot of conversation. It comes up almost annually as a question and we are doing some research and study to help policymakers and legislators know what the options might be. What those costs might look like and choices that they may have available to them. And then for us it just becomes part of

improving the health overall in our state. Really working to help lower uninsurance rates - we enjoy a low uninsurance rate. We hope to continue to enjoy a low uninsurance rate. And also improving access to care so people have affordable coverage that they can actually go and use. And then this is my last slide and these are just two quotes from people who are on our MinnesotaCare program. We had put out a publication a few years ago that included information on our Medicaid program and our MinnesotaCare program and I'm not going to read them to you but essentially this program is covering entrepreneurs. It's covering farm families. It's covering people who work jobs that maybe don't have employer sponsored coverage or people who are working several part time jobs. So they don't qualify for their employer sponsored coverage. So to us, we can build any program and we can get everything we think is right but if the people who it serves don't like it or don't think it serves them well, then it's not a success. And so the quote on the left is actually from a woman who is married to a farmer and the importance of that program to making sure their family had coverage. And the quote on the right is from a person who works multiple jobs, likes all of them, can't get coverage from any of them. So this program fits in. And so, as I said, this isn't the Medicaid population. These are folks who are working and some of them working really, really hard and they're important in their contributions to the state so I just wanted to make sure we gave them the final word here.

Rep. David LeBoeuf (MA) stated that I'm curious especially with the Medicaid redeterminations - we don't have county systems. Our counties really don't mean anything, everything is centralized. What I'm curious about is how that's functioning or what role does this plan play in regards to kind of helping that population out? Ms. Marquardt stated that every state is doing redeterminations differently. Minnesota is doing our Medicaid population in 12 cohorts. So, we're doing one cohort per month over a 12 month time period. MinnesotaCare will renew all at once just like they always did, they were always for January 1st coverage. So, what will happen during our redetermination periods are we're going to have families, I'm certain, whose income has changed in the last three years who now may become eligible for MinnesotaCare. So, they are redetermined let's say in this month, they were to be redetermined eligible they move on to the MinnesotaCare program and then we'll have a redetermination that again in November but it will originate from the state and come back to the state. There's a lot of coordination we have to do between counties and the state of Minnesota and we have a really good working relationship with our 87 counties to make all of this work. So you do have to coordinate because families move between these two programs but there is going to be a difference for how that fits in. But we will see people move on to the MinnesotaCare program until we reach that redetermination for all of MinnesotaCare and then we'll see some MinnesotaCare people move off of that program, who may have received employer coverage during this time period too.

DISCUSSION ON INTERNAL REVENUE SERVICE (IRS) PROPOSED REGULATION ON CAPTIVE INSURERS

Rep. Carter stated that last on our agenda is a presentation on the recent proposed regulation from the Internal Revenue Service (IRS) that deals with captive insurers. In your binder on page 54 is an opposition letter that NCOIL submitted to the IRS that you may wish to look at, it's also on the conference app and website.

James Kendrick, First Vice President, Accounting and Capital Policy at the Independent Community Bankers of America (ICBA), thanked the Committee for the opportunity to speak and stated that we're talking about captive insurance transactions. You may or may not know that the IRS is looking for money and we're $32 trillion in debt and probably going higher soon and so they're looking for any way to expand upon sources of revenue with taxpayers. And small banks are in the crossfire there through captive insurance companies. So small banks set up captive insurance companies. They create a sub. They generally are set up to protect against unfunded risk. So you think about cyber risk, you think reputation risk, fraud risk. There are insurance policies there all over the country through different issuers for those types of risks but there are many different reasons why a small bank can't be involved in those products. They are very expensive. There's a hurdle to getting to those products and various other issues there. So the banks want to cover unfunded risk. There's a piece of the tax code that allows for that. The bank can set up what's called a captive insurance company and there are many other industries and types of businesses that create these insurance companies. The bank pays the premium to the insurance company. The bank can take a tax write off for that premium. It's paid to the child entity and the child entity is not taxed on that premium. They're only taxed on investment income. That's section 831 of the Internal Revenue Code. But that's sort of where we've been thus far. This industry has become much larger and there are a lot of third party players that have encouraged and assisted many different banks in getting involved in these types of activities.

And banking is not a high risk business but it's a managed risk business and risks are always there so insurance is very important. So of course the U.S. Treasury and IRS have concerns. They're always looking for abuse and the IRS has come out and said these transactions between the bank and its related party could be considered a micro captive transaction and as such it could be what's called a listed transaction of interest. And so when it becomes flagged as that type of transaction you have to report it. You have to tell the IRS that you're engaging in that transaction. If you do not report to the IRS of course there could be penalties involved and that's never good. So, IRS came out with a with a notice that basically said if your premiums don't cover 70% of the losses you could have what's called the listed transaction or transaction of interest and you have to report that. Of course this was fought very harshly in the courts. For those of you that don't know, at the federal level, there's something called the Administrative Procedures Act (APA). Every federal agency that wants to come out with a rule has to propose the rule. They have to allow for public comment and they have to take the public comment into consideration and issue a final rule. Of course, the IRS did not do that when they issued these notices, so there are some key court cases here - Mann Construction, Inc. v. U.S. in the Sixth Circuit held that when the IRS imposes a new duty on the taxpayer they have to follow the APA. CIC Services, LLC v IRS in a District Court held that this notice that we just mentioned was invalid because it failed to follow the APA.

So now what we have is that the IRS has come around again with an official APA notice and they basically said that these micro captive transactions may be listed transactions or transactions of interest. It's really the same as what they came through with before except this time that 70% ratio has been brought down a little bit to 65%. And then of course, if you're an advisor to a taxpayer now you have to report if you've got one of these listed transactions or transactions of interest. You all have sent comments on this. We have sent comments on this. This is a big deal. Obviously if you think about a

community bank it’s a managed risk business from a lot of different aspects. But your catastrophe so to speak or your risk events don’t happen on an annual basis. For example, if you’re insuring against cyber risk you may go two, three, four, five years with no cyber events and then you can have one big cyber risk event that comes to fruition. That’s why you have the insurance. It's the rainy day fund so to speak. So we've been very vocal on that front from the standpoint of a small bank, these are very small enterprises, many of them are family owned, they've been in business for 100 years or more. They're not trying to cheat anybody. They're not trying to make a huge profit. They're just trying to serve the people in their specific area and this is really straightforward. There's no need for all of this craziness with getting involved with the tax code for tax items that have been around since the 1980s. So that's kind of where we are now. There was a hearing yesterday on this. The notice of proposed rulemaking, the time limit is up on that so they'll be issuing the final rule on that and hopefully they will consider our comments.

ANY OTHER BUSINESS

Rep. Carter stated that I have one more piece of business to address. You may have seen the news last week that the Federal Departments of Health & Human Services, Treasury and Labor have released their proposed regulations dealing with issues such a short term limited duration (STLD) and fixed indemnity plans. In 2016, similar regulations were proposed and NCOIL submitted a comment letter which you can view on the website and on the app. Also, in 2020, NCOIL adopted an STLD insurance Model Act. Accordingly, following this conference NCOIL leadership and staff will review the proposed regulations and it's likely that NCOIL will comment in some manner. It is also possible that the NCOIL Health Insurance & Long Term Care Issues Committee will hold an interim Zoom meeting in September to discuss the proposed regulations and their implications. If you have any questions on this, please reach out to NCOIL staff.

ADJOURNMENT

Hearing no further business, upon a motion made by Sen. Klein and seconded by Rep. Ferguson, the Committee adjourned at 1:00 PM

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Mental Health Parity Model Act

Sponsored by Rep. Rachel Roberts (KY)

To be introduced and discussed during the Joint State-Federal Relations & International Insurance Issues Committee on November 18, 2023.

Section 1 – Definitions

(a) The following definitions apply for purposes of this Act:

(1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment. Valid, evidence-based sources reflecting generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including but not limited to patient placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

(2) "Medically necessary treatment of a mental health or substance use disorder" means a service or product addressing the specific needs of that patient, for the purpose of screening, preventing, diagnosing, managing or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

(i) In accordance with the generally accepted standards of mental health and substance use disorder care.

(ii) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(iii) Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

(3) “Mental health and substance use disorders” means a mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems, or that is listed in the most recent version of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders. Changes in terminology, organization, or classification of mental health and substance use disorders in future versions of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders or the World Health Organization’s International Statistical Classification of Diseases and Related Health Problems shall not affect the conditions covered by this section as long as a condition is commonly understood to be a mental health or substance use disorder by health care providers practicing in relevant clinical specialties.

(4) "Mental health and substance use disorder emergency services" means the continuum of services to address crisis intervention, crisis stabilization, and crisis residential treatment needs of those with a mental health or substance use disorder crisis that are wellness, resiliency, and recovery oriented. These include, but are not limited to, crisis intervention, including counseling provided by 988 centers, mobile crisis teams, and crisis receiving and stabilization services. As used in this subsection, "988 center" means a center operating in this state that participates in the National Suicide Prevention Lifeline network to respond to 988 calls.

(5) "Mental health professional" means any of the following persons engaged in providing mental health services:

(i) A physician or psychiatrist licensed to practice medicine or osteopathy under [xxxxxx];

(ii) A medical officer of the government of the United States;

(iii) A licensed psychologist, licensed psychological practitioner, certified psychologist, or licensed psychological associate, licensed under [xxxxxxxx];

(iv) A certified nurse practitioner or clinical nurse specialist with a psychiatric or mental health population focus licensed to engage in advanced practice nursing under [xxxxxx];

(v) A licensed clinical social worker licensed under [xxxxxxx] or a certified social worker licensed under [xxxxxxx];

(vi) A licensed marriage and family therapist licensed under [xxxxxxxx] or a marriage and family therapist associate holding a permit under [xxxxxxx];

(vii) A licensed professional clinical counselor or licensed professional counselor associate, licensed under [xxxxxxxx];

(viii) A licensed professional art therapist licensed under [xxxxxx] or a licensed professional art therapist associate licensed under [xxxxxxx];

(ix) A [state] licensed pastoral counselor licensed under [xxxxxxxx];

(x) A licensed clinical alcohol and drug counselor, licensed clinical alcohol and drug counselor associate, or certified alcohol and drug counselor, licensed or certified under [xxxxxx]; or

(xi) A physician assistant licensed under [xxxxxxxxx] who meets the criteria for being a qualified mental health professional under [xxxxxxxxx]; and

(6) “Mental health wellness examination" includes but is not limited to:

(i) A behavioral health screening;

(ii) Education and consultation on healthy lifestyle changes;

(iii) Referrals to ongoing treatment, mental health services, and other supports; and

(iv) Discussion of potential options for medication.

(7) “The Mental Health Parity and Addiction Equity Act” means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and any amendments to, and any federal guidance or regulations relevant to, that act.

(8) “Utilization review” means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insureds, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to insureds.

(B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in an insurance policy is covered as medically necessary for an insured.

(9) “Utilization review criteria” means any criteria, standards, protocols, or guidelines used by an insurer to conduct utilization review.

Section 2 – Ensuring Mental Health and Substance Use Disorder Medical Necessity Determinations Follow Generally Accepted Standards of Care

(a) Every insurance policy issued, amended, or renewed on or after [insert date], that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders.

(b) An insurer shall not limit benefits or coverage for chronic or pervasive mental health and substance use disorders to short-term or acute treatment at any level of care placement.

(c) All medical necessity determinations made by the insurer concerning service intensity, level of care placement, continued stay, and transfer or discharge of insureds diagnosed with mental health and substance use disorders shall be conducted in accordance with the requirements of subsections (e) and (f).

(d) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer’s behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care. All denials and appeals shall be reviewed by a professional with the same level of education and experience of the provider requesting the authorization.

(e) An insurer that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the insurer, and any entity acting on the insurer’s behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.

(f) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, an insurer shall apply the criteria and guidelines set forth in the most recent versions of the treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(g) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subsection (f), an insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subsection does not prohibit an insurer from applying utilization review

criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:

(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subsection (f), provided the utilization review criteria were developed in accordance with subdivision (e).

(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (f), provided that the utilization review criteria were developed in accordance with subdivision (e).

(h) An insurer that authorizes mental health or substance use disorder treatment shall not rescind or modify the authorization after the provider renders the health care service in good faith and pursuant to the authorization for any reason, including, but not limited to, the insurer's subsequent rescission, cancellation, or modification of the insured's or policyholder's contract, or the insurer's subsequent determination that it did not make an accurate determination of the insured's or policyholder's eligibility.

(i) An insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.

(j) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the [relevant section of code], by order, assess a civil penalty not to exceed [xxxx] for each violation, or, if a violation was willful, a civil penalty not to exceed [ten thousand dollars (xxxxx] for each violation.

Section 3 – Ensuring Coverage of Mental Health and Substance Use Disorder Benefits are at Parity with Medical/Surgical Benefits

(a) The commissioner shall implement and enforce the provisions of the Mental Health Parity and Addiction Equity Act by doing, at minimum, all of the following:

(1) proactively ensuring compliance by individual and group policies, including by requiring that insurers submit comparative analyses demonstrating how they design and apply nonquantitative treatment limitations, both as written and in operation, for mental health or substance use disorder benefits as compared to how they design and apply nonquantitative treatment limitations, as written and in operation, for medical or surgical benefits;

(2) evaluating all consumer or provider complaints regarding mental health substance use disorder coverage for possible parity violations;

(3) performing parity compliance market conduct examinations of insurers including, but not limited to, reviews of:

(A) nonquantitative treatment limitations such as prior authorization requirements, concurrent review, retrospective review, step therapy, network admission standards, reimbursement rates, geographic restrictions, and any other nonquantitative treatment limitations deemed relevant by the commissioner;

(B) denials of authorization, payment, and coverage; and

(C) other specific criteria as may be determined by the commissioner.

(4) Adopting rules, as may be necessary, to effectuate any provisions of the Mental Health Parity and Addiction Equity Act of 2008 that relate to the business of insurance.

(b) Not later than [date], and annually thereafter, the commissioner shall issue a report to relevant committees and/or elected officials and provide an educational presentation to said [relevant committees and/or elected officials]. Such report and presentation shall:

(1) Cover the methodology the commissioner is using to determine compliance with the Mental Health Parity and Addiction Equity Act and Section 1 of this Act.

(2) Identify market conduct examinations conducted or completed during the preceding 12-month period regarding compliance with the Mental Health Parity and Addiction Equity Act and Section 1 of this Act and summarize the results of such market conduct examinations.

(3) Detail any educational or corrective actions the commissioner has taken to ensure insurer compliance with the Mental Health Parity and Addiction Equity Act and Section 1 of this Act.

(4) The report must be written in non-technical, readily understandable language and shall be made available to the public by, among such other means as the commissioner finds appropriate, posting the report on the commissioner's website

(c) If the commissioner determines that an insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the [relevant section of code], by order, assess a civil penalty not to exceed [xxxxxx] for each violation, or, if a violation was willful, a civil penalty not to exceed [xxxxx] for each violation. The civil penalties available to the commissioner pursuant to this section are not exclusive and may be sought and employed in combination with any other remedies available to the commissioner under this code.

Section 4 – Increasing Access to Medications to Treat Substance Use Disorders

(a) Notwithstanding any provision of law to the contrary, beginning January 1, 20XX, an insurer that provides prescription drug benefits for the treatment of substance use disorders shall, for prescription medications that are on the insurer's formulary:

(1) Not impose prior authorization requirements on any prescription medication approved by the FDA for the treatment of substance use disorders.

(2) Not impose any step therapy requirements as a prerequisite for coverage for a prescription medication approved by the FDA for the treatment of substance use disorders.

(3) Place medications approved by the FDA for the treatment of substance use disorders on lowest tier of the drug formulary developed and maintained by the insurer.

(4) Not exclude coverage for any prescription medication approved by the FDA for the treatment of substance use disorders and any associated counseling or wraparound services solely on the grounds that the medications and services were court ordered.

(5) Not refuse to cover such medication based on whether an insured participates in counseling or wraparound services.

Section 5 - Mental Health or Substance Use Disorder Emergency Care Benefits

(a) Mental health or substance use disorder benefits shall be considered emergency care benefits for the purposes of classifications of benefits if they are provided by the following health or substance use disorder emergency services providers:

(1) A crisis stabilization unit;

(2) A 23-hour crisis relief center;

(3) An evaluation and treatment facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department of health;

(4) An agency certified by the department of health to provide crisis services;

(5) An agency certified by the department of health to provide medically managed or medically monitored withdrawal management services; or

(6) A mobile rapid response crisis team that is contracted with a behavioral health administrative services organization to provide crisis response services in the behavioral health administrative services organization's service area.

Section 6 – Coverage of Mental Health Wellness Examinations

(a) To the extent permitted by federal law, all health plans shall provide coverage for an annual mental health wellness examination of at least forty-five (45) minutes that is performed by a mental health professional.

(b) The coverage required by this section shall:

(1) Be no less extensive than the coverage provided for medical and surgical benefits;

(2) Comply with the Mental Health Parity and Addiction Equity Act of 2008, 42 U.S.C. sec. 300gg-26, as amended; and

(3) Not be subject to copayments, coinsurance, deductibles, or any other cost sharing requirements.

EXECUTIVE COMMITTEE MATERIAL

NATIONAL COUNCIL OF INSURANCE LEGISLATORS
EXECUTIVE COMMITTEE
2023 NCOIL SUMMER MEETING – MINNEAPOLIS, MN
July 22, 2023
DRAFT MINUTES

The National Council of Insurance Legislators (NCOIL) Executive Committee met at the Marriott Minneapolis City Center in Minneapolis, MN on Saturday July 22, 2023 at 12:30 PM.

NCOIL President, Representative Deborah Ferguson, DDS (AR), Chair of the Committee, presided.

Other members of the committee present:

Rep. Kerry Wood (CT)
Rep. Matt Lehman (IN)
Sen. Bob Hackett (OH)
Sen. George Lang (OH)
Rep. Forrest Bennett (OK)
Rep. Edmond Jordan (LA)
Rep. Brenda Carter (MI)
Sen. Paul Utke (MN)
Sen. Vickie Sawyer (NC)
Sen. Jerry Klein (ND)
Asw. Pamela Hunter (NY)
Rep. Carl Anderson (SC)
Sen. Mary Felzkowski (WI)
Del. Steve Westfall (WV)

Other legislators present were:

Rep. Megan Srinivas (IA)
Rep. Michael Meredith (KY)
Rep. Sarge Pollock (KY)
Rep. Rachel Roberts (KY)
Rep. David LeBoeuf (MA)
Sen. Michael Webber (MI)

Also in attendance were:

Will Melofchik, NCOIL General Counsel
Pat Gilbert, Director, Administration & Member Services, NCOIL Support Services, LLC

QUORUM

Upon a motion made by Sen. Paul Utke (MN), NCOIL Secretary, and seconded by Rep. Brenda Carter (MI), 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. Matt Lehman (IN), NCOIL Immediate Past President, the Committee voted without objection by way of a voice vote to approve the minutes of the Committee's March 12, 2023 meeting in San Diego.

FUTURE MEETING LOCATIONS

Rep. Ferguson stated that the 2023 Annual Meeting will be in Columbus, OH from November 15th-18th. For 2024, the Spring Meeting will be in Nashville, TN from April 11th – 14th, the Summer Meeting will be in Costa Mesa, CA from July 17th – 20th, and the Annual Meeting will be in San Antonio, TX from November 21st – 24th.

ADMINISTRATION

Rep. Ferguson stated that there were 338 total registrants for the Summer Meeting including 55 legislators from 30 states and of that number there were 17 first time attendee legislators from 12 states. Additionally, 5 Insurance Commissioners participated with 13 total insurance departments represented.

Will Melofchik, NCOIL General Counsel, gave the unaudited financials through June 30th of this year showing revenue of $805,969.79 and expenses of $621,184.41 leading to a surplus of $184,785.38.

Mr. Melofchik stated that the Audit Committee met on Wednesday and received the audits of both NCOIL and the Insurance Legislators Foundation (ILF) from Jim Cunningham of Collins & Company. Mr. Melofchik said that in reviewing the audits Mr. Cunningham rendered an unqualified opinion meaning the financials looked proper and up to industry standard financial practices. He also noted there was a positive change in net assets for NCOIL in excess of $300,000.

Hearing no questions or comments, upon a Motion made by Rep. Lehman and seconded by Rep. Forrest Bennett (OK), the Committee voted without objection by way of a voice vote to accept the audits.

CONSENT CALENDAR

Rep. Ferguson 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 and staff in the time between Executive Committee Meetings.

The Consent Calendar included:

- The Health Insurance & Long Term Care Issues Committee adopted the NCOIL Hospital Price Transparency Model Act and the NCOIL Biomarker Testing Insurance Coverage Model Act.

- The Financial Services & Multi-Lines Issues Committee adopted the NCOIL Federal Home Loan Bank (FHLB) Insurer-Member Model Act and a Resolution in Support of Existing Law Exemptions for New Data Privacy Laws.

- The Articles of Organization & Bylaws Revision Committee adopted amendments to NCOIL Articles of Organization & Bylaws.

- The Workers' Compensation Insurance Committee readopted: Model Act on Workers' Compensation Coverage for Volunteer Firefighters; Workers' Compensation Pharmaceutical Reimbursement Rates Model Act; Construction Industry Workers' Compensation Coverage Act; and Model Act Regarding Workers' Compensation Insurance Coverage in Professional Employer Organization (PEO) Relationships.

- The Property & Casualty Insurance Committee readopted: Consumer Protection Towing Model Act, Model Act Regarding Auto Airbag Fraud; Model Act Regarding Disclosure of Rental Damage Waivers; Model Anti-Runners Fraud Bill; Model State Uniform Building Code (until the Annual Meeting); and Property and Casualty Insurance Domestic Violence Model Act.

- The Life Insurance & Financial Planning Committee adopted a Resolution Opposing the Return of a U.S. Department of Labor Fiduciary Rule.

- Ratification of decisions made and actions taken by the NCOIL Officers and staff in the time between Executive Committee Meetings.

Rep. Ferguson said that amendments were adopted during the NCOIL Articles of Organization & Bylaws Revision Committee (Committee), but after that Committee concluded, there were some discussions about perhaps making some language clearer. She then removed those amendments from the consent calendar and stated that the Committee will work on improving that language going into the Annual Meeting in November. Upon a motion made by Rep. Lehman and seconded by Del. Steve Westfall (WV), the Committee voted to adopt the consent calendar, with the amendments to the bylaws having been removed from said calendar, without objection by way of a voice vote.

NEW EXECUTIVE COMMITTEE MEMEBERS

Rep. Ferguson stated that 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. As such, Rep. Michael Meredith (KY), Chair of the KY House Banking & Insurance Committee and Asm. David Weprin (NY), Chair of the NY Assembly Insurance Committee should be added to the NCOIL Executive Committee.

Rep. Ferguson then asked if anyone else would like to make any nominations to the Executive Committee.

Rep. Bennett stated that he would like to nominate Rep. Sarge Pollock (KY), Rep. Rachel Roberts (KY), and Rep. David LeBoeuf (MA).

Rep. Carter stated that she would like to nominate Rep. Megan Srinivas (IA). Rep. Ferguson informed her that since Iowa is not a dues-paying NCOIL Contributing State, Rep. Srinivas is not eligible to serve on the Executive Committee.

Upon a motion made by Rep. Lehman and seconded by Sen. Hackett, the Committee voted without objection by way of a voice vote to add Rep. Meredith, Rep. Pollock, Rep. Roberts, Rep. LeBoeuf, and Asm. Weprin to the Executive Committee.

OTHER SESSIONS

Rep. Ferguson stated that the Institutes Griffith Foundation held a legislator luncheon during which Professor Paul E. Traynor gave a great presentation titled “Litigation Roundup: The High Court and the Circuits Speak on Insurance.”

There were also three interesting and timely general sessions including: Part two of our year-long series of general sessions focused on Environmental, Social, and Governance (ESG) Policy; Silicon Valley Bank, Signature Bank, and First Republic Failures: Are We in a Banking Crisis?; and The Ongoing Effort to Achieve Mental Health Parity.

The keynote speaker was Professor Jill Hasday of the University of Minnesota Law School who gave a highly interesting and informative keynote address discussing the Supreme Court’s recent landmark decisions.

RESOLUTION HONORING PAST PRESIDENT SEN. CARROLL LEAVELL (NM)

Rep. Ferguson stated that Sen. Carroll Leavell (NM), former NCOIL President, passed away recently at the age of 86. Rep. Ferguson asked the Committee if anyone would like to say a few words about him.

Rep. Lehman stated that Sen. Leavell was someone he looked up to when he first came to NCOIL as someone who led by example, was very pragmatic, and exemplified leadership. As Rep. Lehman began serving in the NCOIL leadership, Sen. Leavell was a model for him as well as a great leader in New Mexico. Rep. Lehman stated Sen. Leavell was very dedicated to his family and that this Resolution honoring him is well crafted and well deserved for our former President.

Rep. Ferguson said she remembered meeting Sen. Leavell when he served as President and she noted that it was well known how he treated everyone with dignity and that he represented what a statesman really is.

Upon a Motion made by Sen. Jerry Klein (ND) and seconded by Sen. Hackett, the Committee voted unanimously to adopt the Resolution by way of a voice vote.

ANY OTHER BUSINESS

Paul Martin, Vice President of State Relations for the Reinsurance Association of America (RAA), stated that the RAA and State Farm on behalf of the Industry Education Council (IEC), suggest NCOIL have a future session centered on inflation. There has been a lot of news on inflation relating to rates, future expected lost costs, and interest rates. There are good resources and speakers who can come and have a good discussion on the impacts of inflation.

Rep. Lehman stated since it looks like we are moving into a hard market for the first time in over a decade, it would be interesting to tie that into not just inflation but what legislators will be facing as we move into a hard market in terms of both access to the market and premiums.

Rep. Ferguson concluded by stating that this was a great conference and she appreciates everyone participating and is pleased to see NCOIL continue to get better and better.

ADJOURNMENT

Hearing no further business, upon a motion made by Rep. Carter and seconded by Del. Westfall, the Committee adjourned at 1:00 p.m.

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CHIEF EXECUTIVE OFFICER: Thomas B. Considine

National Council of Insurance Legislators (NCOIL)

Model Act to Support State Regulation of Insurance Through More Informed Policymaking

Adopted by the NCOIL Executive Committee on December 8th, 2018
****Sponsored by Asm. Ken Cooley, CA***

****To be considered for re-adoption during the Executive Committee meeting on November 18, 2023.***

Preamble:

The purpose of this Law is to secure more informed legislative oversight of the insurance industry. Under the McCarran-Ferguson Act, 10 U.S.C. § 1011, primary responsibility for setting insurance regulatory policy rests with the States. In order to regulate a large, sophisticated industry in interstate commerce, the States must work together to, among other things, develop model insurance legislation. Most such model laws, however, are written not by legislators but rather by executive branch officials, through the National Association of Insurance Commissioners (NAIC).

State insurance commissioners act at NAIC in large part operating under a delegation of authority from the states' legislative branch, but without oversight of state legislators. Although technically NAIC models must be passed in the States, in reality, the most important models are mandated under the NAIC accreditation system.

NAIC, a fully funded 501(c)(3), generates almost all of its approximately $100 million budget from funds generated through its members' status as government regulators. Today that funding base has diversified to include assessments of licensees mandated to use NAIC's services by insurance commissioners, but a key original funding source that allowed NAIC to grow to where it is today was NAIC bylaws-required assessments of member States.

Due to the fact that State legislators must be educated about the complexities of insurance public policy, and be kept abreast of developments and trends in insurance markets and regulation in order to be able to work together as lawmakers to draft appropriate national model legislation, State Legislators specializing in insurance-related issues organized the National Council of Insurance Legislators (NCOIL) in 1969. State insurance budgets

should ensure that both NAIC and the NCOIL are properly supported to ensure the purposes set forth in this Preamble.

Section 1. Purpose

The purpose of this Act is to ensure that NAIC and NCOIL are properly supported to ensure that insurance public policymakers are kept informed concerning issues which are dependent upon legislative authority for their positive resolution and which are being debated by state regulators. This Act will further amend a State's insurance code provision establishing the powers and duties of the office of Insurance Commissioner to require that State Insurance Commissioner shall make a presentation, or coordinate with the NAIC for such a presentation to be made, which can inform Members of key policy and fiscal oversight committees, at least every other year, on the status and activities of the National Association of Insurance Commissioners and the role therein of legislative delegation and incorporation by reference of existing or future NAIC policy adoptions. Finally, to support the informed exercise of legislative delegation in the field of insurance regulation, this measure will require the insurance commissioner to support more informed participation by key policy and budget legislators in the NCOIL and NAIC process.

Section 2. Insurance Department and Legislative Participation in NAIC & NCOIL

(a) The State Insurance Commissioner, (during even numbered years or the first year of each legislative biennium) shall appear before each insurance committee of this state, and as optionally determined by the Committee on Rules of each House, each budget committee, to provide a presentation on the National Association of Insurance Commissioners accreditation process. The presentation shall provide an overview of the role of the delegation of legislative authority for policy development which enables the NAIC accreditation process to function.

(b) This presentation shall provide an explanation, including citations to the relevant sections of state law which reflect NAIC accreditation standards or incorporation of existing NAIC rules, standards and processes by reference.

(c) Provisions of state law which can operate to authorize future NAIC changes to be operative in this state without additional authorization by the Legislature shall be identified in a standalone format which highlights the future delegation authority as it appears in existing law or regulation of this state.

(d) The presentation shall further provide an overview of the minimum NAIC accreditation standards pertaining to (1), Laws & Regulations, (2), Regulatory Practices & Procedures, and (3), Organizational & Personnel Practices. The Commissioner shall provide an overview of the specific laws and regulations which the accreditation standard specifies, the intended purpose of each, when they were adopted by the NAIC and in this state, and any changes to any of these standards since the last briefing provided to the Legislature pursuant to this provision.

(e) This presentation may be done at a hearing that is held jointly with the relevant House and Senate standing committees and budget committees.

(f) The Insurance Department shall put in writing the information which is required to be provided or presented in accordance with subdivisions (a), (b), (c), (d), and (e), and will share that information along with any updates either yearly or once during each biennium session with relevant policy committees.

(g) In lieu of the presentation specified in Subdivisions (a), (b), (c), (d) and (e) above, the Insurance Department may coordinate with the National Association of Insurance Commissioners to conduct a similar training session during any NAIC National Meeting in which case the Department of Insurance shall provide from its general operating funds necessary expenses for registration and reimbursement for reasonable food, travel and lodging during the National meeting for no more than two policy committee members from each house and one budget committee member.

> ***Drafting Note:*** *States may opt to revise Section 2(g) pertaining to whether the source of funding for legislator participation at an NAIC National Meeting is sourced from the State Insurance Department or from the State's General fund or other fund.*

(h) In the event that the NAIC opts to conduct training for lawmakers, the following conditions must be met:

(i) the information provided in association with the training must be provided in writing.
(ii) the training must be held in a forum that is open to the public.

(i) The Insurance Department shall report, in writing, annually or once for each legislative biennium on the nature of its NAIC participation, including such matters as the number of staff attending NAIC meetings, the key policy issues of interest to the state that staff are participating in the development of, and what the state Insurance Department is specifically advocating on those topics of state interest.

(j) Information provided in accordance with subdivisions (f), (h), and (i) of this section shall be made available online via a publicly accessible website.

(k) The Department of Insurance shall annually from its general operating funds provide funding for the state's membership in, and reasonable food, travel and lodging sufficient to provide for the chairmen and ranking members of the House and Senate insurance committees of jurisdiction, and the budget committees, to fully participate in the National Council of Insurance Legislators.

Drafting Note: *States may wish to revise Section 2(k) pertaining to whether the source of funding for legislator participation in NCOIL is sourced from the State Department of Insurance or from the State's General fund or other fund.*

Section 3. Effective Date

This Act shall take effect _____